

SELF-HARM AND SUICIDALITY

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At the core of child abuse and neglect is a family pattern in which the child's body, mind and emotions are available to be exploited by adults, either to gratify their needs or provide an outlet for their tensions (Miller, 1994). It should not surprise us, then, that children whose bodies have been used in this way might become adults who in turn use their bodies to relieve tension or act out impulses. Their experience is that a body is a vehicle for tension and has no other real value. To make matters worse, abused children are also deprived of the normal experiences of tension relief. When distressed, most children seek connections with others, preferably adults, to find soothing, reassurance, or comfort. Children who have experienced neglect or abuse have learned to avoid connection, rather than seek it, and to rely almost exclusively on their own resources.

A patient of mine recalls compulsively riding her rocking horse at a furious pace until she achieved a trance-like state of calm. At the age of 39, this successful sales rep will go into her bedroom when distressed and rock herself into that same state, then play hours of video solitaire to maintain it. Still another patient retreats to her closet and sits for hours in the dark. If that does not work, she has found that making small cuts with a knife or a piece of glass induces relief, or banging her head with her fists or engaging in some strenuous physical activity (like leaf-raking or gardening) until her muscles are "screaming" in pain.

Because they are unable to trust or to effectively use other people for support, survivors of trauma seek relief in a variety of behaviors that share the common characteristic of not requiring reliance on anyone but themselves. Some use drugs and alcohol to numb; some use self-starvation or bingeing and purging to achieve a similar state of calm or "non-feeling." Still others engage in a variety of self-injuring behaviors, such as cutting, scratching, burning, hitting or punching, head-banging, and even blood-letting. Ingesting sharp objects or inserting them into the vagina or other orifices is also a common type of self-injury among trauma survivors. Relief may also be sought through high-risk behaviors (speeding, walking in dangerous areas at night, walking in front of cars) which induce an adrenaline response and therefore an state of calm. Fantasies of suicide and planning suicide methods can easily induce the same psychobiological effects and therefore can also become a paradoxical way of coping and calming.

The most common mistake made by therapists is the **assumption that self-harm and suicidality cause pain, rather than relieve it**. If we assume that self-harm induces pain, then we will interpret it as masochism or self-punishment or a cry for help. And if we do

that, we will miss the core issue in self-harm of mastery- and relief-seeking. Because to interpret it as self-punishment usually leads the patient right into her feelings of shame and worthlessness, and she responds by thinking or saying, "But I am bad—I do deserve to be punished—and since I'll never feel anything but hate for myself, I'll never stop my self-harm." Or, "Since I will never be able to help myself, my only hope is to keep crying for help."

If, on the other hand, we go to the heart of the matter (to the fact that hurting the body, or planning to, brings welcome **relief** and is in fact an ingenious attempt to **cope** with overwhelming distress and tension), the patient will feel understood, and the therapist will be able to share the dilemma with her. If we acknowledge that self-harm and suicidality **work** in a paradoxical way and that the patient currently has no better way to soothe herself, we can begin to talk with her about why self-harm works and what other ways of achieving tension release could fulfill the same needs.

Let us go back to the fact that the body has become the expected vehicle for tension relief and that accessing help or support is not an option because connection with others has always been more dangerous than helpful. Let us also remember what we know about the psychobiological effects of trauma: that the patient has become accustomed, perhaps even addicted, to adrenaline. She has learned that adrenaline is calming, that dissociation is calming, and that pain can increase the production of endorphins inducing an analgesic effect. And all of these ways of calming the body are completely under her control: she does not have to depend on anyone to achieve relief from distress through any of these avenues. Thus, self-harm of any sort "makes sense": all forms of self-harm either induce adrenaline responses, dissociation, or an increase in endorphin production. And the self-harm "doesn't matter" because the body doesn't matter. No wonder our patients are surprised and sometimes even annoyed that their self-harm and suicidality matter so much to us! In fact, they may even interpret our interventions to prevent or reduce suicidality as our not caring about how they feel.

The most common mistakes that well-intentioned therapists make in trying to deal with self-harm and suicidality are:

- Not understanding the degree of relief associated with self-harm
- Not understanding the need of trauma survivors to rely on their own resources or to avoid relying on others
- Not understanding that care of the body is not a priority to them
- Not understanding the shame and secrecy that surrounds self-harming thoughts and behavior
- Not understanding that the patient has no internalized protective introjects, only an internalized abuser, a helpless child, and a non-protective bystander
- Becoming engaged in a struggle with the patient about safety in which the therapist becomes the spokesperson in favor of safety and the patient the spokesperson in favor of self-harm
- Neglecting the task of helping the patient to struggle with her own internal conflicts about self-harm

How do we transform these potential pitfalls into therapeutic victories?

First, if we approach the patient's report of having harmed herself in some way as an attempt to get relief from intolerable feelings, then we start by asking about what she was **feeling** instead of what she did to herself. If we then inquire about other ways she tried to deal with these feelings before she turned to self-harm, we will get a better idea of her coping repertoire. If we ask her to walk us through the suicide attempt and describe the "early warning signs" that the feelings were becoming intolerable and when she began to think of suicide, when she began to plan, and how much, if any, relief she got from the planning, she will sense our interest in help her to feel better, not just to act better. If we ask about exactly **how** the self-harm worked to help her feel better, we will get some idea of what alternative coping mechanisms might help. We can empathize with how hard and overwhelming the feelings can be, and even with her conviction that she had to do something. We can re-frame the suicidal ideation as her "bail-out plan," always available as a comfort or alternative if everything else fails, a way to survive the pain by having a way to control it, rather than a way to die. If we have done that much, we will now have established enough credibility as therapists to talk frankly about the costs of continuing to get relief in this way. I usually start by asking the patient a series of questions in as tactful and gentle a way as possible:

- What feelings and thoughts and sensations trigger the urge to self-harm? What symptoms is s/he trying to 'treat'?
- Does it bring relief just to think about it?
- How can s/he tell that she 'has' to self-injure?
- Most importantly, how long does the relief last? (As with all addictive behavior, the periods of relief generally get shorter as tolerance increases.)
- Is there ever any "backlash" after s/he self-harms? (for example, shame, pain from the self-injury, feelings of being crazy, increased suicidality)

Having had such a discussion (in which the patient is validated as not crazy but resourceful and the therapist allies with the goal of decreasing her distress), it becomes meaningful to talk about "the downside of self-harm:" how it neurobiologically brings short-term relief but prevents long-term recovery. Because the therapist has established that he or she understands, the patient is not so quick to engage in the struggle about her need and right to self-harm. I tell my patients very frankly that any type of unsafe behavior in their current lives will prolong their therapeutic journey. Using psychoeducational information about trauma, I outline the risks and benefits of self-harm in terms that are meaningful to that individual with that particular history: it might be that safety is essential for their wounds to heal, for them to feel safe in the present, or for their bodies to become convinced that they are finally safe. I emphasize that the two most important tasks facing us are creating safety in the present and finding safe ways to "take the edge off the pain." I deliberately use the phrase, "take the edge off," to emphasize that we can't give them complete relief of the sort they wish for but we can help them learn how to soothe and reduce the intensity of their distress.

We must understand that all the different types of self-harm or self-injury originated with the reality that, even as small children or infants, these patients were forced to depend on their own minds or their bodies for self-soothing or distress relief. In so doing, they discovered that they could capitalize on the very same psychobiological self-protective responses caused by the trauma. The next related important piece of understanding is that the survivor's other resources are very limited by virtue of her experience of inadequate parenting. Bessel van der Kolk's study of the childhood origins of self-destructive behavior found that neglect, not severity of abuse, was the variable most highly related to frequency and treatment-resistance of self-harm. The conclusion was that neglect, even more than abuse, forces the child to turn to herself and only herself when in distress. Abuse and neglect also both decrease the sense of trust in others and increase the sense that it is safer to turn to cutting or starving or risk-taking. It is very helpful for the therapist to validate that the self-harming behavior has become the patient's "friend" over the years, that even being able to think about suicide or self-harm at times can be a comfort, and conversely, that being told to call the emergency service or the therapist or even a friend can increase distress. Initially, it is often helpful to encourage the patient to find other ways of getting some relief without having to turn to others: for example, learning to induce numbing by rubbing an ice cube on her arm instead of cutting, or drawing cut marks with a red magic marker if she needs the sight of blood to induce an adrenaline rush, or putting rubber bands on her wrists and snapping them to create just enough pain. Over time, the therapist can begin to help the patient learn how and when to turn to others. In the meantime, the patient needs our concern and commitment to pain relief more than our actual availability because the only ways she knows to "ask for support" are to ask indirectly through action or provocative behavior, or to just throw up her hands and give up any attempt to help herself. Both of these tend to backfire because the therapist's response is usually either to tell the patient to keep herself "safe" (the only ways she knows how, of course, are unsafe) or to go to the Emergency Room (signaling to the patient that the therapist can't or won't help.)

So, what do we do?

The core concept in work with self-harm and suicidality is to try to keep our own anxiety from interfering with our ability to ally ourselves with the patient around the core dilemma inherent in unsafe behavior:

She desperately wants relief from her overwhelming pain—she desperately wants to "get better" or to feel better—and the only she knows how is to hurt herself or to threaten her own life. She cannot ask for help in a healthy way because her experience of connection and closeness with others has been unsafe. Pain and connection to others has gone hand-in-hand. She has great difficulty even imagining realistic, safe, pain-free relational connections.

So, rather than try to make a relational connection by emphasizing that she call us or our institution, we can empathically ally ourselves with her around the dilemma. If she calls and does not get a response that brings some relief, she will feel more suicidal and impulsive. If she does not reach out, she will continue to have to solve the dilemma in a

way that prevents her getting better. We can struggle with her, rather than against her, to find ways that work: does it help to write to her therapist about the pain? Does it help to call a friend? Does it help to ally with herself by reminding herself why she is feeling so unsafe? Does it help to remember that every minute she keeps herself safe will take weeks or months off the total time of her recovery? Does she need to remind herself that, the longer it takes to achieve safety and stability, the longer it will take to "get better."

Another common mistake we therapists make in treating suicidality and self-harm is to forget that the body to a trauma survivor is a source of shame, not pride: it either has no value or is experienced as disconnected and unreal. Self-harm is much more ego-syntonic if the body does not matter or if it is an object of disgust. Our reactions as therapists to self-harm arise from our very different perceptions: that the body is a temple or at least a house. We cannot expect trauma survivors to adopt these attitudes, but we can teach them how to treat the body respectfully. As Esther Cancelli (a therapist and trauma survivor herself) says, "I had to learn to treat myself the way I would treat someone I loved and respected, even though I did not believe it." Learning how to treat the body with respect now helps to undo the effects of the disrespect of the past. Trauma survivors do know that abuse in the abstract is wrong and disrespectful, even though they may have developed a self-image of being so bad they deserved their own abuse. We can build on their intellectual understanding that abuse is unjust in order to ask them to "right the wrong" by treating their bodies differently, even when they do not want to. We may want to give them some psychoeducation about the effects of neglect on the ability to care for themselves physically or seek medical and dental care or to drive safely and wear a seatbelt or to eat regular, healthy meals. But if we don't start with some compassionately stated explanation for why they neglect their bodies so badly, we may inadvertently increase their shame. If we do not understand the magnitude of their disconnection from their bodies, we may have difficulty helping them to see it. For example, we need to appreciate that suicidal ideation is "magical thinking" that, by threatening the survival of the body, the mind will find peace. That fantasy is a fantasy that depends on the trauma survivor's perception of her body as "not her." (In DID patients, that disconnection reaches such an extreme that "killer" alters often think that they can "kill" the body but they themselves will live.) We need to help patients to understand that this disconnection and lack of value she places even on the survival of her body is the result of her abuse: she survived by disconnecting from and devaluing her body, by retreating to the safety of her mind. Her body was threatened and assaulted, and she was helpless to prevent that, but she was not so helpless that she could not find the one escape route: into her own mind. Now, if that mind of hers turns on the body and treats it as her abusers did, she will be able to achieve the sense of disconnection again, but she will keep paying the same price she did as a child.

Which brings us to the next most common mistake made by therapists working with patients who self-harm: not understanding the shame and secrecy that accompany self-destructive thoughts and feelings. At the moment the distress feels intolerable, the need to do something supercedes any other thought or priority. However, at some level, the patient knows that there is something "wrong" with what she is doing: thus, most self-harm is a solitary act performed when the patient is alone in an atmosphere of secrecy not

unlike that which accompanied the original abuse. After the relief comes, the shame is not far behind. These patients feel bad, crazy, defective, repulsed, and humiliated as they project onto others what they think about themselves. Take the patient who hides in the dark closet for hours then cuts herself if the darkness is not sufficient to trigger dissociative numbing. A married mother of two and an active participant in community organizations, she has always been extremely reluctant to tell any therapist after she has cut because of the shame. Any attempt to discuss alternatives to cutting historically increased her shame and focused her on feelings of worthlessness that she then used to justify the cutting. Only when she was able to re-frame the cutting as a valiant attempt to cope as best she knew how could we then begin to talk about her wish to find another way to cope.

Similarly, explaining to the patient that it is important to report self-injury has to be done thoughtfully and carefully. If we emphasize that the goal of reporting it is to ensure her safety, she may feel shamed. If we emphasize that the goal in telling us is to ensure that we know when she is in distress and can work on alleviating it in safer ways, then there is less shame and more hope because now the self-harm is not a bad behavior but a symptom. If we re-state our understanding that secrets were so much a part of her childhood experience that eventually the secrets she kept to protect her family began to feel like her own protection from shame, then she is more likely to be able to resolve her internal conflict around telling or not telling.

Notice again that the emphasis is on the internal conflict she experiences: to hurt or not to hurt, to be safe or not to be safe, to tell or not to tell. Notice, too, that the therapist's role is one of pointing out the conflict, explaining why the conflict is so difficult to resolve, and allying with the patient in finding creative ways to resolve it, rather than attempting to prevent unsafe behavior. The compassionate, non-defensive position that a therapist cannot replace or substitute for the absence of self-protection is a crucial part of the work because the patient will understandably look to the therapist to either repair or repeat the past. If we do not address this dilemma directly and talk about the limitations on our ability to be responsible for her safety, the patient will make her own assumptions about the role she would like or be afraid we will play, based on her experience that those offering care are either Perpetrators, Non-protective Bystanders or potential Rescuers. If we fail to be a Rescuer, then we may be perceived as a Non-protective Bystander. If we succeed too well in acting as a Rescuer, she will lose the opportunity to develop her capacities to take on that role and come to lean more and more on our greater capabilities in that area.

Last but not least, the final most common mistake made by us as therapists is to become engaged in a struggle with the patient in which we become the advocates for safety and the patient becomes the advocate for her right to give up, to die, or to hurt herself. When that happens, we become exhausted; the patient becomes exhausted; and the patient loses the opportunity to struggle with her own ambivalence instead of with us. But how do we avoid being engaged in the struggle?

First, we can avoid the struggle by reframing the suicidal ideation or impulse to self-harm. Suicidal ideation is rarely, if ever, about wanting to die. Its intent is to make life bearable by giving the patient an "out," a way of feeling some control over her pain and shame. Originally, it may have developed during the abuse as an attempt to tolerate the fears that the abuse would annihilate her: if you want to die, dying is not so terrifying. In adulthood, it is also a way of controlling the overwhelming fear and pain. When we reframe the suicidal ideation and impulses in this way, we can empathize with the survivor's struggle: she longs for death as a way to live. She is in so much pain that dying seems like the last hope for relief: the "parachute," "bailout plan," or "safety valve."

The second key to avoiding polarization and struggle around suicidality is to not allow suicide to be used as a negotiating tactic or a form of interpersonal currency. I was taught this lesson by a patient who told me years later, "If I could get to talk to you only if I was unsafe but not when I just needed to hear the sound of your voice, what incentive did I have to stay safe?" She advocated strongly that I could have helped her more by limiting phone calls, by taking stronger stands and setting clearer limits. To decrease the use of suicide as negotiating currency, there are a few things we can do: first, we can try to work on our own anxiety so that the patient's threat does not trigger our own adrenaline reaction and mobilize a massive response on our part. If we can maintain a posture of calm, a stance that this is a familiar dilemma or struggle that we can help the patient to work out, the threat is less likely to work. Secondly, we can be clear with the patient early in treatment that the threat of suicide means that we have an opportunity to work on her recovery rather than negotiate whether she will live or die. If she cannot take advantage of the opportunity to do a piece of work and instead is firmly committed to making the issue into one of life versus death, then we can move to the usual discussions of safety contracts and hospitalizations while noting that we can figure what was really going on once she is safe. The message then is this: "you brought me the solution, but you forgot to tell me the problem. Maybe next time we can talk about the problem first."

The third key to avoiding polarization is to be as clear as possible about your position in regard to suicide and self-harm. If the therapist works in an agency, the position might be: "When you are unsafe, I will work with you to try to understand what has gotten triggered and how to manage the pain in safe ways so that a year from now, it won't be so bad. If you are not able to work on keeping yourself safe, then we will use the hospital to keep you safe, but each time we do that, we will be postponing the work of managing the pain." In a private practice setting, where the therapist has more control over therapeutic boundaries, it might be, "Therapy is not about deciding whether to live or die. Therapy is about doing recovery work, and 'remaining alive is a prerequisite for therapy' (Chu, 1998, p. 101)."

A fourth key to maintaining focus on the patient's own internal struggle about safety is to establish an alliance focused on what the patient does want out of therapy. If the patient's goals can be verbalized to some degree, then it is possible to have a focus on the positive outcome and the process of reaching it, and safety issues can be framed as obstacles to

what the patient really wants. If the patient is not capable of being entirely safe today, then the alliance can allow for discussion about what kinds of safety are necessary to permit the work toward her goals to be done. For example, if she is in and out of the ER or the hospital, then the work cannot go on. If she can be safe enough behaviorally to stay out of the hospital, even though she feels unsafe, then the therapy can progress. Once again, notice that in the trauma treatment model, the therapist is much more active and directive, much more work-focused. The communication of unconditional positive regard comes less from passive acceptance and more from an active reframing of the behavior and the symptoms in the light of the neurobiological research. The sense of safety in the therapy does not come from just the absence of criticism or blame but also from the therapist's making sense out of the patient's chaos and providing psychoeducational tools and a clear path into the future. Stabilization is a prerequisite for working through the trauma because otherwise "working through" will be re-traumatizing: intrusive affects will overwhelm the patient without her permission and leave her feeling depleted and demoralized, just as she felt at the time of the original trauma. As Judy Herman (1992) tells survivors, "It is bad enough that you were robbed of your childhood—it is unacceptable to lose the present and the future."

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