Chronic Self-Injury in Adult Survivors of Childhood Abuse

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

by David L. Calof

[Editor's Note: This article is the second in a series discussing chronic self-injury in adult survivors of severe childhood abuse. In the first article, the author distinguished parasuicidal (that is, self-injurious) from suicidal behaviors, and discussed how self-injury acts as a container for unresolved or on-going psychophysiological trauma. In this article, Calof explores other functions, sources, and motivations of self-injury, including affect regulation, secondary gain, trance logic, and magical thinking.]

Survivors of childhood abuse often engage in forms of self-injury as functional attempts to regulate intrusive sensory, affective, and cognitive states. Though driven usually by severely distorted and anachronistic thinking, self-injury is best understood as an attempt to manage rather than end a difficult existence. The patterns of thought and belief that typically support this behavior appear illogical to us on the surface (for example, "Hurting will relieve the pain"). Yet, in the context of the abused child's mental universe—distorted in time, fragmented, deprived of information—these patterns are internally logical and rational. Understanding this logical context will better equip clinicians to interpret accurately the underlying motives driving self-injury and to provide alternative means of satisfying its deep, self-protective intent. In this article, the second in this series on chronic self-injury, I'll discuss various self-regulative functions of self-injury and the varieties of trance logical and magical thinking that potentiate them.

Regulating Affect, Sensation, and Knowledge through Self-Injury

Adult survivors of childhood abuse may experience overwhelming anxiety, fear, guilt, pain, loss, shame, doubt, confusion, abandonment, loneliness, and emptiness. These feelings often intensify in psychotherapy, and clients may experience a strong tendency to get caught in cognitive, affective, and sensory loops (partial flashbacks, catastrophizing, phobic states, escalating self-deprecation, anticipatory dread, and so on). Under these circumstances, self-injury may function to keep clients oriented to the present and distracted from difficult, intrusive, cyclical material. In this way, self-injury is a management means, a *counterirritant* to unwanted affects, sensations, and knowledge.

The fundamental trance logical stance of the self-injuring client is, Hurting will relieve the pain or prevent worse pain.

Self-injury is thus closely associated with the capacity for dissociation and trance. Survivors may use methodical self-injury as a means of inducing autohypnotic states that serve a number of purposes, including psychic and physical numbing, reduction of tension, and dissociation from on-going experience. Teaching clients more direct means of tension reduction (such as warm baths, breathing techniques, progressive relaxation, stretching, and exercise)—as well as autohypnotic techniques for managing intrusive affective states, body sensations, and cognitions—can alleviate the use of self-injury to achieve these same ends.

Preventing or Consequenting Disclosure through Self-Injury

Clients may self-injure both to prevent the disclosure of secrets or as a punishing consequence for telling. Probing for historical data in post-abuse therapy can potentiate self-injury that is serving to keep a lid on secrets. Perceived danger, guilt and shame, instability and poor ego-strength, and secondary gain (for example, financial dependence, family affiliation, and

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threats of extortion) all cause survivors to cling tightly to their secrets. Several other factors potentiate the aversion to disclose. Clients may harbor the distortion that disclosing will contaminate, overwhelm, or harm the therapist. Perpetrators typically model or threaten negative consequences for victims' breaking secrets, thus reinforcing victims' distorted beliefs in contamination and aversive consequences for disclosure. Self-injury may function as its own aversive consequence as a means for managing secrets.

Secondary Gain in Self-Injury

We mistake ourselves when we overemphasize the idea that self-injury in abuse survivors amounts to a manipulative ploy for "special" attention. Self-injury may emerge from an interpersonal manipulation for attention on some occasions, but more often it's an indirect effort to garner a greater sense of safety, containment, or limits. Escalating self-injury may be a plea for hospitalization, for example, or a means by which abuse survivors indirectly express their worries that their therapists are overwhelmed or angry. In my experience, only rarely is self-injury a way to demand the therapist's "special" attention or favor. More often it has escalated behind a veil of secrecy that the client maintains and only reluctantly discloses to the therapist.

Sexual stimulation associated with self-injury can become a form of secondary gain. The pairing of pain with sexual arousal during childhood sexual abuse creates a strong link between sexuality and pain, and so some adolescent and adult survivors turn to self-injury as a way to trigger sexual arousal. Working with these clients, therapists must help them break the link between sexual pleasure and pain.

Physical pain and sexual arousal are often paired in childhood abuse. This pairing may be intended, often the case in sadistic abuse, or it may result from the inappropriate and traumatic physical demands placed on a child's body by sexual abuse. Sexual arousal tends to lessen the experience of painful sensations, and so, through a mental leap of trance logic,[1] the victim confuses the reduction or distraction of pain with pleasure. Another cognitive distortion adds to this confusion. Survivors of childhood sexual abuse often conclude that sexual arousal concomitant to abuse must have meant they "liked it." Otherwise, they reason, why would they have found certain aspects of the abuse pleasurable? Perpetrators reinforce this distortion by claiming that victims somehow "asked for it." Thus, the admixture of traumatic and pleasurable sensations may become linked with the idea of volitional pleasure.

The generalization that pain is sexually pleasurable carries over into adolescent and adult sexuality. Victims who manifest this type of distorted trance-logical thinking may purposefully induce pain and injury to bring about sexual arousal. Some aspects of the abusive acts may have been sexually stimulating, but to maintain that these acts *in toto* were pleasurable demands that victims consider the sensations quite out of context. Clients who show such confusion and distortion must learn that they're denying, dissociating, and minimizing important physical and emotional feedback to keep up the "pain is pleasure" trance logic. This distorted view of the "pleasure" of abusive acts ignores all the unpleasant aspects. Viewed in the context of terror, violence, physical pain, secretiveness, shame, and humiliation, the experience can hardly be called "pleasurable." Clinical work must reintroduce appropriate affects, body sensations, and denied or minimized knowledge.

I've found the following question helpful in this reintroduction: "So, you say you liked it. Does this mean you would like the abuse to happen again?" Almost universally, of course, the answer is a resounding "No!" I follow this response with another question: "Well, then, why not?" The answer to this question leads to the aspects of the experience that clients have learned to overlook, minimize, deny, or dissociate. Through ideomotor (finger signaling, use of the Chevreul Pendulum, automatic writing), ideosensory (imagery, inner dialogue), and other techniques, clients can regain this dissociated sensory, emotional, and cognitive data. When clients recall the full experience of the abusive acts and diffuse the reinforcing injunctions, they usually let go of the belief that the acts were pleasurable and associate to the appropriate affects and sensibilities. Since this approach can trigger unexpected abreactions, clinicians must be judicious in its use, considering both pacing and containment issues.

Ultimately, the client must break the link between sexual arousal and painful trauma. Logs of behavior, feelings, and cognitions around sexual arousal may be helpful to the client to track where these two currents cross. Measured exploration of autosexuality or appropriate sexuality with a partner may also yield opportunities to break the link, to reconfigure triggers and cues. Bibliotherapy can also help clients learn appropriate sexuality.

Another possible source of secondary gain with self-harm emerges from the addictive euphoria that often accompanies it. Some people report before, during, or after acts of self-injury that they feel carefree, calm, and often elated. This euphoria probably derives from a number of factors. Dissociation, depersonalization and derealization, endorphin and other biochemical effects all provide psychic numbing and analgesia. Surviving self-injury also provides a sense of overcoming assault. This mastery and freedom from pain, however brief, brings with it a measure of relative joy and excitement. In contrast to the state of dread often preceding self-injury, it may be interpreted as a euphoric state.

The sight of the blood more than the associated sensations or feelings may thus function as literal "proof" for depersonalized clients that in fact they're alive and real ("capable of bleeding").

Trance Logic and Magical Thinking in Self-injury

Orne (1959) coined the term "trance logic" to refer to one of the unique characteristics of a deeply hypnotic subject, the ability to freely mix perceptions derived from reality with those derived from imagined events. In general, the term refers to the subject's ability to tolerate, without apparent disturbance, the coexistence of multiple incongruous perceptions or logically inconsistent ideas (Udolf, 1981; Brown & Fromm, 1986). This subjective logic characterizes the somnambulist, the magical child, the dreamer, and the dissociative trauma survivor. Each case involves a fluidity in orientation to person, place, time, and sensory perception, as well as a boundary diffusion between the mental environment and external reality.

The fundamental trance logical stance of the self-injuring client is, *Hurting will relieve the pain or prevent worse pain.* In the follow-

1 I'll discuss trance logic in more detail in the next section of this article.

ing sections I describe several varieties of trance logic and magical thinking that commonly motivate self-injury.

I can't know I'm alive or real unless I hurt or bleed.

Traumatic demands, sexual objectification, and the internalized paradoxical communication of sexually abusive family systems potentiate depersonalization and derealization in survivors of severe childhood abuse. Quite often such survivors may claim that they don't know for sure if they're alive or if their experiences are real. Simpson (1975) and others have observed that depersonalization and feelings of unreality often precede self-injury, and so the practice sometimes functions as a defense against these states (Asch, 1971; Miller & Bashkin, 1974; Calof, 1992). Gioviaccini (1956), for example, proposed that the pain associated with self-injury creates a self-representation: feeling is equated with life, non-feeling with non-existence. Miller and Bashkin (1974) suggest that, in the presence of a perceived threat of psychic dissolution, self-injury reconstitutes the self, thus ending the episode of depersonalization.

Self-injury often occurs without pain or with greatly dulled pain (Bach y Rita, 1974; Bach y Rita & Veno, 1974), so the sight of the blood more than the associated sensations or feelings may thus function as literal "proof" for depersonalized clients that in fact they're alive and real ("capable of bleeding"). Self-injury may offer young victims such immediate relief from terrifying feelings and sensations that they quickly internalize it as a prescription for chronic self-injury: *I can't know I'm alive or real unless I hurt or bleed.* Self-injury gives survivors the ability to terminate depersonalization without having to feel disturbing emotions or distressing body states. Self-injury thus becomes an external feedback loop.

Before clients can abandon this external verification loop and derive their sense of personal reality through connections with inner states grounded in body sensations, they must often work first to develop a sense of safety, ownership, and control of their own bodies. I've found variations of the following method useful in bringing about this development.

Using sensory-dense internal imagery, I suggest to clients in a receptive state of inner focus that they review a wide variety of daily, satisfying, benign physical experiences. I ask them to remember times when they quenched a powerful thirst, experienced a satisfying yawn or sneeze, unkinked through a good stretch, found themselves spontaneously moving to music, scratched an itch, broke forth in a great belly laugh, and so on. To reduce threat, I usually begin "above the belt." In short, I ask them to focus only on those things that feel good about living in a body, no matter how basic or small. Through these memories, clients begin to learn that they're real, with bodies that don't always feel bad.

Varieties of Self-Injury in Survivors of Childhood Abuse

Survivors of childhood abuse show a great range of self-injurious behaviors. Among the most common are

- cutting
- burning
- lip and mouth biting
- nail and cuticle mutilation
- self-hitting
- injurious masturbation
- insertion of dangerous objects into body openings
- self-induction of pain without physical injury

More extreme behaviors include

- head-banging
- application of caustics and abrasives
- scalding showers
- swallowing foreign objects
- stereotypy such as hair-pulling and abrasive scratching
- aggravating chronic wounds

At their most extreme, these practices include

- self-surgery
- self-suturing
- attempted removal or alteration of body parts (including clitoridectomy, castration, eye enucleation, and so on)

Certain practices may fall within subcultural norms of expression, including self-adornment or identification. These practices, however, show wide variations in severity, chronicity, and morbidity, and so they should be evaluated for self-injurious intent in cases including suspected histories of child abuse. These practices include

- tattooing
- extensive, excessive shaving of body parts
- piercing of the ears, nose, tongue, nipples, and other body parts
- branding

Self-injurious intent may also be expressed through passive collusion. This can include

- failure to seek or follow through with required medical care or medication
- failure to practice necessary personal care
- transient avoidance of food or fluids
- colluding with or provoking others to harm the self
- frequent or severe accident proneness

If I hurt myself, I'll become pure.

The desire for purification emerges from the magical thinking abused children harbor toward the hurtful, dirty deeds done to them. A kind of psychological contraction occurs in children who are hurt by the people who should have protected them. To preserve the illusion of benign and adequate caregivers, children transform what was *done wrong* to them into what *is wrong* with them. Victims of severe childhood abuse often believe that dirty things happened to them because *they* were dirty, or at best they believe that they became dirty because dirty things happened to them. Self-cutting most clearly shows the desire for ritual or symbolic purification. As with the antiquated practice of bloodletting, self-cutting lets out the "bad vapors," reflecting the belief that what got put inside can be bled out.

The misfortune happening to me is about me.

The illusion of control makes up another form of magical thinking prevalent among abuse and trauma victims. We all have a basic need to feel a degree of mastery over our destinies. In non-traumatic times we take this mastery for granted, but when traumatic events threaten our sense of security, we often create rationalizations to preserve at least the illusion that we control our lives. Abuse survivors aren't alone in their use of this rationalization. Think back to the last time you had a flat tire during rush hour, or your plumbing broke mid-way through your morning shower, or your computer crashed the night before you had to submit your thesis. Probably you experienced a moment of impotent rage, followed by some variation of the questions "Why me!?" or "What did I do to deserve this!?" In that moment, you acted as though some rational force brought this calamity upon you, that something about you or something you did "caused" this bad thing to happen to you. In this way, of course, you preserved the illusion that you could do something to control it, or at least you *could* have done something. In other words,

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if you had been "good enough" in the past, you wouldn't have incurred this present calamity, and if you could only be "good enough" in the future, you might never again suffer such a calamity.

We find this illusory control preferable to the idea that we all live under the threat of random events, the natural disasters or evil acts beyond our control. The illusion of control allows us to live our lives despite the reality of random peril posed by drunk drivers, arsonists, gang members, terrorists, disgruntled loners, plane crashes, epidemics, natural disasters, nuclear meltdowns, and a thousand other calamities waiting in the wings.

Abuse survivors often draw on this widely used rationalization: *The misfortune happening to me is about me.* Though generally irrational, this stance preserves the belief that the bad things that happen to them are somehow within their control. In effect, victims of severe childhood abuse often conclude that the abuse must be their fault. Thus they preserve the illusion of benign and just caregivers, and they create a sense of an internal locus of control: *If the bad things happening to me are about me, because I'm bad, then it's within my control to change, and there's hope for me. If they're not fundamentally about me, if I haven't done anything to deserve these bad things, then there's nothing I can change to control it, so I'm powerless and without hope.*

In survivors of severe childhood abuse, rationalizations of illusory control become a closely held personal logic, a logic often manifested in self-injury. Self-injury long has been associated with the traditional conception of *feminine masochism.* In this way of thinking, self-injury (especially of the genitalia) represents the desire for subjugation or sexual abuse, or sexual gratification derived from pain. Freud described this type of erotogenic masochism as the "lust of pain"; feminine masochism was thus an expression of feminine nature (Hensie & Campbell, 1974). In the trauma orientation to human dysfunction, we understand the motivational framework for self-injury very differently. Rather than having purely intrapsychic meaning, the motivation for self-injury takes on an interpersonal dimension. Self-injury often seeks to prevent or extinguish aggression in others. In this sense, victims use self-injury to ward off even more dangerous perceived threats (Bieber, 1974). The stance, *I'll hurt myself to make you stop,* a fundamental statement of the illusion of control, embodies this dynamic. The correlative statement, *Even if I can't make you stop, I'll hurt myself worse than you can hurt me,* reflects the magical belief that victims can make others hurt them less by hurting themselves more. A power stance often underlies both these statements: *I can survive your punishment because I can survive my own even worse punishment.*

Another related magical belief emerges from this same dynamic: *Since I'm going to be hurt anyway, let me take control of it and get it over with.* This stance encourages self-injury as a way to manage acute anxiety. Let's examine this motivational framework more closely.

Unrecovered childhood abuse survivors live trapped in past time, in that they still experience the same hypervigilance and the same expectation of imminent harm that characterized their childhoods. Several alter personalities named "Amber" I've encountered in my DID clients suggest this suspension in time. Present anxiety and tension tend to become associated with unmetabolized affects and body sensations of early traumatic experiences. These usually unconscious or vaguely conscious associations trigger a sense of helplessness and danger coupled with an expectation of inevitable harm. Thus, the traumatic past superimposes a template of behavior, affect, and belief onto the present. In this frighteningly powerless (regressed) position, survivors experience a natural yearning to cling to some measure of control and to end their anticipatory dread.

Survivors learn to associate "safety" with those times immediately following episodes of traumatic abuse. At least for a while after an abusive episode, they may have some certainty of freedom from further harm. In time, victims come to associate this "safety" with an end-state that may include bleeding, body marks, various levels of residual pain, or unconsciousness. Present fear or stress can trigger a desire to recreate the elements of this end-state, and self-injury may offer the way to recreate them. Thus, people who engage in self-injury may be attempting to preserve the illusion of control by "getting it over with," thus ending the dread and creating "safety."

The illusion of control also often underlies self-injury used to mark out body ownership or boundaries. After an especially traumatizing and insensitive handling of an invasive medical procedure, for example, one hospitalized survivor of sadistic abuse carved her initials deeply into her hip. She literally used her body to state, "This is my body and I'm the only one who can hurt it." When compounded by identity confusion and boundary diffusion from early boundary intrusions, this magical belief may transform itself into vindictive destructive behavior: *When I hurt myself, you'll feel the pain.* In effect, victims come to believe self-injury is a way to get even, to make someone else hurt by hurting themselves.

Self-mutilation and neglectful self-care also can serve to make survivors feel sexually unattractive, thus safer from sexual assault. Child victims are led to believe others could not help but hurt them. They struggle to find something in their own control that makes adults treat them so. They look to the same body parts that fascinate and "provoke" their perpetrators. In their black-and-white thinking, they reason that without those parts they will no longer attract such treatment. A long-term fantasy of removing breasts or genitalia may develop into a powerful compulsion to act it out.

The following case illustration shows the extent to which the illusion of control can motivate gross self-injury. Trying to master her horrific history of unresolved abuse, the client attempted to convert her enormous emotional pressures and unresolved traumatic stress into simple, manageable acts of self-mutilation.

Case Illustration: The Unkindest Cut

A 26-year-old female client had a history of sadistic childhood sexual abuse by multiple perpetrators, including being prostituted by her father to various associates during her grade school and early junior high school years. The assaults by multiple perpetrators usually occurred at drunken "parties" that typically culminated in brutal gang rape. This terrifying finale followed the men's sexual stimulation of the child through various means. Apparently the men had an ongoing competition to see who could have the greatest sexual effect on the girl. By the time this methodical assault reached its peak, it usually brought extreme discomfort, pain, and injury to the child.

During one episode, the girl found the way to simulate arousal while dissociating from the actual sensations. This simulation allowed her to curtail the escalating severity of the abuse by apparently strongly responding to the men. It also allowed her to dissociate during the subsequent gang rape. The next time she tried this ploy, however, the men quickly detected it, and they meted out severe punishment. As a result, the girl could no longer dissociate during her ordeals, because she couldn't manifest sexual arousal while dissociated nor could she adequately disguise the simulation. She thus became a prisoner unable to escape the

unwanted sensations in her own body.

In therapy, this client eventually revealed a chronic practice of genital cutting going back to preadolescence, primarily involving her clitoris and to a lesser degree her labia. By the time she entered therapy with me, the cumulative effect of these numerous self-woundings had caused the nearly complete removal of her clitoris along with extensive genital scarring. After severe episodes, the client often chose to suture herself rather than seek medical attention. She avoided medical attention because of her deep shame over the acts and her fear that the doctors would discover how "bad" she had been. She expressed a strong fear that the doctors would commit her to an institution if they discovered the extent of her chronic self-mutilation.

I noticed that the pattern of reported genital cutting escalated each time we approached any of the "party" memories. My first attempts to moderate these morbid practices proceeded from my assumption that they represented self-hatred born out of identification with her perpetrators. I assumed that the client needed to understand and metabolize the rage she harbored for her perpetrators so she could stop displacing it onto her own body. Extensive probing and numerous interventions within this framework, however, did very little to moderate either the severity or frequency of genital mutilation. In fact, the episodes seemed to worsen.

Realizing the futility of my approach, I finally shifted my position to suggest that, despite their injurious effect, these practices must have an undiscovered positive intent. If we could find this intent, I reasoned, perhaps we could help her find less injurious ways to carry it out. This framework rang true to the client who, despite her grave shame and embarrassment for this bizarre behavior, clearly didn't want to give it up.

Shortly after introducing this new frame, I noticed a slight but discernible reduction in the reported cutting. Eventually I asked the client to imagine a time in the distant future when she could stop the cutting altogether, because it had finally achieved its end. The client described a fantasy in which her clitoris had completely disappeared, thus making her incapable of sexual arousal. I asked, "And what's good about that?" In an emotional burst of self-disclosure and insight, the client cried out, "If I didn't have one of those things [meaning a clitoris], then this abuse wouldn't have happened to me!" In the magical thinking of a child, she believed that if she became incapable of arousal, her past and all potential future abusers would leave her alone.

Self-injury often seeks to prevent or extinguish aggression in others.

Clearly the client's fantasies and actual attempts at clitoridectomies gave her the illusion of power and control. She unconsciously believed that she could stop the drunken abuses of out-of-control men merely by altering her anatomy. After the client revealed this material, I understood that my earlier probing into the sensations, beliefs, and feelings associated with the "parties" had triggered a regressive effect. The probing had thrown the client back to the demand characteristics of the abuse, thus heightening her need to exert control through self-injury. I also realized that my earlier framing of her genital mutilation as "self-destructive" (identification with her perpetrators) had only added to this client's sense of shame and fail-

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ure, because she had interpreted my stance as saying that she stood at fault.

Once we discovered the positive intent of the genital mutilation, we redirected our efforts toward achieving a greater sense of immediate safety for the client, including better emotional insulation from her father who still lived in the area. We delayed any exploration of the "party" memories until the client achieved stability and decreased the self-mutilating behavior to near extinction, thereby lessening her sense of deep shame and increasing her ego strength. Once the client achieved these goals, she was able to metabolize her memories of terrible abuse with only a few minor escalations of her old practices of self-mutilation.

To work effectively with self-injury in survivors of childhood abuse, clinicians must understand that various forms of distorted thinking resulting from early abuse motivate self-injury. In these trance logical, magical ways of world-making, clinicians may discern the self-protective intent behind self-injury and self-mutilation.

In general, therapists must work with the self-injuring aspects of the clients' selves that cling to illusory control and other forms of magical thinking, although self-protective in intent, that perpetuate self-injury. We do this work by validating the protective functions of these aspects, recognizing their unsung efforts and miseries, and offering clients other ways to carry out the specific underlying positive intent of their self-injurious behavior.

In the next article of this series, I will explore the special relationship of self-injury to unmetabolized traumatic rage. I will discuss how displaced traumatic rage can drive self-injury and will describe a rage-reduction procedure for depotentiating self-injury. ■

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