Chronic Self-Injury in Adult Survivors of Childhood Abuse

Sources, Motivations, and Functions of Self-Injury (Part I)

by David L. Calof

This article is the first in a series discussing chronic self-injury in adult survivors of childhood abuse. In this article and a companion article to appear in the next issue of Treating Abuse Today, *the author explores the common sources, motivations, and functions of self-injury. In this first article, he distinguishes parasuicidal (that is, self-injurious) from suicidal behaviors, and discusses how self-injury acts as a container for unresolved or on-going psychophysiological trauma. Several case illustrations show that present day forms of self-injury can reenact or reveal patterns of early abuse.*

Self-injurious behaviors in survivors of childhood sexual and physical abuse commonly begin during childhood as efforts to protect the self from unmanageable pain and loss, and to cope with the demands of overwhelming trauma and family dysfunction. When left unaddressed and untreated, self-injury tends to become chronic and more extensive, with additional forms often developing in adolescence (Gil, Briere, and Calof, 1993). By adulthood, survivors often weave these behaviors into the fabric of their personalities.

Adolescents and adults who engage in self-injurious behaviors typically have histories of early sexual abuse, significant incidences of childhood losses, poor childhood health, physical abuse, witnessed violence, and substance abuse (Matthews, 1968; Green, 1968; Crabtree and Grossman, 1974; Ross and McKay, 1979; Walsh and Rosen, 1988; Gil et al., 1993). The nature of the trauma and the age at which it occurs affects the specific type of self-injury that results (van der Kolk, Perry, and Herman, 1991; Calof, 1992). In adult survivors of childhood sexual abuse, severe self-injury shows a positive correlation to greater frequency, severity, and sadism of the early abuse (van der Kolk et al., 1991; Gil et al., 1993).

While we have no precise way of describing completely the distinction between self-injurious and suicidal behavior, we move in the right direction when we distinguish underlying intent, motive, and function of self-injurious acts.

Many clinicians are reluctant to address self-injury directly with their clients because of panic, uncertainty, or incompetency. They may hold to the mistaken belief that discussing this issue will potentiate or reinforce it, a position similar to the old mistaken idea that discussing teen suicide would potentiate it. This way of thinking actually mirrors a universal attitude of dysfunctional systems: "If we don't talk about it, it won't hurt us." Only through valid training, information, and clinical experience with chronic self-injury will clinicians learn to forego countertransference avoidance and unwitting collusion in the problem.

Therapists must address self-injury whenever it presents clinically. In addition, thorough assessment of personality or dissociative disordered clients should include an evaluation for self-injury. Because self-injury may grow worse during therapy to become a vexing management issue, clinicians should proactively assess the potential for these behaviors. Before attempting any depth work, they should develop intervention strategies to limit, contain, or convert self-harming behaviors into more benign (behavioral/affective/sensory) expressions.

Self-Injury Versus Suicidal Intent

While self-injury often accompanies suicidal behavior and ideation in survivors of childhood sexual abuse, it doesn't always have a suicidal intent. Clinicians and others often mistake acts of self-injury for suicidal or self-destructive behavior. In sexual abuse survivors, however,

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self-injury is an indirect attempt to manage unresolved traumatic stress. Chronic self-injury is more an attempt to adapt to and manage a difficult existence than to end one. Gil et al. (1993) found that clients who chronically self-injure most often feel misunderstood when clinicians frame self-injury as *suicidal.*

In an extensive review of the literature on suicidality and self-harm, Walsh and Rosen (1988) traced a half-century history of attempts to distinguish self-mutilation from suicide and other forms of self-harm. This history began with efforts to distinguish between suicide and attempted suicide (Menninger, 1935; Menninger, 1938; Hendin, 1950; Stengel, 1964) and led to the description of a wide variety of extra-suicidal behavioral syndromes or impulse control disorders, including among others *wrist cutting syndrome* (Graff and Mallin, 1967; Grunebaum and Klerman, 1967; Nelson and Grunebaum, 1971; Rosenthal, Rinzler, Walsh, and Klausner, 1972); *para-suicide* (Kreitman et al., 1969; Schneidman, 1973); *non-fatal deliberate self-harm* (DSH) (Morgan, Burns-Cox, Pocock, and Pottle, 1975; Morgan, Barton, Pottle, and Burns-Cox, 1976; Morgan, 1979); and *indirect self-destructive behavior* (Simpson, 1976, 1980).[1]

Clinicians agree that there's a need to distinguish clinically between self-injurious and suicidal behavior (Pao, 1969; Walsh and Rosen, 1988; Steele, 1990; Feldman, 1991; van der Kolk et al., 1991; Calof, 1992). While we have no precise way of describing completely the distinction between self-injurious and suicidal behavior, we move in the right direction when we distinguish underlying intent, motive, and function of self-injurious acts.

Unlike suicidal behavior, acts of self-injury reveal a distinct survivor's mentality, a kind of "I will manage it" stance quite distinct from the "I will end it" stance of suicidal intent. When we understand self-injurious acts as functional posttraumatic dissociative sequelae to early abuse, we can more easily see them as attempts to manage life (survive), rather than as acts meant to destroy it. Symbolically, they mirror the mindset common to prisoners of war who would break their arms or legs gladly, if it meant they could escape their captors. In fact, self-injury often reveals the animal self-protectiveness of the fabled wolverine that will chew off its own paw to escape a trap. The loss of the paw could bring death, but the wolverine isn't trying to kill itself. Instead, it's grasping at life by making a desperate bid to escape the clutches of certain death. In the space of a flashback, a trauma victim often feels the same overwhelming desperation to escape at all costs the brutal presence of a perceived death.

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Thus, chronic self-injury is parasuicidal, not truly suicidal. Behaviorally it may resemble suicidal behaviors, but survivors of sexual abuse most often use self-injury as a way to manage emotional states, body states, thoughts, and psychological function. Rather than hastening self-destruction, self-injury prevents a worse harm or destruction perceived by the survivor. The fantasy of suicide (suicidal ideation) may provide a similar self-regulating function, as when Nietzsche (in *Jenseits von Gut und Böse*) observes, "The thought of suicide is a great source of comfort: with it a calm passage is to be made across many a bad night."

A typical act of chronic self-injury rarely prefaces a suicidal act, even in clients who manifest both suicidality and parasuicidality. While suicidality and self-injury may show common features (for example, use of self-injurious implements, use of substances, potential for lethality, and so on), their intents differ. Of course we neither hope for nor encourage self-injury as a management tool for our clients, but in the context of the time distorted, fragmented, information-deprived, and trance-logical realities of still-traumatized victims of abuse, self-injurious behaviors often become sane choices for survival. More than one sexual abuse survivor has told me, "That I'm even here is evidence that it [self-injury] works." At the least, self-injury expresses unresolved trauma and disowned affects. Emerging from many sources and driven by various motivations, self-injury in sexual abuse survivors encompasses a variety of functions.

Self-Injury as a Behavioral Reenactment of Traumatic Experience

Present-day self-injury may behaviorally reenact unintegrated traumatic memory. To understand this process, we must understand the ways that sexual abuse survivors store unmetabolized, unintegrated traumatic experience. We know that trauma victims use dissociation to "chunk" (split off and compartmentalize) traumatic experiences (overwhelming stress and inescapable shock), and their posttraumatic responses to them, into manageable components. Pièrre Janet (1889) first observed that spontaneous dissociative reactions act as defenses to keep traumatic memories out of consciousness. He later argued (1924) that memories of traumatic experiences could still influence thought, behavior, and affect *even when* they were split off from the mainstream of consciousness. Morton Prince (1914) reached the same conclusion when he argued that experiences "may be reproduced subconsciously without rising into awareness" (p. 3).

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Janet's concept of *split consciousness* and Prince's concept of *co-consciousness* help us understand dissociative compartmentalization, the splitting of traumatic experiences into manageable components. These components include behavior, affect, body sensation, and knowledge (awareness, cognition, imagery, beliefs, and so on), often denoted by the acronym "BASK," (Braun, 1988). Trauma victims also store unresolved trauma as on-going "mind/body conversations," that is, physical symptoms, affective/behavioral disregulation, disease processes, psychophysiological (tissue) memories, and stigmata

1 For additional descriptions of extra-suicidal behavior, see Pao (1969); Litman, Faberow, and Wold (1974); and Favazza, DeRosear, and Conterio (1989).

(Calof, 1990). Victims may also store unresolved trauma among split-off dissociative identities as in dissociative identity disorder (DID, formerly MPD). These various component systems become the containers of unresolved trauma.

These containers, however, aren't perfect; they leak. At any time, traumatized individuals tend to over-represent certain of these components in consciousness (*flooding*) while under-representing others (*suppression*). For instance, a client will present with conscious knowledge of certain incidents of early sexual abuse, but without appropriate affect or sensation and without appropriate knowledge of its consequences. This client may take the stance, "Well, there was some abuse, but it wasn't a big deal and it didn't really effect me." In effect, the client has stored the real significance of the abuse, as well as its effects, in those components of the experience not yet "owned": phobic states, inappropriate affects, avoidance of sensation, self-injurious behaviors, and so on. Other clients will have no conscious knowledge of the traumatic experience, but will reveal it in intrusive body sensations dissociated from all other aspects of the BASK. For example, female victims who have psychogenic amnesia or partial amnesia for early sexual abuse sometimes seek medical attention for non-specific gynecological complaints, such as vague pain, discomfort, or bleeding. When these chronic complaints show no organic origin, they may be the expression of unintegrated body reactions of earlier trauma.

Quite often, then, some components of the traumatic experiences remain hidden from present consciousness while others intrude. We may think of this selective state of intrusion as a *partial flashback*. Partial-flashbacks occur most often in response to triggering events reminiscent of the unintegrated traumatic experiences. The trigger may be wholly outside awareness. Self-injury is sometimes a behavioral form of these partial flashbacks. The following three case illustrations show self-injury functioning as a behavioral flashback to unintegrated traumatic experience.

Case Illustration: Caught at the Edge of Death

A 24-year-old female client with DID would abruptly tear and pull at her breasts in sessions, as though trying to pull them off. Several times I had to physically restrain this client, because I feared she would inflict severe injury to herself. At first, I tried to make sense of her behavior as

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"self-mutilation," a desire to cut off her sexual characteristics to obtain illusory control over the threat of sexual assault, or as the consequence of displaced rage and revenge. I eventually found, however, that this behavior belonged to an alter personality who identified with the client's close childhood friend. This friend had killed himself by running in front of a bus, which crushed him. This alter had internalized the dead friend, and the violent gestures I observed in sessions reflected this alter's compulsive attempts to pull out his hallucinated, crushed-in chest. In the dissociative, trance-logical world of this DID client, the violent tugging on her breasts became a way to affirm life, not to destroy it. Until I understood the context of this behavior, the client, in the traumatic transference, saw my efforts to physically restrain her as homicidal in intent.

Case Illustration: Pins and Needles

A 38-year-old female client with borderline personality disorder had been the victim of sadistic childhood sexual abuse perpetrated both by her mother and her father. She frequently inserted sharp objects into her vagina and rectum, and she often stuck pins in her perineum during masturbation. I learned in time that these behaviors reenacted aspects of her childhood abuse. This client's mother had frequently masturbated her daughter with sharp instruments, and she had forced her daughter to perform cunnilingus, after which the mother stuck sewing needles into her perineum while berating her for her "filthy thoughts." Thus, the client's compulsive behavior reenacted the behavioral component of a memory, a partial flashback, while the appropriate related affects, sensation, and knowledge remained submerged.

Case Illustration: Spiders and Snakes

A 43-year-old female DID client, working through memories of severe childhood abuse perpetrated by her sadistic brother, developed a drastic self-injurious behavior of violently scratching at her scalp and pulling out her hair in clumps. She couldn't point to the motivation for this behavior, reporting only that it would "overtake" her, leaving her helpless to stop what felt like automatic behavior to her. She speculated that extreme frustration ("pulling her hair out in frustration") might be driving the behavior. I noted, however, that the behavior didn't seem to occur in connection with frustration but rather with fear. Typically, it would come when she experienced fearful affects that we eventually linked to her early trauma. We found the motivation only after the client consented to have me induce the behavior through hypnotic suggestion, allowing her to free associate to it. It turned out to be the body sensations associated with a partial flashback to an episode of abuse in which spiders and a garter snake had been placed in her hair. The hair-pulling behavior reflected her unconscious attempt to tear the frightening, repulsive creatures from her hair.

An escalating frequency or severity of self-injury often indicates that the client can no longer effectively contain leaking unmetabolized traumatic material. In this case, clinicians and clients should first direct their efforts to shoring up the client's defenses, developing ego strength, enacting containment strategies, and managing external stressors. These efforts may give the client sufficient resources to proceed with depth work, resources that McCann (1991) described as affect tolerance, the ability to self-calm and self-soothe, and the ability to moderate self-loathing. When these intrapsychic resources are coupled with a stable, supportive interpersonal network and adequate therapeutic support, the intrusive memories may be fully abreacted or otherwise resolved clinically, so that they will no longer leak to manifest themselves as self-injury.

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Showing Without Telling: Self-Injury and Alexithymia

Self-injurious behaviors help manage the burdens of painful secrets but, paradoxically, they're also a way to show exactly what happened without breaking the abuser's fundamental injunction to keep the secret. At the least, self-injury indirectly expresses forbidden and painful sentiments, both of which are strongly enjoined in sexually abusive families. As a result, survivors of overwhelming trauma often suffer from alexithymia, a difficulty observing, describing, symbolizing, or using their feelings. They lack a "language of feelings" (Krystal, 1984; Hoppe, 1984) to express their pain, and so self-injury may become an alternative language for expressing forbidden secrets, sensations, and sentiments. The following case histories involve clients with similar histories of abuse, both of whom used self-injury to compulsively reenact their sentiments about early abuse, even when they couldn't express them in other ways.

Case Illustrations: Bound to the Past

Two female clients, ages 29 and 40, separately presented with long histories of acute and chronic wrist-rubbing and -scratching as features in polysymptomatic presentations. The 40-year-old couldn't remember when this behavior began, but she could remember occasional episodes of compulsive wrist-scratching as far back as her early grade school years. She reported that the behavior had become chronic by early adulthood. At presentation, this client would spend several hours a week in the evenings just sitting in a trance and rubbing her wrists. She reported that the frequency of her wrist-rubbing related directly to her stress levels, ranging from no episodes for weeks on end followed by a "binge" of daily acute episodes.

The 29-year-old client had faint memories of occasional wrist-rubbing and minor wrist-scratching episodes by late grade school. She also remembered sometimes finding her wrists red, irritated, and abraded upon awakening in the mornings during these years. Several times in junior and senior high school, she awakened in the middle of the night to find herself violently scratching at her wrists. By junior high, she had become deeply self-conscious of her wrists, and she began to use chronic compulsive wrist-scratching to reduce tension, manage stress, and regulate affect. Beginning in junior high school, she had experienced frequent intrusive and disturbing fantasies of lethally cutting her wrists with a large kitchen knife. These fantasies, however, related less to her wrist-scratching compulsion than to her chronic suicidality, a condition that led to two unsuccessful attempts to kill herself with drug overdoses during her teenage years. Her episodes often began as absent-minded wrist-rubbing

or -scratching, usually starting early in the day following a night of agitated sleep. Throughout the day, she experienced a steady increase in the intensity and frequency of the compulsion to deeply scratch, bringing with it an intensification of the actual rubbing and scratching behaviors. In the most severe episodes, she would isolate herself and, while transfixed in hypnotic fascination, she would mindlessly scratch one or both of their wrists for hours, often sustaining moderate injury.

Both clients denied ever cutting their wrists with any instruments more severe than their own fingernails, and both managed to hold jobs despite the symptoms. At the time they entered therapy, stress and extreme agitation would trigger acute compulsive scratching episodes in either client, with most severe episodes lasting for many hours. After such aggressive episodes, they each felt tremendous relief and mild euphoria. Both also reported frequently falling into a deep sleep soon afterward. Each of these clients reported at least one episode in which they had so severely abraded and gouged their wrists that they had to seek medical attention, despite a strong aversion to revealing the self-injurious nature of the wounds.

In the context of the time distorted, fragmented, information-deprived, and trance-logical realities of still-traumatized victims of abuse, self-injurious behaviors often become sane choices for survival.

In therapy, both clients eventually revealed histories of childhood sexual abuse marked by incidents of sexual assault involving wrist bondage. The 40-year-old client revealed two childhood incidents of gang rape and on-going incestuous sexual abuse that she had suffered during her school years. During at least one of the rapes, she had been bound by her wrists. In addition, she reported a year-long involvement with a sadistic older boyfriend during her early twenties. Throughout this sadistic, master/slave sexual relationship, she often had to submit to a variety of sexually sadistic acts while gagged and bound by the wrists.

The 29-year-old client eventually disclosed an incestuous relationship with her father that started when she was "about six" and continued until she turned ten. As a part of at least one sadistic sexual assault, her father had bound her by the wrists. She also disclosed a periodic incestuous relationship with her brother. In one especially violent memory of fraternal sexual abuse, which occurred when she was seven and he was 15, her brother had bound her by her wrists to a cot in the basement of the family home. Then, along with two of his friends, he sexually assaulted and tormented her.

In therapy, both clients came to understand the genesis of their wrist-scratching compulsions in the unintegrated traumatic feelings, sensations, and knowledge of sexually abusive bondage. Unable to know or tell their stories directly, they had shown them time and again through the unconscious symbolism of self-injury. As they integrated the traumatic memories, their wrist-scratching compulsions gradually subsided then stopped altogether. Looking back to early adolescence, they realized that, since then, any acute sense of entrapment or danger would trigger kinesthetic sensations of wrist restraint, which in turn led to scratching. This scratching wasn't a means to injure or destroy themselves; rather, it indicated an unconscious attempt to point to the cause of their real distress.

For survivors of childhood sexual abuse, chronic self-injury is both a sequelae to and a *behavioral container* for unintegrated traumatic stress. As these case illustrations show, acts of self-injury sometimes reenact early traumatic abuse; at other times, they act as a way to show exactly what happened without breaking the abuser's injunction of silence. Rather than having self-destructive intent, they're functional attempts to manage intrapsychic and interpersonal stress. For survivors of chronic childhood sexual abuse—their personal realities fractured, distorted in time, deprived of information, informed by the logic of trance—self-injurious behaviors point to other areas of dysfunction. Clinicians who misinterpret this self-regulative (self-protective) intent as suicidal (self-destructive) run the risk of worsening self-injurious behaviors or contributing to their chronicity.

In the next issue, I'll continue this analysis of the sources, motivations, and functions of self-injury, including an exploration of their clinical implications. I'll examine the role of self-injury in self-regulation as well as the relationship between self-injury, rage, and other forbidden affects. I'll conclude this first two-part presentation with a discussion of trance logic and magical thinking in self-injurious clients. In future articles in the series, I'll explore cultural aspects of self-harm and countertransference issues involved in self-injury. I'll conclude the series with a presentation of intervention guidelines for chronic self-injury. ■

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David L. Calof is a working clinician in Seattle, Washington, who also frequently consults and lectures internationally on the treatment of sexual abuse, posttraumatic stress, and the dissociative disorders. He is the author of numerous articles and book chapters on these topics, as well as hypnotherapy and family therapy. He is the editor of *Treating Abuse Today.*