Self-Injury and Self Capacities: Assisting an Individual in Crisis

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This article reports findings of a study on self-injury, childhood abuse, and self capacities that supports a theory for understanding and assisting self-injuring individuals in crisis. In the study, 233 adults from partial hospital settings and an outpatient clinic answered questions concerning self-injury, abuse history, and three self capacities (the ability to tolerate strong affect, the ability to maintain a sense of self-worth, and the ability to maintain a sense of connection to others). More than 60% reported childhood abuse. More than half reported self-injury. Individuals with a history of self-injury showed greater impairment of self capacities than individuals who did not report self-injury. Individuals with a history of childhood abuse showed greater impairment than did individuals who did not report childhood abuse. Greatest impairment was associated with both self-injury and abuse. Implications of the results are explored and the theory for assisting self-injuring individuals in crisis is presented. © 2000 John Wiley & Sons, Inc. J Clin Psychol 56: 1173–1191, 2000

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Emergency and other clinical practitioners frequently care for individuals who have deliberately harmed their own bodies. When confronted with the physical consequences of such behavior, treatment providers may respond with anger, confusion, pity, frustration, or other strong reactions. Providers are better able to help when they understand the psychological meanings and functions of self-injury. They can help by exploring the meanings and purposes of the behavior and assisting the client in developing short-term strategies for managing distress—specifically, the distress around interpersonal connection, affect and self-esteem, since they often underlie self-injury. In this article, the authors briefly review some of the psychological literature on self-injury and present results of a recent study. Results provide support for a theoretical framework for understanding and addressing self-injury in emergency settings, which was presented by Deiter and Pearlman (1998) and is reviewed here in light of new findings.

It is difficult to estimate the number of people who engage in self-harming behaviors, in part because the behaviors may be hidden or hard to identify. However, Briere and Gil (1998) found that 4% of the general population and 21% of a clinical sample reported self-injury during the six months prior to data gathering, and that self-injury was prevalent equally among men and women. Favazza, DeRosear, and Conterio (1989) found that 14% of a college sample had engaged in direct self-injury at least once. Favazza et al. suggested that self-injury is present in as many as 40% of individuals with bulimia, and 24 to 34% of selected other clinical populations (Conterio & Lader, 1998). Walsh and Rosen (1988) estimated the number of individuals self-injuring in the United States at up to 1.4 million per year, and reported that epidemiological researchers consistently have cited an increased incidence of self-harm behaviors since 1965. Conterio and Lader (1998) wrote, ". . . self-injury has become pervasive in the United States and all signs indicate it is growing. The syndrome is more prevalent than most people think and yet it is still grossly under-reported and misdiagnosed" (p. 20). They noted a pattern of increased attention to self-injury in the media and among high-profile individuals, including popular musicians, actors, and the late Princess Diana, among others.

In this article, the authors use the term "direct self-injury" to refer to deliberate acts resulting in damage to one's own body tissues when these acts are not intended to bring about death. Familiar forms of direct self-injury are cutting, burning, or scratching at one's skin, especially on wrists and forearms. Direct self-injury may take many other forms, including destruction of oral tissues, nails, cuticles and other tissue through biting, self-hitting, hair pulling, swallowing and insertion of objects into the body, injurious masturbation, head banging, scalding, and aggravation of chronic wounds. Other forms of deliberate, indirectly self-harming behavior occur, and may be seen along with direct self-injury in a patient in crisis. These include problematic eating and elimination behaviors, risky sexual behaviors, substance abuse, neglect of medical needs, and nonsexual risky behaviors like handling weapons, driving recklessly, and provoking aggression from dangerous others.

Self-injury presents a number of challenges to the clinician. The behavior may appear bizarre, disturbing, or inexplicable. Treatment can be time-consuming, complicated, and frustrating for both the clinician and the self-injuring individual. Level of risk may be dynamic and hard to assess. It may not be possible to protect the individual from danger. The difficulty of assessment and treatment may provoke desire to take control of the self-injuring individual. Frances (1987) wrote, "The typical clinician (myself included) treating a patient who self-mutilates is often left feeling a combination of helpless, horrified, guilty, furious, betrayed, disgusted and sad" (p. 316). These difficulties can result in failed attempts to make a meaningful connection with the self-injuring person, or to make an impact on self-injuring behavior. "Too often a struggle emerges between the

client and the therapist in which the client feels misunderstood and the therapist feels ineffective and overwhelmed" (Himber, 1994, p. 620).

Addressing self-injury especially is challenging in emergency settings, for at least three reasons. First, emergency work often is done without cues of context and relationship; treatment providers may not know the individual, the individual's resources, history, or the stressors that led to this crisis. The treatment provider may not see the person afterward, and thus may never have assurance that the individual benefited from the emergency intervention. Alternatively, the provider may see the same client repeatedly in crisis, but never see the person's everyday strength or periods of positive progress. This can lead to a sense of frustration, anger, or inadequacy for both the provider and the patient in crisis. Second, issues of time and legal liability tend to be pressing in emergency settings. Self-injuring patients may require a great deal of time to assess and treat, while providing little assurance of future safety. The provider may be called upon to provide opinions about behavior that resembles, but does not match exactly, suicidal behavior, creating tension and uncertainty for the provider. Third, the provider is faced with a patient who is in crisis around a complex, often secret behavior, which is also a serious and poorly understood symptom of distress. The patient is likely to be highly stressed and afraid, and quite possibly mistrustful of those who say they want to help. These factors can make it difficult to establish a therapeutic rapport.

Bongar, Peterson, Golann, and Hardiman (1990) conducted a study of patients seen in a psychiatric emergency room. They concluded that almost 80% of the patients whom they saw repeatedly and treated as "chronically suicidal," actually could be considered deliberate self-harmers. The group of patients identified as chronically suicidal in that study comprised 1% of patients seen in the psychiatric emergency service in the year studied, but accounted for 12% of the visits to the service that year. Fennig and Fennig (1992) wrote about such patients, "While their number is small in comparison to other disorders, they consume a disproportionate amount of energy in terms of time and emotional involvement" (p. 318).

A history of abuse during childhood is emerging in the literature as an important factor in later self-injury. Van der Kolk, Perry, and Herman (1991) reported that 79% of adults who reported self-cutting also reported a history of childhood physical abuse; 89% reported traumatic disruption of parental care leading to neglect. Tobin and Griffing (1996) reported that 80% of 40 eating-disordered patients who reported direct self-injury had been abused sexually. Strong (1998) observed among self-injurers "a range of painful childhood experiences, including emotional deprivation, physical neglect, emotional abuse, physical abuse, sexual abuse, and childhood loss" (p. 43). Favazza reported that over half the people who engage in direct self-injury have had "hellish childhood experiences, involving physical and psychological abuse and the prolonged absence of love, nurturing, and physical contact" (Strong, 1998, p. 6).

Some research suggests that earlier abuse and more severe abuse leads to more, and more severe, self-injury. "In adult survivors of childhood sexual abuse, severe self-injury shows a positive correlation to greater frequency, severity and sadism of early abuse" (Calof, 1995, p. 11). Romans et al. (1995) reported in their sample "a clear statistical association between sexual abuse in childhood and self harm that was most marked in those subjected to more intrusive and severe abuse" (p. 1336). Van der Kolk, McFarlane, and Weisarth (1996) reported that, in their sample, childhood sexual abuse before the age of 13 was related more strongly to adult self-injury than were other forms of childhood trauma. In a review of the childhood-sexual-abuse literature, Polusny and Follette (1995) identified self-mutilating behavior as a long-term correlate of sexual abuse in childhood, as did Neumann (1995) in a meta analysis of the empirical literature on the same subject.

The literature identifies several other trauma-related factors associated with later self-injury. These include chaotic and neglectful childhood homes, childhood separation from caregivers, parental alcoholism, early surgical trauma, and residence in a full-care institutional setting.

When it is viewed within constructivist self development theory (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995)—the theoretical framework presented in this article—self-injury can be understood as an adaptive behavior with idiosyncratic meaning and defensive purpose. The theory describes three self capacities, which are developed within the context of a psychologically healthy childhood environment, and which allow individuals to tolerate strong affect, maintain a sense of self-worth, and maintain a sense of connection to others. Childhood abuse profoundly interrupts the development of these self capacities. The authors believe that self-injury is one common outcome when these self capacities are impaired. Further, the authors believe that addressing the distress that results from impaired self-capacities, and facilitating the long-term work of building self capacities, can lead to the cessation of self-injury. This perspective helps treatment providers to take a position of respect and collaboration with self-injuring individuals, facilitating better understanding and more effective interventions.

A Study of Self-Injury and Self-Capacities

The authors conducted a study examining the relationship among self-injury, childhood abuse, and self-capacities in 233 adults.

Method

Sample. Participants were volunteers drawn from two types of sites: partial hospital-treatment centers, where clients attend an intensive hospital outpatient program for several hours a week, and an outpatient psychotherapy clinic, where clients take part in approximately weekly individual psychotherapy. These settings provide therapies for general psychological issues and for specific concerns including trauma. Self-report data were collected using paper-and-pencil questionnaires. Sites were in the same geographic region, within a 60-mile radius.

Measures. Self-injury was assessed with a checklist of 17 self-injurious behaviors, including direct self-injury behaviors (cutting, burning, hitting, punching, biting, scratching, head-banging) and indirect self-harming behaviors (behaviors in the following categories: problematic eating and elimination; high-risk sexual activities; substance abuse; nonsexual risky behaviors). Participants were asked to indicate whether they had ever engaged purposely in each behavior in order to hurt themselves. This questionnaire was adapted from one that Sakheim and Stanek (1994) developed with the collaboration of patients in a trauma-focused partial hospital program. It has been used for clinical assessment of partial hospital patients and to guide partial hospital staff in theory and treatment (Sakheim & Stanek, 1994). It was used here to determine whether subjects reported direct self-injury.

Abuse history was assessed using the Traumatic Stress Institute (TSI) Life Event Questionnaire (MacIan & Pearlman, 1992). This is a 19-item measure listing traumatic life experiences. Respondents indicated (a) whether they had the life experience, and (b) if so, at what age or ages. The scale was used here to determine whether participants reported physical, sexual, or combined forms of abuse in childhood.

Disruption in self capacities was measured using the TSI Inner Experience Questionnaire (IEQ). The IEQ is a 24-item questionnaire assessing three self capacities (the ability to tolerate, manage, and integrate affective experience; the ability to maintain a sense of self as viable, benign, and positive; and the ability to maintain a sense of inner connection with others). Respondents indicate level of agreement with statements using a Likert scale of 1 to 5. Scores obtained include a total score (24 items) and three subscale scores (eight items each). The instrument is in development at the Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy LLC. The full scale and subscales demonstrated good internal consistency with coefficient α of .93 for the full scale and .81 to .92 for the subscales. The scale demonstrates acceptable correlations with the TSI Belief Scale (total score correlation = .82) and the 10 scale scores of the Briere Trauma Symptom Inventory (range of correlations .19–.66), suggesting acceptable convergent and divergent validity at this stage of development. It performed similarly in a subsequent study (Litzenberger, Robohm, & Pearlman, 1999). It was used here to yield a full-scale score. A higher score indicates greater impairment in self-capacities.

Results

The mean age for the sample was 38 years, with an age range of 18 to 77 years (SD = 10.93). The sample was 75% female.

Both childhood abuse and direct self-injury were common among participants. Fifty-eight percent of participants reported a history of direct self-injury. Sixty-nine percent reported a history of childhood abuse. Forty-seven percent reported a history of both childhood abuse and direct self-injury.

A 2 (direct self-injury vs. no direct self-injury) by 2 (childhood abuse vs. no childhood abuse) analysis of variance (ANOVA) was conducted to determine whether full-scale IEQ scores differed based on reported self-injury and childhood abuse. A main effect for direct self-injury $F(1,226) = 28.83$, $p < .001$ revealed that participants who reported a history of direct self-injury showed significantly higher IEQ scores (i.e., greater self-capacities impairment). A main effect for childhood abuse $F(1,226) = 10.921$, $p < .001$ revealed that participants who reported childhood abuse also showed significantly higher scores. An interaction between direct self-injury and childhood abuse was revealed $F(1,226) = 4.055$, $p < .045$. The interaction showed that the highest IEQ scores were associated with histories of both self-injury and abuse (see Fig. 1), followed by scores for individuals reporting self-injury without a history of childhood abuse.

Summary

In this sample of individuals in partial hospital treatment and outpatient psychotherapy, a history of direct self-injury was common. More than half the participants reported a history of direct self-injury. A history of childhood abuse also was common, with more than half the participants reporting that they experienced abuse in childhood. Forty-seven percent reported both direct self-injury and a history of abuse in childhood. This amplifies the importance of sensitive and thorough interviewing about history when assessing an individual in a self-injury crisis.

Individuals who reported self-injury, when compared to individuals who did not report self-injury, indicated greater impairment in self capacities (abilities to tolerate strong affect, maintain a sense of self-worth, and maintain a sense of connection with

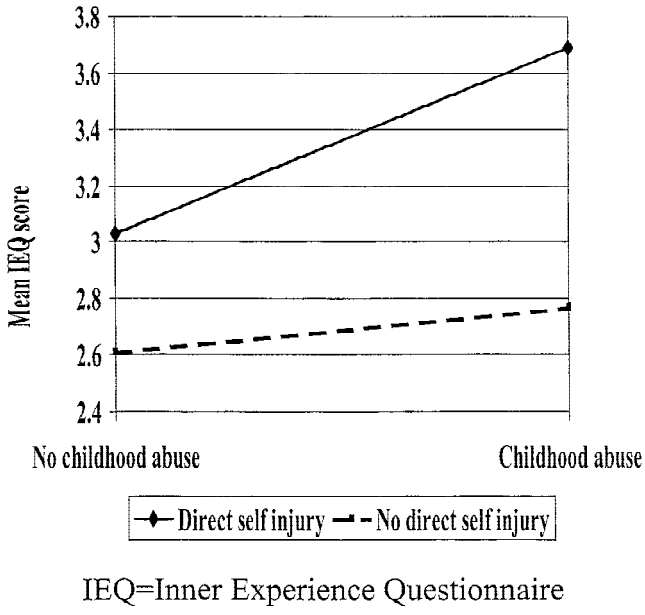

Figure 1. Self-injury, childhood abuse, and mean IEQ scores.

others). The authors believe that impaired self capacities can give rise to self-injury, and that attention to the development of self capacities is important in relieving self-injury.

Individuals who reported childhood abuse, when compared to individuals who did not report childhood abuse, indicated more impairment in self capacities. The authors believe that self capacities cannot develop fully in an abusive childhood environment, and that the resulting impairments contribute to many problems in living, including, as noted above, the development of self-injury (Pearlman, 1998).

The greatest level of self capacities impairment was observed in individuals who reported both direct self-injury and a history of childhood abuse. This indicates that self-injuring individuals who reported a history of childhood abuse showed the greatest trouble with abilities to tolerate strong affect, maintain a sense of self-worth, and maintain a sense of connection with others. Individuals who reported self-injury without childhood abuse showed the next-highest level of self-capacities impairment. Self-injuring individuals, whether or not they were survivors of childhood abuse, reported more self-capacity impairment than individuals who did not report self-injury.

Self-injury may emerge as a compensatory strategy when self-capacities are not developed fully. Attention to self capacities can guide intervention around self-injury, and the authors believe that long-term work on self-capacities can lead to the cessation of self-injury. The theory that informs this view is presented below, with attention to practical issues in assisting the self-injurer in crisis.

Limitations of this study include the type of data collected on self-injury. Self-injury was explored as a set of behaviors that one had ever done, with no attempt to measure recency, frequency, or severity of behaviors. It also should be noted that this study relied on paper-and-pencil measures and self-report; responses could be influenced by problems with reading, comprehension, concentration, and issues of bias in responding. The sample also had limitations. Participants were volunteers who agreed to complete questionnaires, as opposed to a random sample of outpatients and partial hospital patients. As

noted above, this sample included some individuals seeking trauma-specific psychological services. This limits the generalizability of results. Finally, this study suffers from a limitation in measures, because the Inner Experience Questionnaire is still in development and has not been validated independently or normed on clinical and nonclinical samples.

Results presented here make it clear that assisting individuals who self-injure requires sensitivity to the distress underlying self-injury, the possibility of past trauma, and awareness of the probability of connection between them. A psychological theory of the impact of traumatic experiences can provide a framework for treatment providers and survivors in their work together, making self-injury understandable and guiding treatment. This framework can guide providers in work with self-injurers who do not report a trauma history, as well.

Constructivist Self Development Theory Framework

Constructivist self development theory (CSDT; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995) views the impact of traumatic experiences as unique to every individual. The impact is determined by an interaction of aspects of the event that are psychologically meaningful to the individual, with aspects of the individual, including psychological resources, defenses, and needs. The impact of traumatic experiences is shaped further by the cultural and social context within which they occur. Constructivist self development theory delineates aspects of the self that are impacted by trauma. These include frame of reference, psychological needs, ego resources, the memory system, and self capacities.

This article focuses on self-capacities because of their connection to self-injurious behaviors, posited by theory presented by Deiter and Pearlman (1998) and supported in the research reported here. The development of self capacities is central to work with self-injurers who are survivors of trauma, including childhood abuse (Deiter & Pearlman, 1998; Saakvitne, Gamble, Pearlman, & Lev, 2000). In emergency interventions, interviewing for self capacities allows the treatment provider to identify areas of need and strength. In addition, the provider and client can develop temporary measures to shore up or increase self capacities to help the client through a crisis. Constructivist self development theory describes three self capacities, or inner abilities, people require in order to maintain a sense of self and to maintain a state of internal balance. They are the ability to maintain a sense of connection with others, the ability to experience, tolerate, and integrate strong affect, and the ability to maintain a sense of self as viable, benign, and positive.

The authors believe that self capacities are not developed fully in abusive or neglectful homes (Pearlman, 1998). The capacity to maintain a sense of connection with others is the basis from which affect regulation and self-worth develop. Ideally, connection to others is fostered by early, empathic, and consistent care from loving others; that is, in the context of Bowlby's "secure base" (1981). The adult survivor with impaired self capacities may live in alienation instead of connection, experience terrible affects that he or she cannot soothe, and experience him or herself as toxic, unworthy of living or unable to live.

The ability to maintain a sense of connection cannot develop fully when empathic attunement, affection, and nurturance are lacking. When children experience shaming and punitive rhetoric or physical blows, rather than responsive words, there can be no effective internalization of loving others. Instead, the images and voices the individual internalizes are challenging, harsh, and mocking.

The ability to experience, tolerate, and integrate strong affect cannot develop fully when strong feelings are met with punishment or derision and need and longing are met with neglect or humiliation. The child learns not to want and not to need. In order to accomplish this, he or she also must learn not to feel. Thus, numbing, dissociation, or self-punishment (through words of reprobation or through actions of self-harm) may become natural responses to, or substitutes for, feelings.

Finally, the ability to maintain a sense of self as viable, benign, and positive cannot develop fully when a child's existence and accomplishments are met with silence or abusive words or actions. The child does not learn that she/he is a person of value. Rather, the lesson is existential self-doubt and self-loathing.

The theory views self-injury as one adaptation that helps the survivor live through the inner life that has resulted from the original abusive environment. So-called symptoms, such as self-injurious behavior, then may be viewed as adaptations to powerful psychological circumstances rooted in otherwise impossible developmental conditions (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne et al., 2000). Further, such symptoms can be used positively by the self-injurer and the clinician to learn more about areas of strength, weakness, and openness to change.

Self Capacities and Meaning in Self-Injury

When self capacities are impaired, self-injury may serve as a substitute for their essential regulatory functions. We review below some meanings and functions of self-injury for individuals lacking full development of self capacities. (See Nicholls, Deiter, & Pearlman, 1999, for a presentation of data on clients' reported reasons for self-injury.)

Connection. When the capacity to maintain an inner sense of connection with others is impaired, self-injury can serve to manage the work of connection. Self-injury can be a way for a client to manage conflict with the therapist internally, since interpersonal conflict might feel like annihilation. Self-injury might demonstrate loyalty to perpetrators and symbolize identification with the aggressor. This can serve to assure oneself that the connection with early caregivers is not destroyed through awareness of their sadism and inadequacy in the face of the child's needs. In therapy, as awareness of the injustices experienced by the child grows, self-injury might emerge or increase in an effort to protect abusive caregivers. Self-injury also can be a way of taking control of victimization—being the one to decide when, how, and how much one will be injured can provide a sense of mastery of the roles of victim, aggressor, and helpless witness that the child was forced to live out during abuse, an experience Miller (1994) has termed the "tripartite self." Self-injury at times may be an effort to obtain recognition, attention, or other forms of interpersonal connection that are sometimes identified as secondary gain. Such efforts demonstrate the level of desperation a trauma survivor may experience in the effort to connect.

Affect Regulation. If the capacity to experience and tolerate strong affect is impaired, self-injury may serve as a solution. The rituals and sensations around it are generally experienced as reducing unbearable tension, that is, self-soothing for individuals who have never had the opportunity to internalize a soothing other. Self-injury can serve as punishment for affect that is forbidden or split off. It can be a way to deal with sexual feelings, especially if sexual abuse has linked together terror, pain, and sexual feeling (Davies & Frawley, 1994). Self-injury also is used commonly to manage depersonaliza-

tion and more extreme levels of dissociation. Some clients report that it is useful to induce dissociation or trance; others report that it brings them back to their bodies and to physical sensation, reducing the dysphoria or the terror of prolonged dissociation. Self-injury can be used to invoke a sense of safety and relief. If abuse is inevitable, its occurrence removes dread and terror. If the safest times of a child's life are the hours following an abusive episode, the aftermath of abuse may feel comforting and safe (Calof, 1994; Sakheim, 1996). Finally, tissue self-injury has a physiological component, releasing endorphins into the system, which provide a shift in affective state (van der Kolk, 1994).

Expressing or externalizing affective states is a primary function of self-injury, and developing new ways of expressing affect is central to the treatment of trauma survivors. Calof (1996) has written in detail about the difficulty childhood-abuse survivors experience in feeling, naming, and comprehending anger (a condition termed alexythymia by Krystal in 1978). The individual moves from arousal to action without mediating stages of feeling awareness, feeling identification, feeling expression, and self-soothing. This rapid and unmediated movement from arousal to action is demonstrated in the rising sense of tension that self-injurers describe, their preoccupation with achieving self-injury, and the sense of relief that follows the act.

Self-Worth. When the capacity to maintain a sense of self as viable, benign, and positive is impaired, self-injury serves a host of functions. It may be used for purification, transcendence, or penance, as in mystical practices. It may provide punishment and degradation of the unworthy self. It may serve to reassure the survivor that he or she is a human being—flesh and blood—pretty much like others. It may serve to threaten or remind the individual of her/his intrinsic vileness, and of her/his fragile hold on the world of other people. It also may serve to reassure the individual that she/he is, indeed, tough, resilient, able to take abuse, and carry on.

Calof (1995) noted that much of the logic that governs self-injury is "trance logic." Trance logic may include elements of primary process, magical thinking, and affect-driven problem solving. It may be marked by dissociated memories and related functions of self-injury. Miller (1994) described a Trauma Reenactment Syndrome. In this syndrome, individuals who persistently injure or abuse their bodies are understood as unconsciously reenacting elements of past abuses they have endured. Walsh and Rosen (1988) identified a series of events, feelings, and behaviors that individuals experience in both an episode of child abuse and an episode of self-injury. They, too, clearly elucidated the relation between past abuse and current self-injury. Bearing in mind the idiosyncratic and unarticulated meanings possible in trance logic, reenactment can help clinicians and clients together understand self-injury. A perspective of curiosity, openness, patience, and respect can help the client and the treatment provider when the meaning of self-injury is not yet clear.

Assisting during a Self-Injury Crisis

Constructivist self development theory (CSDT) provides a way to understand self-injury and a framework for a therapeutic response. This particularly is important in emergency settings, where contact may be brief and clinical information minimal. CSDT allows the treatment provider to move with respect and purpose to assist the self-injuring individual in a crisis. Within this framework, four organizing principles guide intervention. They are

1. return control to the individual in crisis,
2. interview for self capacities,

3. develop short-term strategies to shore up self capacities, and
4. link self-injury to an external or internal antecedent event.

The treatment provider should facilitate medical care first, then assess the interpersonal context of the encounter. The intervention process we describe here applies to all persons who present with self-inflicted injuries, including those who are not childhood trauma survivors.

Medical Care and Interpersonal Context

If medical care is required, some general principles are important. Medical and other providers should avoid punitive and shaming responses; avoid expressing shock, disbelief, or horror; avoid being very solicitous, pitying, or engaged by the behavior. They should attempt to provide low-key, dispassionate, matter-of-fact, and medically appropriate care. They should ask the individual about general comfort in the setting and about level of pain. The should ask permission to touch the individual if touching is required. They should give a description of necessary medical procedures and answer any questions.

In responding to self-injury, the mental health professional's role in staff education and patient advocacy is as crucial as her/his role in psychological assessment. In some settings, it is common to provide punitive treatment, e.g., refusing care, stitching cuts without anesthetic, failing to educate about pain management, shaming the patient, or judging or diagnosing the patient without a psychological assessment or a therapeutic goal. Without education and advocacy, the stage may be set for negative outcomes for the patient and the staff, including retraumatization, power struggles, patient alienation from helping professionals, invitation for the client to work for secondary gains or to attempt to punish providers (i.e., the establishment of a traumatic bond between the patient and caregivers), and even lawsuits.

In the often-rushed and impersonal climate of emergency settings, attention to the interpersonal context is an especially important beginning in responding effectively to the self-injuring patient. The first issue is willingness to take part in the crisis intervention. A person who was pressured or forced to an emergency room will feel and behave differently from someone who is seeking emergency assistance.

For many trauma survivors, encounters with medical providers have been traumatic. A suspicious attitude toward powerful others whose formal role is to help is a natural outcome of childhood abuse. It is essential that the provider be direct, honest, and respectful of the patient, behaving in a trustworthy way without expecting unearned trust. Childhood-abuse survivors are attuned exquisitely to manipulation and deception, and the encounter cannot succeed if the provider is behaving in an authoritarian, indirect, or otherwise disrespectful manner. The provider should elicit questions and feedback throughout the course of the interview.

The encounter should begin with introductions, in which the provider states his or her name and role and the purpose of this contact. If others have accompanied the patient, the provider should check with the patient about whether she/he wants them to stay or to leave, and respect the patient's stated wishes. If other treatment providers are present, the main provider should introduce them and explain their roles, remaining sensitive to the meanings of being observed and objectified to a childhood-abuse survivor.

If the client has a psychotherapist, the therapist should be contacted with the client's consent. The therapist may be able to provide understanding of the client, opinions about the severity of this crisis, and extremely valuable information about what helps and what should be avoided. This contact also serves to demonstrate respect for the client and may increase the client's perceived safety by demonstrating alliance with the client's chosen

helper, and by widening the client's support network to include both regular therapy and emergency services working together.

Four Principles

1. To Whatever Extent Possible, Return Control. Returning control to the individual may be counter intuitive when the client appears to be out of control. In the CSDT framework, however, the treatment provider's job is not to take control, but to help the client regain control and move toward safety. The provider expects and requests the individual's collaboration in figuring out what is needed to reach this goal. Together, the provider and the individual in crisis can determine what level and type of assistance is needed. This approach minimizes the possibility of retraumatizing events in the crisis setting, including affect-driven escalation on the part of the client and reenactments of past abuses like inappropriate restraint, labeling, rejection, or abandonment. Clients who are accustomed to surrendering control may be ambivalent about collaboration. Even if invited by the client to take over the interview and disposition, the treatment provider should state a commitment to the client's self-control and responsibility, and should encourage collaboration.

It is useful to accept that a self-injuring individual in crisis may need more time than another type of patient and try to arrange for a somewhat slower pace. Although this can be a strain, it is likely to save significant time and trouble overall by facilitating a more-effective encounter.

Physical surroundings have meaning to trauma survivors. Being placed in a waiting room, cubicle, or interview room may be perceived as restraint, exposure, or isolation. Persons in audible pain in nearby spaces may evoke memories such as witnessing abuse of others. Therefore, it is useful to check out a client's comfort level with the surroundings, including levels of noise, privacy, and perceived safety in order to minimize triggering stimuli that would increase distress.

It is important to interview the client briefly about any pressing fears or concerns that might be stimulated by the crisis situation or emergency-services setting. The person may be coping with distressing fears or expectations. For example, the client may feel at risk for having a flashback, being restrained, experiencing violence or possible abuse by staff, or becoming violent or otherwise out of control. With the client, briefly explore what actions could help if these fears became more pressing or began to come true. What should the provider do? What should the client do? Discuss what would make the situation worse. Agree on a simple plan to help keep the situation under control if trouble begins; for example, you might agree that the interview will stop, the client will take some deep breaths, and a door will be opened so the client can see out of the room, until the client feels safe and appears to be in control.

The real limits, procedures, and risks of the setting should be reviewed, so that the client has the information that is needed to make informed decisions about behavior and to influence the outcome of the intervention. (For example, clients in a hospital emergency room need to be informed of the gross criteria for release and for hospital admission so that both parties can operate in an above-board and respectful fashion with reduced fears of being manipulated, trapped, or, in the client's case, abandoned.)

If the client begins to escalate, the first step is to remain calm and to communicate the expectation that the client can and will remain calm. Remind the client of what you discussed earlier, about what can help if trouble begins. Call on the person to join with you in carrying out the plan. Keep in mind the possibility that the person is managing flashbacks, panic, or dissociative experiences. Taking a break, "grounding" techniques or

"talking-down" techniques may help (e.g., asking the client to review with you the date and place, the client's age and name, the current time and time since arrival; to look around and name some objects in the room, to look at one's own driver's license or other familiar objects.) Suggestions for deep breathing or visualizing a calm scene may be helpful, but only if the client is feeling somewhat safe in the current setting.

Every attempt should be made to avoid restraint or seclusion, which can have retraumatizing effects on survivors. If you must advocate unwanted treatment for purposes of saving a client's life, clearly connect your actions to your motivations; for example, you might explain that you are acting temporarily as an advocate for the safety of the client's body. Communicate the wish that the client soon will feel for her or himself the hope and respect that you feel for her or him. Explain that it is hope and respect that motivate you to advocate for the client's safety. If you must make the decision for the client, carefully explain the dilemma of balancing control and safety and invite the client to help solve the problem in some way on which you can both agree. Identify every decision that remains under the client's control and work together to make those decisions. With survivors of childhood abuse, forcing unwanted treatment may have some damaging effects. If such a course must be pursued, it is important to acknowledge that you know you may be causing some harm, but that you don't know another, better way to solve the immediate problem. Failure to acknowledge the hurtful parts of an intervention can be experienced as a repetition of the denial accompanying childhood abuse, and so may increase the client's distress.

2. Together Assess Self Capacities and 3. Together Develop Short-Term Strategies to Shore Up Self Capacities. Assessing self capacities will guide the therapeutic dyad in making meaning of the incident of self-injury and planning for increased safety. The development of self capacities is a long-term therapy goal. However, deficits in self-capacities can be addressed in small ways to help stabilize a crisis, and to guide disposition. Planned efforts to build self capacities can have strong benefits as short-term interventions, and can focus a client's behavior and attention on self-care in the aftermath of a crisis.

The capacity to maintain an inner sense of connection is marked by a belief that there exist some people who are benevolent, who are interested in and care about the client, and who are available to the client through the client's internal processes, and, ideally, in the interpersonal world. The person in whom this self capacity is undeveloped experiences a sense of profound alienation and emptiness and may feel exiled to the outside, looking in at life. Attachment difficulties are a hallmark of such impairment, and this individual may live essentially alone in the world, or may function in a social system built on exploitation of the individual and neglect of the individual's needs. (See Pearlman, 1998, for a fuller discussion of the development of self capacities, implications of underdeveloped self capacities, and treatment approaches.)

In order to assess this self capacity, the treatment provider might ask whether the client can think of anyone in the world who cares for the client, and whether it is possible to imagine or recall that person's caring now. (For some very isolated individuals, the caring other may be a pet.) If the client can tune into messages or voices from important others from the past, ask what they say. Are they caring or hateful, supportive or threatening? How about messages or voices from people in the present? Try to amplify any caring or supportive messages and focus on the person associated with them.

The capacity to maintain an inner sense of connection can be shored up through invoking in fantasy a benevolent other or temporary surrogate. If the client can imagine or remember a caring other, ask the client to call on that caring other for inner support and

reminders that the client is not alone. Individuals who cannot achieve this sometimes benefit from physically holding an object. If objects associated with human beings (photographs, letters, clothing) are too threatening or inspire too much pain, objects from the natural world can be considered. A "friendly" object like a rock or a seashell can be relied upon to be unchanging, real, and present when the client needs it. Music, books, or poems may allow a sense of connection with others (authors, others who love music, the characters described in literature), and can be useful during times of alienation and abandonment. A business card, brochure, or other object from the emergency setting or local hotline also might be useful as evidence of caring others. The goal is to identify an object or being that can be contacted or held in the client's mind—or the client's hand—and can be viewed as benevolent, protective, available. In long-term psychotherapy, this becomes the role of the therapist; guiding the client to therapy referrals or back to therapy is the central goal of crisis intervention with self-injuring individuals who cannot hold an inner sense of connection with others.

The capacity to tolerate strong affect is marked by experiencing strong feelings, either positive or negative, and expressing them without harm to self or others. The person for whom this capacity is extremely undeveloped may be desperately afraid of or numb to strong feelings, and may appear depressed, emotionally detached, or anxiously avoidant. The person may be involved in substance use or other analgesic or tension-reducing practices, and may overreact when strong feelings are aroused and behave in an out-of-control fashion. On the other hand, the person may remain numbed, vigilant to the risk of feeling stimulation, and may avoid losing control by experiencing no feelings at all.

The capacity to manage strong affect can be assessed through observing the client's reactions to the present situation, as well as to questions that invite an emotional response. The treatment provider can ask whether the client is aware of having feelings in daily life. If so, what kind? How does she or he usually respond to strong feelings (anger, loneliness, sadness)? What is soothing when the client feels upset? Does the client ever feel pretty good? When?

As our research shows, difficulties managing strong affect are almost certain to be found in clients who self-injure. Shoring up this capacity involves developing a few strategies for managing strong affect. Such strategies are many, but most individuals can make use of only one or two during a crisis. If the client can collaborate in brainstorming, try to put together a list of practical, simple ways to deal with feelings. [Bass and Davis (1988) suggest creating an emergency list together for later use.] Clients in crisis typically need to soothe themselves through quiet activities or to reduce tension through tension-reducing activities (Briere, 1995). The list can include strategies for both kinds of coping. Soothing activities might include making tea, taking a bath, listening to music, working in a garden, doing an art activity, looking at a beautiful scene, imagining a safe and pleasant place, petting or grooming an animal, etc. Activities to reduce tension might include walking fast, tearing up paper, throwing something in a safe place (a soft ball in the house, a tennis ball against a wall), hitting golf balls or going to a batting cage to hit softballs, working with clay, yelling, crying, beating on pillows, etc.

Because these activities inherently are not curative, suggesting them as solutions to deep internal pain can seem superficial. It is important to recognize, however, that the client feels like things are unbearable inside. In crisis intervention, the goal is to find some way to feel even a little bit better, even for just a little while. This is a familiar goal for self-injuring individuals. What is unfamiliar is using multiple self-care strategies to achieve it, instead of achieving it through self-injury. In long-term therapy, the client will discover other ways to feel better, and will begin to feel better more of the time with less

effort. Strategies developed in times of crisis are intended to support the individual while working toward long-term change. Acknowledging this fact will help the self-injuring client feel understood.

The capacity to maintain a sense of self as benign and viable is marked by the belief that one is essentially decent, deserving, and worthy of living. The person in whom this capacity is extremely undeveloped perceives criticism, loss, or failure as evidence of a toxic, damaged, or repulsive nature, and as evidence that abuse was or is deserved. This person may believe that she or he is flawed inherently or damaged irreparably, and therefore does not belong in the world. This person may believe that she or he has no right to live, and should or will be degraded, rejected, and abused by self and others.

Assessment might include asking about how the client sees her or himself. What words does the client use to describe her or himself? What expectations does the client have for self-care, achievement, and rewards in life? How does the client view suicide? How does the client make sense of unfair or unkind treatment by others? Can the client think of anything positive or valuable about her or himself? Can the client remember or imagine having such a thought?

If the capacity to experience the self as viable and benign is not developed, interventions for shoring it up are intended to direct the client's attention to his/her status as a member of the human race, an individual who is not toxic and who deserves to be in the world. For some clients, any discussion of achievement, positive qualities, personal rights, or shared humanity will invoke painful feelings like shame, rage, and loathing. If the client can tolerate exploration, search openly together for any evidence that the client is a person more or less like other people, yet unique. Does the client have a political or philosophical perspective that prescribes tolerance or appreciation for others? If so, is there any room for her or himself in that perspective? Does the client value any aspect of her or himself, any talents, abilities? Has the client ever done a nice thing? In other words, look, with the client, for any existing schema, no matter how narrow or fragile, that includes caring and that could be expanded and nurtured to begin to include the client. Bring the client's attention to the interaction at hand and note the ways that the client is behaving like a viable and benign individual here. Self-help, political, and volunteer activities can foster development of the self capacity, but again, development is long-term work, and direction to long-term therapy is critical.

4. Work with the Client to Identify the Antecedent to This Episode. Linking self-injury to an event promotes self-understanding and can provide a view of one's experience as making sense and of oneself as coping, as opposed to being out-of-control and "crazy." Linking can be approached by asking the client to think about the minutes, hours, and day before the injury took place. What was going on? Was anything important changing? Was anyone important missing or acting different? Was there an interpersonal event, anniversary, television show, or therapy session that served as a memory trigger or otherwise stirred things up? Was tension building? When did the tension become noticeable? When did the idea of self-injury come to mind? How did the person move from thinking about it to doing it? Work together to put words to the wish behind self-injury. Did it seem like the injury would help? Did it help? What problem was it meant to solve? How did the emergency service get involved?

If the person is a repetitive, ritualized, or frequent self-injurer, there might be a sense, from the client or from others around the client, that this behavior has no meaning and that efforts to understand are futile. It is important to note that this episode is somehow different, because this episode led to the interview. The provider and client must take it seriously and examine it together, avoiding the temptation to dismiss it as only part of an

ongoing pattern. The client has created a new interpersonal reality, one that allows for the possibility of change. This time the injury can be known and discussed. Of course identifying patterns of behavior also is important. That should be done in a supportive and exploratory way, not in a way that shames the client. The clinician might state, "I notice that you seem to hurt yourself and come to the emergency room around the beginning of each month. I wonder what you know about that pattern?"

Once an antecedent is identified, alternatives can be explored. The key issue is learning what might help the client cope. What is the first clue or "red flag" that self-injury will follow the antecedent? Is it possible to do anything different at that point? What is the smallest effective change that could be imagined or instituted? The provider should be aware that this discussion will not necessarily lead to change, and should not involve asking the client to promise never to use self-injury to cope in the future. The purpose of this discussion is to challenge gently the view that self-injury is out of the client's control, is "crazy" or inexplicable behavior, or is the only alternative available. Further work on this idea must take place in longer-term therapy.

The Question of Suicide

Most self-injury is a survival technique. It is a reaction to almost unendurable circumstances or internal experiences. It is intended to allow the individual to endure and to carry on. Self-injury is not typically an expression of hopelessness and helplessness; it is not typically an expression of the wish or decision to die. Rather, it generally can be seen as a victory of life instinct over death instinct, as Menninger (1938) saw it.

There is some agreement in the literature of theory (Allen, 1995; Conterio & Lader 1998; Linehan, 1993; Walsh & Rosen, 1988) and research (Fulwiler, Forbes, Santangel, & Folstein, 1997; Sabo, Gunderson, Najavitis, Chauncey, & Kisiel, 1995; Simpson & Porter, 1981) that self-injury and suicide attempts are distinct events. It is asserted further in the literature that individuals who self-injure do not typically kill themselves using the same methods that they use for self-injury (Allen, 1995).

Clinically, there is room for caution here. Overdose, infection, or other severe injuries can lead to death without the explicit intention of suicide. Briere and Gil (1998) noted that some self-injury may be practice at or preparation for self-destructive behavior in individuals planning suicide. Some subset of self-injurers can be assumed to be at risk for planned or unplanned suicide, as are other individuals who manage chronic dysphoria, a sense of alienation, and impulsive behavior, including impulsive self-injury.

Conterio and Lader (1998) reported that suicide appears to occur in self-injurers who "suffered from a very long-term and profound depression, with sustained feelings of hopelessness" (p. 30), so it is important to attend closely to these risk factors in assessing suicide risk. Bongar (1991) cautioned that attempted suicide is a strong, although not certain, predictor of completed suicide, so it is important to assess for past attempts. Of course, it is necessary to rule out psychotic states, delusional beliefs (somatic, sexual, religious, persecutory), and command hallucinations as motivations—if these are present, physical safety and stabilization of these symptoms become the focus of care. The sudden onset of new self-destructive behavior may signal an underlying pathological (inter-or intrapersonal) process of some kind, and should be viewed differently from an established pattern.

Assessment of suicidality or lethal potential in self-injury and corresponding decisions about protection and treatment should take place in dialogue with the injurer. A

standard suicide-assessment interview is called for [e.g., assessing level of depression; perceived helplessness and hopelessness; suicidal intent, plan, preparations, access to means, and previous attempts; social supports; history of suicide in family members; recent bereavement or job loss, age, gender, etc., (Bongar, 1991; Fauman & Fauman, 1981)]. Straightforward discussion of suicide risk is essential in the context of self-injury. Some self-injuring individuals are practiced and thoughtful in self-injuring and are able to discriminate between impulses toward injury and suicide. If this is not so, or if a frank discussion about suicide cannot be achieved, suicide risk should be evaluated with additional reason for concern.

Self-Injury and the Treatment Provider

Countertransference and Vicarious Traumatization

As discussed in the introduction of this article, dealing with self-injury can stimulate strong reactions in treatment providers. Understanding and managing countertransference and other reactions is essential to the effective treatment of self-injurious individuals. In data gathered from 117 licensed psychologists, self-injury was rated the most distressing and stressful client behavior, and the client behavior that psychologists found to be most traumatizing to encounter professionally. When the self-injurer was also a trauma survivor, therapists reported even greater levels of distress and stress (Gamble, Pearlman, Lucca, & Allen, 1994). In emergency situations, the complexity and unusual depth of personal feeling they confront can trouble clinicians encountering self-injury. Each clinician must understand and monitor his/her reactions to this work in order to protect the clinician's own resources and to remain available the self-injuring client. This can best be accomplished through self-awareness on the part of the treatment provider, a supportive and informed treatment team to fall back on, and the use of ongoing supervision or consultation.

Vicarious traumatization is the experience of a transformation in the self of a treatment provider as a result of empathic engagement with trauma survivors and their material, in the context of feeling responsible or committed to help the survivor (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). It differs from countertransference in that it does not refer to a single therapy relationship, but rather to the cumulative impact across time of working with trauma survivors. Encountering and managing self-injury, especially in survivors, demands a great deal of the treatment provider. This can be extremely difficult work, and it can result in treatment providers feeling a great deal of strain.

In order to remain effective clinically, and connected to her or his own humanity, the treatment provider must address and transform deleterious effects of working with people who self-injure (Saakvitne, Pearlman, & the staff of the Traumatic Stress Institute, 1996). To do so requires attending to professional needs like continuing education, ongoing supervision, and consultation from trauma-sensitive colleagues. Personal needs also must be addressed regularly, through balancing this work with other work and with play and rest. Finally, in order to transform vicarious traumatization, providers must create meaning in work and in personal life (Charney & Pearlman, 1998). Only through these means can providers hope to remain over time vital, alert, and attuned to the complex needs of self-injuring trauma survivors. (For a more detailed discussion of countertransference and vicarious traumatization in emergency treatment of self-injuring individuals, see Deiter & Pearlman, 1998).

Conclusion

A study of 233 outpatients and partial hospital patients was reported at the beginning of this article. More than half of the participants reported direct self-injury. More than 60% reported a history of childhood abuse. Almost half reported both self-injury and a history of abuse during childhood. Individuals with a history of self-injury showed significantly more impairment on a measure of self capacities (the ability to tolerate strong affect, the ability to maintain a sense of self worth, and the ability to maintain a sense of connection to others) than individuals who did not report self-injury. Self capacity impairment also was elevated in survivors of childhood abuse, as compared to individuals who did not report childhood abuse. Those individuals who reported both self-injury and childhood abuse showed the greatest level of self capacity impairment, followed by self-injuring individuals who were not survivors of childhood abuse.

The authors presented an approach to assisting the self-injuring individual in crisis. This approach is based on constructivist self development theory. It focuses on addressing distress that arises from impaired self capacities, which are one result of childhood abuse. Attention to self capacities can allow for a productive intervention, thereby gently challenging the client's sense of alienation and lack of alternatives to self-injury.

The authors assert that self-injurious behavior has many meanings and functions. It represents desperate attempts to cope with that which feels unendurable, especially in the wake of childhood abuse. The cessation of self-injury (and other positive changes) can come about in the context of a respectful therapeutic relationship through the combined efforts over time of the client and a therapist. The role of treatment providers in emergency settings is to provide a respectful human encounter, to facilitate medical treatment if it is needed, to help begin or advance the process of understanding self-injury as an adaptation or a reaction, and to collaborate on strategies that temporarily shore up self-capacities. The emergency-treatment provider has the opportunity to impart hope that such work, approached over time with a trustworthy helper, can help reduce suffering—both the suffering made visible on the body, and that which the self-injurer endures alone in an inner world.

References

Allen, J.G. (1995). Coping with trauma. Washington, DC: American Psychiatric Press.

Bass, E., & Davis, L. (1988). The courage to heal: A guide for women survivors of child sexual abuse. New York: Harper & Row.

Bongar, B. (1991). The suicidal patient: Clinical and legal standards of care. Washington, DC: American Psychological Association.

Bongar, B., Peterson, L.G., Golann, S., & Hardiman, J. (1990). Self mutilation and the chronically suicidal patient: An examination of the frequent visitor to the emergency room. Annals of Clinical Psychiatry, 2, 217–222.

Bowlby, J. (1981). A secure base. New York: Basic.

Briere, J. (1995). Attacks on the body: Meaning and management of self-mutilation in trauma therapy. Invited clinical symposium presented at the XI Annual Meeting of the International Society for Traumatic Stress Studies, Boston, Massachusetts.

Briere, J., & Gil, E. (1998). Self mutilation in clinical and general population samples: prevalence, correlates and functions. American Journal of Orthopsychiatry, 68(4), 609–620.

Calof, D.L. (1994, November). Self-injury and self mutilation in trauma survivors. Workshop presented at the "Healing the Heart" seminar, Madison, Connecticut.

Calof, D.L. (1995). Chronic self-injury in adult survivors of childhood abuse: Sources, motivations and functions of self-injury (part I). Treating Abuse Today, 5–3, 11–16.

Calof, D.L. (1996). Chronic self injury in adult survivors of sexual abuse: Developmental processes of anger in relation to self injury (part I). Treating Abuse Today, 5–6(1), 61–62, 64–67.

Charney, A.E., & Pearlman, L.A. (1998). The ecstasy and the agony: The impact of disaster and trauma work on the clinician. In P.M. Kleespies (Ed.), Emergencies in mental health practice: Evaluation and management (pp. 418–435). New York: Guilford.

Conterio, K., & Lader, W. (1998). Bodily harm. New York: Hyperion.

Davies, J.M., & Frawley, M.G. (1994). Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective. New York: Basic.

Deiter, P.J., & Pearlman, L.A. (1998). Responding to self-injurious behavior. In P.M. Kleespies (Ed.), Emergencies in mental health practice: Evaluation and management (pp. 235–257). New York: Guilford.

Fauman, B.S., & Fauman, M.A. (1981). Emergency psychiatry for the house officer. Baltimore, MD: Williams & Wilkins.

Favazza, A.R., DeRosear,L., & Conterio,K. (1989). Self mutilation and eating disorders. Suicide and Life Threatening Behavior, 19(4), 352–361.

Fennig, S., & Fennig, S.N. (1992). The interpersonal aspect of the decision making process in the psychiatric emergency room [Correspondence]. The International Journal of Social Behavior, 38(4), 318.

Frances, A. (1987). Introduction to section on self mutilation. Journal of Personality Disorders, 1,316.

Fulwiler, C., Forbes, C., Santangelo, S., & Folstein, M. (1997). Self-mutilation and suicide attempt: Distinguishing features in prisoners. Journal of the American Academy of Psychiatry and Law, 25(1), 69–77.

Gamble, S.J., Pearlman, L.A., Lucca, A.M., & Allen, G.J. (1994, October). Vicarious traumatization and burnout among Connecticut psychologists: Empirical findings. Paper presented at the Annual Meeting of the Connecticut Psychological Association, Waterbury, CT.

Himber, J. (1994). Blood rituals: Self-cutting in female psychiatric inpatients. Psychotherapy, 31(4), 620–631.

Krystal, H. (1978). Trauma and affects. Psychoanalytic Study of the Child, 33, 81–117.

Linehan, M.M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford.

Litzenberger, B., Robohm, J.S., & Pearlman, L.A. (1999). The impact of childhood abuse and neglect on the development of sexual orientation. Manuscript in preparation.

MacIan, P.S., & Pearlman, L.A. (1992). Development of the TSI Life Events Questionnaire. Treating Abuse Today, 2(1), 9–11.

McCann, I.L., & Pearlman, L.A. (1990). Psychological trauma and the adult survivor: Theory, therapy, and transformation. New York: Brunner/Mazel.

Menninger, K. (1938). Man against himself. New York: Harcourt, Brace & World.

Miller, D. (1994) Women who hurt themselves: A book of hope and understanding. New York: Basic.

Neumann, D.A. (1995). The long-term correlates of childhood sexual abuse in adult survivors. In J. Briere (Ed.), Violent victimization: Assessment and treatment. San Francisco, CA: Jossey-Bass.

Nicholls, S.S., Deiter, P.J., & Pearlman, L.A. (1999). Self-harming behaviors and reasons for self-harm: Data from a clinical sample. Unpublished manuscript.

Pearlman, L.A. (1998). Trauma and the self: A theoretical and clinical perspective. Journal of Emotional Abuse, 1, 7–25.

Pearlman, L.A., & Saakvitne, K.W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: W.W. Norton.

Polusny, M.A., & Follette, V.M. (1995). Long term correlates of child sexual abuse: Theory and review of the empirical literature. Applied and Preventive Psychology 4(3), 113–166.

Romans, S., Martin, J., Anderson, J.C., Herbison, C., Mullen, P., & Phil, M. (1995). Sexual abuse in childhood and deliberate self-harm. American Journal of Psychiatry, 152(9), 1336–1342.

Sabo, A.N., Gunderson, J.G., Najavitis, L.M., Chauncey, D., & Kisiel, C. (1995). Changes in self destructiveness of borderline patients in psychotherapy. Journal of Mental and Nervous Disorders. 183(6), 370–376.

Saakvitne, K.W., Gamble, S.J., Pearlman, L.A., & Lev, B.T. (2000). Risking connection: A training curriculum for working with survivors of childhood abuse. Lutherville; MD: Sidran.

Saakvitne, K.W., Pearlman, L.A., & the staff of the Traumatic Stress Institute. (1996). Transforming the pain: A workbook on vicarious traumatization. New York: W.W. Norton

Sakheim, D.K. (1996). Clinical aspects of sadistic ritual abuse. In: L. Michelson & W.J. Ray (Eds.), Handbook of dissociation: Theoretical, empirical and clinical perspectives. New York: Plenum.

Sakheim, D.K., & Stanek, L.J. (1994, Fall). Self-injury in trauma survivors. Raising Issues I, 1–17.

Simpson, M.A., & Porter, G.L. (1981). Self mutilation in children and adolescents. Bulletin of the Menninger Clinic, 45(5), 428–438.

Strong, M. (1998). A bright red scream: Self-mutilation and the language of pain. New York: Penguin Putnam.

Tobin, D.L., & Griffing, A.S. (1996) .Coping, sexual abuse, and compensatory behavior. International Journal of Eating Disorders,20(2), 143–148.

van der Kolk, B.A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. Harvard Review of Psychiatry, 1, 253–265.

van der Kolk, B.A., Perry, C., & Herman, J.L. (1991). Childhood origins of self-destructive behavior. American Journal of Psychiatry, 148(12), 1665–1671.

van der Kolk, B.A., McFarlane, A.C., & Weisarth, L. (Eds.). (1996). Traumatic stress: The effects of overwhelming experience on mind, body, and society. New York: Guilford.

Walsh, B., & Rosen, P. (1988). Self-mutilation: Theory, research and treatment. New York: Guilford.