

## **Mental Health and Society week 19**

### **The mind and the body – self-hatred, self injury and their therapies**

In addition to the lecture content here there is some internet support for this issue, including links to a collection of papers on the subject and a variety of sites and pages on the web dealing with the issue. These are accessible at <http://www.brown.uk.com/selfinjury/selfinjury.htm> At <http://www.brown.uk.com/selfinjury/silist.htm> there are some useful, fairly accessible overview by e.g. Clarke & Whittaker (1998) and a qualitative account by Harris (2000). I've also put in some papers from a special issue of *Applied and Preventative Psychology* from 2008 and *Journal of Clinical Psychology* from 2007. But do have a look at the others too. Anyway, let's get started

#### **Body change and distress - Self injury**

'I reach out for help by cutting myself. It may be stupid but I get results. People help me when I cut' (Favazza & Favazza, 1987, p111)

Focus is shifting. Previously seen as some aspect of psychopathology, manifestation of 'personality disorder'

Many authors on the subject see self mutilation as an aspect of severe psychopathology e.g. Scheffel et al (1986) report the case of a 20 year old black male patient who dissected off his face in a state of 'psychotic analgesia'. Subsequently he persistently refused to admit that he'd done it himself. Often described as focusing on symbolic parts of the body e.g. face, genitals. Sometimes symbolic messages e.g. carving boyfriend's initials into arm (Michelman et al, 1991) or writing 'F\*\*\* the world'. May involve symbolically 'sharp' objects like glass, razor blades, Stanley knife blades.

How widespread? We don't know. Some figures have been proposed by Tantom & Whittaker (1992) 1 in 600 adults injure themselves enough to need hospital treatment. T&W say more men than women do it but more women undergo psychological treatment. Nearly one in three (28%) secondary schoolgirls and 12% of boys in Edinburgh admitted harming themselves by cutting or stabbing with knives, pulling out hair, bruising, pinching, burning skin or overdosing on pills in an interview study of 4,300 youngsters (McAra, 2005); In the same study 5% of girls at 15/16 said they had attempted suicide. May be more common than eating disorders. There is an increasing concern with the effects of self injury on carers, family, friends and the turbulence it causes - very emotive.

**Why? 1) Reasons proposed from inside the psychiatric profession.** Various reasons proposed. None definitely predispose self harm but have been associated with it in case reports and surveys of 'patient' groups i) Absence of competent male for identification in childhood associated with male self castration (Martin and Gattaz, 1991) ii) 'mental disorders' like borderline personality disorder and dysthymia (Trull and Widiger, 1991) Schizophrenia, depression. iii) Sexual abuse, forced sex. (DiClement et al, 1991) (Not associated with gender, age, ethnicity or psychiatric diagnosis. Physical abuse (Rose, 1991) iv) Post traumatic stress disorder (Lyons, 1991) v) Eating disorders, (Gouldner et al 1991) vi) Dissociative disorders e.g. MPD and psychogenic amnesia (Coons & Milstein, 1990) vii) Incarceration (Josephson, 1991; Favazza & Favazza, 1987). Women constitute 6% of the UK prison population but account for 25% of the self harm incidents (HM Prison Service, 2005) viii) Culture

Cultural predispositions E.g. damage to the eyes seems to be unique to Christian culture. Often people are calm after enucleation believing that they have done as their deity wanted, or have rid themselves of an evil spirit (Favazza & Favazza, 1987) ix) Suicide. Menninger (1938) 'a mutilation is therefore an attempt at self healing, or at least self preservation... Local self destruction is a form of partial suicide to avert total suicide.' (p271) People who injure themselves are more inclined to exhibit dissociative symptoms, such as symptoms of depersonalization, derealization, identity entanglement, or loss of control, than patients who do not injure themselves (Bracke, van Leeuwen, & Verhofstadt-Denève, 2001; Noll, Horowitz, Bonnano, Trickett, & Putman, 2003; Zlotnick et al., 1996, 1999). There is a strong association between self-injury and dissociative disorders: 86% of a group of patients with dissociative disorders were found to injure themselves (Saxe, Chaawla, & van der Kolk, 2002). More than half of the patients who injure themselves suffer from one or more psychiatric disorders, the most common of which are depressive disorders, (borderline) personality disorders, eating disorders, posttraumatic stress syndromes, and substance abuse (Barr, Leitner, & Thomas, 2004; Parker et al., 2005; Ruths, Tobiansky, & Blanchard, 2005; Solano, Fernández-Aranda, Aitken, López, & Vallejo, 2005).

### **Why? 2) Reasons proposed from within counselling oriented professions.**

(i) Way of expressing emotional pain and self disgust by 'cutting the dirt out' if you hate yourself you feel you deserve it (Rogers, 1993). (ii) Rage as a result of physical or sexual abuse, inability to express emotions (Rogers, 1993) (iii) Internalising anger 'frightened' of turning anger outwards and the destruction it will cause (Rogers, 1993) (iv) Guilt - relationship with parents. If feel that parents unloving, rejecting or neglecting then maybe feel that one is bad or deserves to be punished (Rogers, 1993). (v) Feelings of unreality - Feel emotionally disconnected in response to trauma so pain is a way of feeling part of the real world (Rogers, 1993) (vi) Being in violent relationships - only pain they can control in their lives (Jones, 1993) (vii) Low self esteem - as a result of abuse, rejection, loss, bereavement in childhood (Jones, 1993) (viii) Anger and hurt and nobody is listening (Jones, 1993) (ix) Connection made in childhood between punishment and pain - pain you can control (Jones, 1993). Humanistic approaches are useful, say Rayner & Warner (2003), because many who self-injure prefer not to be labeled and diagnosed as this has been unhelpful in the past. It has also been unlikely that they have really been accepted and valued for themselves in the past. Harrison (1994: 81) states: 'Therapies which work with a woman at a pace she is comfortable with, such as humanistic or feminist approaches might be suggested'.

**Why? 3) Feminist arguments** McAndrew and Warne (2005) note that self harm is the most frequent cause of women being admitted to hospital. Burstow (1992) in 'Radical Feminist Therapy' sets self harm in the context of a range of more socially acceptable 'mutilations' that women are expected to perform.

i) Childhood guilt - continuing the punishment started by parents, 'helping them thus getting some feeling of self worth (ii) 'Proof of humanness' wound is visible, tangible proof that she feels (iii) Bringing back feeling - in response to the numbing which might follow abuse (iv) Way of avoiding or distracting from uncomfortable feelings (v) Communication - 'cry of anguish' need to communicate but cannot because do not feel entitled to speak about the pain or fear rejection if they do. In a sense the wounds speak for them. (vi) To get a 'rush', 'high' or other temporary surge, sense of

relief. (vii) Control. Expression of control when you've been controlled by others. Choose how to injure, what to injure, what kind of injuries. Control the pain. (viii) Strength and success. Difficult to experience yourself as strong and successful - endurance, achievement. (ix) Resistance to the ways in which women's bodies have been controlled. Indicting the people who've abused them as children. Some people injure their bodies in ways that exceed or indict the social expectations about women's' bodies. McAndrew and Warne (2005) highlight the way that self harm may be a way of coming to terms with violence from men, and with the double standard whereby activities that are permissible for men are not permissible for young women. **Why ? 4) Psychoanalysis** (Levy et al, 2007). Welldon, (1991) argues it is something to do with 'awakening sexuality' and difficulty in accepting this - so self mutilation occurs (same kind of explanation produced for bulimia and anorexia). Bodies become more like mothers' (this theory is designed for young women) so 'self-mutilation' is some sort of externalisation of any early conflict with mother.

Early psychoanalytic writing on self injury emphasises that it could be an acting out of castration fears (Abraham, 1920; Rado, 1930). Or as a source of masochistic gratification (Brennan, 1952). Later psychoanalytical work emphasised the possibility of self harm emerging from the conflict between separation needs and dependency (Kafka, 1969).

Some Psychodynamic theorists suggest that self-injury is self-destructive in nature and is an externalized representation of an unconscious wish to end life (Tantam and Whittaker, 1992). In contrast, Rayner and Warner (2003) say their clients tend to view self-injury as a way of coping with life rather than ending it. Hence, self-injury is connected with death and self-destruction, but fails to connect with self-preservation and life.

Ferenczi (1956) presented a slightly different psychodynamic theory, suggesting that self-injury occurred when murderous wishes have been redirected from external objects towards the self. Therefore self-harm can also be a method of coping with interpersonal difficulties when direct communication of anger may be difficult.

Psychodynamic perspectives suggest that self-injury is an internally motivated response to difficult feelings that result from interpersonal problems and offers a partial explanation for self-injury.

### **Treatment:**

According to many authors the 'medical model' still predominates in contemporary care (Bosman & van Mijl, 2008; Cresswell, 2005; Harris, 2000; Johnstone, 1997; McAllister, 2003). Thus, self-injury tends to be viewed as a pathological behaviour that must be stopped as quickly as possible (Stevenson & Fletcher, 2002). This view is also found in many therapist-client relationships in which the issue of self-injury comes to dominate the process of therapeutic intervention. It is also found in many contemporary treatment models in which, according to Shaw (2002), the focus still lies mainly on reducing symptoms and the use of cognitive-behavioural therapy techniques, medication, and 'contracts'. This overwhelming focus on symptom reduction and problem solving, and the technical language this entails, may form 'an obstacle in the therapeutic relationship, creating distance and insecurity' (McAllister et al., 2001: 28).

Earlier approaches to treatment are reviewed by Favazza & Favazza (1992). These were often punitive and harsh 1) Neurosurgery has been tried. E.g. amygdala. Other physical treatments e.g. taking teeth out of people who bite themselves. 2) Drugs

e.g. beta blockers, antidepressants, anti schizophrenic drugs. Maybe even stimulant drug - theory that people who self mutilate are low in stimulation, e.g. RAS stimulated then reduce self mutilative behaviour. Drinking can encourage self mutilation. 3) Psychotherapy E.g. help people understand the impulses toward self harm and substitute other behaviour. Various theories, e.g. skin experienced as something foreign, unconscious fears of separation and abandonment. Repressed fantasies, get 'em out into the open then behaviour ceases. Attention seeking, 'emotional blackmail'. Helplessness. Addictiveness of cutting. Oedipal issues (father daughter relationship, incestuous guilt) 4) Behaviour therapy: Token economies. Reinforcement of desired substitute behaviour. Shaping. Desensitisation to the impulse to self harm. Punishment. Can be a problem in that some people are aware of mounting levels of tension and cutting brings rapid relief. 5) 'Administrative' therapy institutional regime changes, in hospitals, young offenders units and prisons. E.g. if there is less time spent locked up, there is less self mutilation. If there are more activities to occupy patients or residents then there is less self mutilation, or if there is more responsibility given to residents. Other issues E.g. sharing of cutting instruments, in closed institutions and schools, risk of HIV, hepatitis. (DiClement et al., 1991).

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## **Mental Health and Society week 19**

### **Self injury and therapy**

Many clients find therapy distasteful or unhelpful. Himber, (1994) identifies ways in which the women in her study of self injurers had found medical personnel unhelpful. 'Emergency room' personnel had often been punitive, sarcastic, or even jocular. In the 1970s a survey of hospital personnel found unfavourable attitudes in 25% of consultants, 44% of junior doctors and 40% of nurses (Patel, 1975, cited in Morgan, 1979, p. 68). The psychiatric profession itself has some difficulties with this kind of behaviour: 'Staff feelings fluctuate between rage, sympathy, guilt, solicitude and the urge to retaliate . . . Distancing oneself from such patients is a frequent manoeuvre of treatment personnel. This is often rationalised by describing the patient as 'manipulative' or 'attention seeking' (Feldman, 1988, p 263). As Arnold (1995) found, 'over and over again women told us of being criticised, ignored, told off, dismissed as attention seeking, a nuisance or wasting time . . . These attitudes . . . reinforce the self hatred and desperation which contributed to their need to self injure (Arnold, 1995, p. 18). Some report being stitched without anaesthetic or even being refused treatment altogether. (Arnold, 1995)

Once in inpatient psychiatric care the women in Himber's study had found it unhelpful to be placed in isolation or restraints, as this was perceived to be unnecessary and punitive. Equally, therapeutic responses which involved doing nothing (presumably a kind of non-reinforcement) were perceived to be isolating. Harrison (1997) says of her own experience of self harm and the professional response 'when I was under psychiatric care, staff dismissed my actions and withdrew any support until I stop self harming or explained to them in words how I felt. But I wasn't able to describe my feelings. I didn't know what they were. Self harm was the most fluent language I had.' (Harrison, 1997, p. 439) People who self injure may be typified as 'attention seeking' or 'manipulative' (McAndrew and Warne, 2005).

Himber's respondents also complained that their therapists did not appreciate the depth of their self hatred or the extent of their being filled with inner badness. For example

'I have a problem in therapy . . . the therapist tells you that you don't have bad blood and its just very confusing' cause you feel that you do and that you have to blood let and they tell you that you don't, that your blood's not bad, so it's difficult' (Quoted in Himber, 1994, p. 627).

The experience of 'contracts' to reduce self harm which mental health professionals impose was reported by Harrison's informants to be negative. 'they said this felt dreadful, impossible - as though they were being silenced and their method of survival condemned.' (p. 439)

Johnstone (1997) says that the problem lies in the fact that mental health services are still organised on the assumption that when people turn up with a problem that this reflects an underlying psychiatric (i.e. medical) condition. This leads the professionals to try to diagnose the condition - often as 'borderline personality disorder'. Also, categories such as histrionic, narcissistic or anti-social personality disorder have been employed as well. Lacey & Evans (1986) propose a category of 'multi-impulsive personality disorder (1986). In addition there are attempts to identify typologies of cutting, such as distinguishing between 'delicate' and 'coarse' cutting, or between those who attack the skin and those who cut the genitalia, or eyes. (Rosen & Walsh, 1988)

### **Better therapies and better lives**

“In the service of the empowerment of clients, feminist therapists strive to create an egalitarian relationship. This egalitarian relationship is structurally situated so as to enhance client power, authority, and autonomy. It is one where the therapist invites the client to participate in a collaborative process in which the therapist’s expertise at creating the conditions under which change is possible joins with the client’s expertise at knowing what is best for her or his own life” (Brown and Bryan, 2007: 1124).

In therapy Burstow (1992) advocates a determinedly non interventionist stance. That is, she sees the client as having the right to do what she wants with her body, because she sees self injury as evidence that people have already interfered with the person and does not want to compound the abuse. Burstow also sees self injury as a way of living rather than as a kind of suicide attempt. By the time people who self injure appear as clients, they have probably been doing it for some time, so interventionist zeal on the part of the therapist may be counter-productive.

Burstow relates two examples of women who had been prohibited from injuring themselves by their therapists who dissociated the self injury so that they would suddenly find themselves badly injured. In one case this dissociation was interpreted as a sign of ‘psychosis’ and resulted in the client being hospitalised.

Burstow’s own approach is concerned with co-exploring with clients the self mutilation experience, with questions such as ‘what does the cutting mean to you?’; ‘what do you remember thinking or feeling before you last cut?’; ‘What do you remember thinking or feeling afterwards?’; or ‘do you have a sense of what the cutting gave you?’ This co-exploration may be useful because: i) it gives the client an opportunity to define the harm as something meaningful rather than meaningless or crazy, ii) it helps counsellor and client appreciate the importance of self harm as an important part of the clients’ coping strategy, iii) it allows a client who is not understood and who thinks she is not understandable to receive and take in understanding, iv) identifying purposes can enable clients to find other activities that meet their needs, v) co-investigation may reveal ‘internalised oppression’. vi) Allows access to early suffering and the opportunity to work on early experiences of abuse.

For example, a client may be self-injuring because she sees her body, or some body part as having been responsible for abuse that she has suffered in the past - they may be seen as ‘seductive’ or ‘contaminated’

Therapy has also begun to grow out of women’s own experiences and self help. Harrison (1997) describes her own transition from self injurer to survivor, and advocates ‘survivor organised services which nurture women’s creative strengths and are supportive of our struggles.’ (1997, p. 440)

There are some professionals who place the onus on the individual self harmer restrict the availability to therapy with self harm. For example Allen (1995) identified what she sees as the important criteria for psychotherapy to be successful, for example if the person has experience of controlling their behaviour, or have been successful in reducing self harm on the basis of ‘practical advice’ from the referrer, and need to have an interest in their thoughts and feelings and some ability to reflect on these (p. 248).

Johnstone (1997) ends with a plea for categorization to be 'replaced by a search for personal meaning, professionalisation replaced by a partnership with those who experience the problem; a lessened emphasis on physical interventions; a central position given to feelings and dynamics; and an awareness of the links between self injury and the culture of which we are all a part.' (p. 425).

Arnold, (1996) is keen on a self help approach which involves the sufferer being able to look after themselves and their injuries and adopting an exploratory approach to self injury, involving asking oneself questions like i) When did I first start, what was going on in my life that might be relevant? ii) How did self injury help me survive in the past? How does it help me survive now? How do I feel; before I hurt myself? How do I feel afterwards? What feelings may I be expressing or avoiding through self harm?

### **Dialectical Behaviour Therapy**

There has been a good deal of interest recently in the application of dialectical behaviour therapy, originated by Marsha Linehan. A reasonably friendly account is given in Swenson et al (2001) or Miller and Smith 2008: 180-184). The authors here point to the negative spiral of hostility and mutual distrust between patients and staff, with staff accusing patients of being manipulative, treatment resistant and patients coming to expect a punitive, rigid and mistrustful attitude from staff. (Swenson et al use the term 'patients'). Dialectical behaviour therapy on the other hand tries to build trust and mutual respect and is focused on problem solving 'in the moment'. The approach was developed by working with people who were suicidal and diagnosed with borderline personality disorder. The underlying theory is that self injury (and borderline personality disorder, a diagnosis which a good many self injurers receive) involves emotional dysregulation. The therapist has to provide a validating environment, attempts to extinguish maladaptive behaviours, teaches skills to help with emotions and relationships and ensures that these skills are reinforced. At the outset there is a good deal of interest in securing the patient's commitment to the programme of therapy and in designing a care plan which emphasises the patient's own goals.

In addition there is support for staff members who are dealing with these demanding patients so as to defuse the negative typifications which frustrated staff are apt to make. For example, rather than describing a patient as 'sabotaging' the therapeutic process maybe the patient was scared of leaving the programme.

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