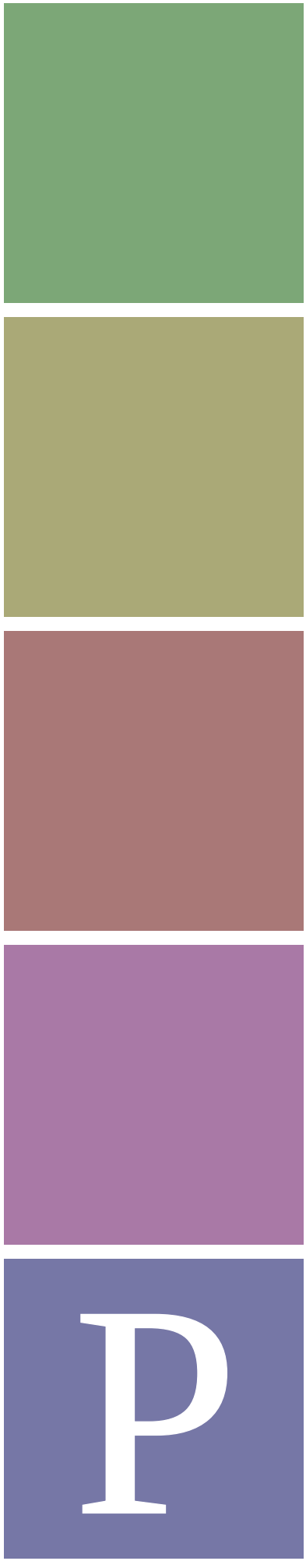
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PSYKE

Information on Self Injury and Suicide

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A bill of rights for those who self-injure

This Bill of Rights was prepared with, what is commonly known as, moderate or superficial self-injury, particularly repetitive self-injury, in mind. These guidelines do not hold for cases of major self-mutilation (i.e., castration, eye enucleation, or amputation). It is recognised that many people do receive a good level of care for their injuries, however, there are also a large number who have reported negative experiences when seeking treatment.

The right to caring, humane medical treatment

Self-injurers should receive the same level and quality of care that a person presenting with an identical but accidental injury would receive. Procedures should be done as gently as they would be for others. If stitches are required, local anaesthesia should be used. Treatment of accidental injury and self-inflicted injury should be identical.

The right to participate fully in decisions about emergency psychiatric treatment, so long as no one's life is in immediate danger

When a person presents at the emergency room with a self-inflicted injury, his or her opinion about the need for a psychological assessment should be considered. If the person is not in obvious distress and is not suicidal, he or she should not be subjected to an arduous psych evaluation. Doctors should be trained to assess suicidality/homicidality and to realise that although referral for outpatient follow-up may be advisable, hospitalisation for self-injurious behaviour is rarely warranted.

The right to body privacy

Visual examinations to determine the extent of injury should be performed only when absolutely necessary and done in a way that maintains the patient's dignity. Many who SI have been abused; the humiliation of a strip-search is likely to increase the amount and intensity of future self-injury while making the person subject to the searches look for better ways to hide the marks.

The right to have the feelings behind the SI validated

Self-injury doesn't occur in a vacuum. The person who self-injures usually does so in response to distressing feelings, and those feelings should be recognised and validated. Although the care provider might not understand why a particular situation is extremely upsetting, she or he can at least understand that it is distressing and respect the self-injurer's right to be upset about it.

The right to disclose to whom they choose only what they choose

No care provider should disclose to others that injuries are self-inflicted without obtaining the permission of the person involved. Exceptions can be made in the case of team-based hospital treatment or other medical care providers when the information that the injuries were self-inflicted is essential knowledge for proper medical care.

The right to choose what coping mechanisms they will use

No person should be forced to choose between self-injury and treatment. Outpatient therapists should never demand that clients sign a no-harm contract; instead, client and provider should develop a plan for dealing with self-injurious impulses and acts during the treatment. No client should feel they have to lie about SI or have therapy terminated. Exceptions to this may be in hospital or emergency treatment, when a contract may be required by hospital legal policies.

The right to have care providers who are not afraid of SI

Those who work with clients who self-injure should keep their own fear, revulsion, anger, anxiety, etc out of the therapeutic setting. This is crucial for basic medical care of self-inflicted wounds but holds for therapists as well. A person who is struggling with self-injury has enough baggage without taking on the prejudices and biases of their care providers.

The right to have the role SI has played as a coping mechanism validated

No one should be shamed, admonished, or chastised for having self-injured. Self-injury works as a coping mechanism, sometimes for people who have no other way to cope. They may use SI as a last-ditch effort to avoid suicide. The self-injurer should be taught to honour the positive things that self-injury has done for him/her while recognising that the negatives of SI far outweigh those positives and that it is possible to learn methods of coping that aren't as destructive and life-interfering.

The right not to be automatically considered a dangerous person simply because of self-inflicted injury

No one should be put in restraints or locked in a treatment room in an emergency room solely because his or her injuries are self-inflicted. No one should ever be involuntarily committed simply because of SI; physicians should make the decision to commit based on the presence of psychosis, suicidality, or homocidality.

The right to have self-injury regarded as an attempt to communicate, not manipulate

Most people who hurt themselves are trying to express things they can say in no other way. Although sometimes these attempts to communicate seem manipulative, treating them as manipulation only makes the situation worse. Providers should respect the communicative function of SI and assume it is not manipulative behaviour until there is clear evidence to the contrary.

Cutting through the pain

Susan was 16 the first time she hurt herself. Using the amethyst ring her grandmother had given her for her birthday, she had scratched her left wrist with the sharp edge of the setting until little beads of blood appeared. After that, Susan's methods varied from cutting to burning to scratching. Kitchen knives, shards of glass from broken light bulbs, cigarettes, her fingernails; all served as tools for self-mutilation.

In October of her high-school senior year, Susan burned out five matches on her right thigh. Too ashamed to tell her parents or her therapist, Susan treated her wounds with rubbing alcohol and bacitracin. The burns festered into semi-circular sores of oozing puss, making walking difficult.

Thanksgiving night of the same year Susan carved into her stomach with a blade she had detached from her pink Schick razor. The next morning, she could not dress herself without causing convulsions of pain throughout her stomach. Susan realized that she needed help beyond the weekly therapy sessions and anti-depressants she was already receiving.

She approached her parents. Huddled on the living room floor squeezing her knees into her chest and rocking back and forth, Susan pleaded for hospitalization. In doing so, Susan forced her parents to acknowledge that, despite their concern and support, their daughter was not a normal teen.

White woman's burden

In addition to the usual teen struggles, Susan suffered from clinical depression. And instead of abusing drugs or alcohol, Susan, along with approximately three million other people in the United States, responded with self-mutilation. Susan belonged to a community of people who hate themselves on general principle and fuel this loathing with self-created scars. Women self-mutilate more commonly than men, and self-mutilation is peculiarly a "White woman's burden."

Most self-injurers are middle-to-upper class, intelligent, White females. Their injurious behavior usually starts in adolescence and continues through adulthood. Self-mutilators put others before themselves, disregarding their own feelings. A large percentage of them were abused, and the majority suffer from a psychiatric disorder, most commonly clinical depression.

These women, like most, are expected to be the Donna Reeds of our generation, but with the added pressures of balancing a career as well as a family. Unlike the majority of women, however, those who self-mutilate cannot cope. They punish themselves for others' faults and their own perceived weaknesses. A self-mutilator's behavior isolates her from her family and community. Finding help often proves difficult. People tend to dismiss self-mutilation as a "cry for attention" and not the addiction that it often becomes.

When Susan asked her parents to hospitalize her, she had hit an addict's definition of rock-bottom. Susan's parents resisted accepting her need for in-

patient treatment, not from a lack of love, but from a sense of guilt and responsibility. They wondered where they had gone wrong. Susan explained to her parents that her behavior wasn't their fault, it was hers. She had hurt herself because, unlike anything else, the act made her feel better.

But still, Susan's parents opposed hospitalizing her. It wasn't until Susan confessed that she could not control her desire to hurt herself that her parents finally admitted her to the county hospital's mental ward. Susan felt like a prisoner on the ward. Rather than finding a group of people with whom she could identify, Susan found one more group from which she was isolated. The patients ranged in age from 12 to 80, with a variety of mental conditions. Some suffered from depression, others from paranoia and hallucinations, many could not function in the outside world. Most patients were on their second, third, fourth hospitalizations.

Mealtime was a bad parody of "One Flew Over The Cuckoo's Nest." Patients tried to steal the metal utensils; they hurled food across the miniature cafeteria at imaginary adversaries; and one man frequently forgot to remove the plastic wrap covering his meals, enthusiastically snacking on the gelatinous material. After a few days of this mayhem, Susan stopped viewing hospitalization as her salvation. The doctors didn't understand Susan's behavior any more than her parents did. And while her parents had offered love, the doctors and nurses offered only probing questions and reprimands. So, Susan learned to play the "get-well" game and, 15 days later, the hospital released her.

Coping tools

Even members of the medical community often misunderstand the motivating forces behind women's self-mutilating behavior. Had these women lived in an earlier decade, perhaps they might have been the functioning alcoholics of the neighborhood. Rather than cutting their flesh, they might have self-medicated by filling their bodies with hourly cocktails.

But, in the nineties, when psychiatrists describe self-mutilation as a "trend," women like Susan cope through the creation, rather than the numbing, of their pain. Unlike their alcoholic sisters, self-mutilators cannot hide their times off the wagon. They wear the evidence of their failed rehab attempts, branding them as forever different and forever alone.

Susan longed to defy this pattern and belong to a normal community, not one defined by statistics and psychiatric evaluations. But, after her brief hospitalization, she continued to self-mutilate for the next three years. Each new mark brought new embarrassment as strangers and friends asked Susan what had happened to her shoulder, her wrist, her knee.

One time a guy pointed to Susan's mutilated thighs left uncovered by her jean shorts and asked her if she had AIDS. Susan used sarcasm to deal with the constant questions. She told people the marks were liver spots or leftovers from her most recent alien abduction, refusing to show how much the inquiries bothered her. Around her friends, Susan called herself a "human ashtray" because of all the cigarettes she had extinguished on her body.

At age 20, after having hurt herself for four years, Susan chose to stop. An old, frequently broken resolution, but, Susan promised herself, this time it would be different.

She committed herself to examining her feelings to discover what triggered her behavior. She invented healthier methods for dealing with her depression. As part of the healing process, Susan began to refer to her scars as "battle wounds."

Living with the scars

It has now been almost two years since Susan self-mutilated. Like a recovering alcoholic, though, she still struggles with the temptation to transform emotional pain into its physical counterpart. During these times, her scarred body reminds her that the temporary relief is not worth the permanent consequences. And yet Susan's control over her behavior is but a small victory. Over time, her scars will only continue to fade, they will never disappear. When Susan meets a man, she worries: Will he find her body ugly with its scattering of white and pink puckered skin? Will he think she's a freak?

What Susan wants is a body she isn't ashamed of. She wants to wear a swimsuit on the beach without inviting questions from strangers. She wants to wear a tank top and not have to create some ridiculous excuse like mutant bug bites or deformed chicken pox scars to explain the marks along her upper arms.

For a little while, it seemed these hopes would become a reality. Susan read an article in a magazine about how laser surgery could hide scar tissue. She hoped this included hers. But, some actions are irreversible. The human body can only withstand so much abuse.

A few minutes into her consultation with a plastic surgeon, Susan discovered that the lasers could turn her scars and slashes into thin white lines - but that they would remain prominent. Unlike the graffiti that "normal" rebellious teens spray paint on building walls, Susan's graffiti can never be washed away or painted over.