CHAPTER 22

Coping Patterns of Sexual Assault Survivors

LEARNING OBJECTIVES:

♦ Describe the general concept of coping mechanisms.
♦ Explain dissociative identity disorder and how to help survivors who have this coping pattern.
♦ Identify the nature of eating disorders and explain counseling for survivors with this coping mechanism.
♦ Describe how substance abuse can be a coping mechanism, and how counselors can address the needs of survivors.
♦ Explain self-injury as a coping pattern and the counselor’s role in helping survivors.

We all have certain coping strategies that we use when we feel upset, tense, frightened, or angry. If stressed, we may find that we are able to alter our emotional state quite efficiently through such diverse activities as playing music, jogging, working on a hobby, painting a room, calling a friend, or walking on a sunny beach. After engaging in such activities, we notice that somehow we feel much better.¹

Research suggests that repetitive childhood sexual abuse significantly affects survivors’ capacity to change or regulate their emotional states. In particular, the changes in the brain caused by repeated early trauma profoundly affect survivors’ capacities to soothe themselves.² They frequently rely on more dramatic means of self-regulation – such as drug/alcohol abuse, binge eating and purging, dangerous or high-risk sexual behaviors, self-injury, or “spacing out” and “forgetting” – to regulate their internal states. Highly dissociative survivors (those with multiple personalities) often have to go to the extreme of switching identities to shift moods or think differently about a problem.

These responses help change the internal or emotional state of survivors when other more ordinary means have failed. Some survivors rely primarily on one of the above methods of coping, while others demonstrate several. But while these behaviors are helpful to survivors in some ways, they ultimately are maladaptive, because they often lead to serious negative consequences.³

Since the individuals who rely on these mechanisms often pay a very heavy price, interventions to assist survivors in finding new coping patterns are clearly warranted. Some attempts at coping can evolve into addictive patterns so that by the time a survivor reaches out for help, she or he is often struggling to fight both the original effects of the sexual assault trauma and problems caused by an addiction. Positive results require patience for both survivor and helping person, but persistence is rewarded.⁴
Chapter 22: Coping Patterns of Sexual Assault Survivors

This chapter is divided into sections on dissociation, eating disorders, substance abuse, and self-injury. These particular coping strategies are so frequently encountered at rape crisis centers that they deserve special attention.

While it is important for counselors to be able to recognize and understand coping patterns, it is usually appropriate to offer survivors more long-term and specific help. Possible referrals include substance abuse treatment programs, therapists experienced in eating or dissociative disorders, and specialized groups. Rape crisis counselors should always work with other helpers in the community to ensure clients access the best and most appropriate services.


A. Dissociation

The term dissociative identity disorder (DID) has recently replaced the term multiple personality disorder (MPD). One reason for the change is that it is theoretically not possible to have more than one personality. Alternating personalities are actually fragmented components of a single personality – each associated with particular memories, roles, and emotions that are at times unusually disconnected from one another and at times personified by the survivor. The term alter has become more accepted. When individuals have mild or partial forms of DID, the terms part, ego-state, or self-state more accurately represent both the reality of the degree of dissociation and a survivor’s healthy understanding that she or he is one person.

Dramatic presentations in film and on television of people with DID have proliferated in recent years, as more individuals with this coping pattern have been identified. Some presentations offer a distorted view, reinforcing misconceptions and making this survival response seem bizarre and foreign. In fact, DID is not clearly observable most of the time, and most people with DID only selectively disclose their dissociation coping styles and/or their extensive trauma histories.

As a rape crisis counselor, you should have some general understanding of DID in order to identify and relate to clients who present in this way. You are not expected to be able to work with these clients in the same manner that a professional therapist would. This underscores the importance of always seeking qualified supervision and building and maintaining referral relationships with local therapists who are familiar with DID and its linkage to trauma. Do not attempt to provide therapeutic help beyond the scope of your training as a rape crisis counselor.

What is Dissociation?

Dissociation is a normal feature of human experience. It is a process that produces an alteration in a person’s thoughts, feelings, or actions – so that for a period of time, certain information is not associated or integrated with other information as it normally or logically would be.¹

Familiar dissociative experiences include mood state shifts and significant changes in behavior based on family versus professional roles.² Dissociation can also be recognized in such automatic experiences as “highway hypnosis,” which allows the driver to escape the tedium of the road by becoming lost in thought, only to return when presented with the trigger of the familiar highway exit sign. Mild depersonalization experiences – feelings of unreality or detachment from oneself – are common during adolescence. A smoothly functioning dissociative process, with flexibility of movement from one internal self-state to another, can be thought of as healthy multiplicity. In fact, individuals who experience too few state changes might be considered rigid and limited.
Dissociative capacity may be thought of as an ability that may have some relationship to hypnotizability, which is the capacity for a variety of trance experiences. Dissociation may be automatically called upon as a coping mechanism in a single-event trauma, such as an earthquake or rape. During the trauma, dissociation creates a barrier between the victim and overwhelming events. However, when dissociation is repeatedly relied upon for survival, particularly in childhood, it often develops into an elaborate coping pattern with real benefits in the short term, but serious complications later.

The quotation below offers an example of a more extreme dissociative coping style – with depersonalization, amnesia, and identity confusion. The quote also demonstrates important differences from the dissociative experience of normal highway hypnosis.

> As soon as I drive a car it starts to feel strange . . . I can see my hands on the steering wheel, but it feels as if it’s not me . . . I see my hands and feet move, do all the necessary things to drive, but it feels as if my hands and feet do not belong to me . . . I can’t drive . . . Sometimes I am unaware of a large part of the journey . . . Sometimes I find myself in a strange place and I have no memory of how I got there, but there’s nobody else with me so I must have driven the car.³

The Dissociative Continuum

Modern theorists have classified a series of dissociative experiences based on the degree of reliance on dissociation.⁴ According to this model, normal dissociative experiences would be located at one end of the continuum; psychogenic amnesia, depersonalization experiences, fugue states, and conversion symptoms would be located further along.

Experts now advocate the inclusion of some cases of obsessive-compulsive disorders, eating disorders, and panic disorders somewhere on the dissociative continuum. As increasing numbers of professionals working with survivors are recognizing the traumatic origins or triggers for many of the “psychiatric disorders,” the role of dissociation in some of these conditions is being increasingly considered.

Milder variations and partial forms of DID come next on the continuum. Some of these milder forms have been termed ego-state disorder (ESD).⁵ People with ESD tend to have fewer episodes of amnesia, may have little or no clear switching of personalities, and usually understand that the “others” in their heads are parts of themselves. ESD clients often experience clear passive influence experiences (in which they feel controlled by someone else, almost like a puppeteer pulling strings), and these parts can often emerge with the aid of appropriate hypnosis.

These milder forms would be followed on the continuum by simple examples of DID, with only a few clearly defined personalities or alters. Next would be classic DID (the average number of alters seems to be rising – 10 to 20 is not unusual). Finally, at the extreme of the continuum would be complex and “polyfragmented” forms of DID. Structured DID is a term used to describe cases in which the original abusers seem to
have worked deliberately to create a system of alters in the child, in the service of very extensive, sadistic abuse.

Newly diagnosed survivors typically are evaluated to place them on the dissociative continuum, and to decide an appropriate course of treatment. It is equally important to find out what strengths the survivor possesses that can be mobilized in the service of getting well. Some survivors with complex identity systems function quite well in certain areas of their lives at the time that they come for help. Many more DID survivors, even those who are leading chaotic and unhappy lives at the time they enter therapy, still have an excellent chance to do very well with appropriate therapy and support systems.6

The Evolution of DID in a Child Abuse Survivor

According to one authority on the subject:

The essence of trauma is physical helplessness, the loss of control over one’s body and environment at a time when pain and damage are being threatened or inflicted. One’s will and desire is overridden by another’s brutality, by accident, or by nature’s indifference. When physical control is lost, mental control becomes paramount.7

As the therapeutic community begins to understand what happens to a child experiencing sexual abuse, it is learning how DID might develop over time. Retrospective reports from adult DID survivors provide one perspective. Observations of children who show prominent dissociative features provide another view. The remainder of this section suggests ways of discerning the evolution of DID in an abused child. At the risk of oversimplifying a very complex process that is still not well understood, it is presented to show DID as a coping strategy.

Three types of dissociative experience – fantasy (or absorption), depersonalization, and amnesia – play major roles in the development of DID.8 Preschool children have the capacity to create and play out vivid fantasies, and become deeply absorbed in pretending to be a mommy, a teacher, or “Supergirl” who can fly. Under conditions of fear and pain, such as sexual abuse, children may wish for a kind of magic trick that will “take me away.” The fear, pain, and wishing all together may induce the child to enter a kind of dreamlike or trancelike state, in which she or he may have the sense of being out-of-body, perhaps floating above.

This sense of being outside one’s own body is one form of depersonalization. In this state, the victim may be able to watch the abuse as though it is happening to another child, lying on the bed below. The child may also experience a reduction in the physical pain of the abuse, similar to pain reduction that people can achieve through hypnosis. The child may be comforted to imagine that the girl on the bed below is Supergirl, who can handle the abuse better – or a “mean girl” from her class, who might “deserve it.” Over time, the image of the girl on the bed, now altered in appearance through fantasy, may come to exist in her head as an imaginary companion. As communication between
imaginary companions or self-states goes on within the mind, one or more of them may gradually take on the role of a mother or big sister. This allows the child some facsimile of an attachment to a loving and consistent caretaker, when a such person is not available to her in the real world.

Other imaginary companions or self-states may act very “tough,” and reassure the small child that she will survive. Over time, some of these tougher self-states may seem able to take on the style of the abuser. These reincarnations of the abuser that have developed inside of the child’s mind may at first feel more predictable and manageable than the original abuser. Thus, they, too, represent a positive attempt to cope. But later, they can lead the survivor not to trust anyone, including someone who tries to help, and may urge the child to self-injure, attempt suicide, or lash out at someone.

When an abusive parent feeds or hugs the child one moment and then sexually abuses that child a half-hour later, the child learns to repeatedly dissociate in order to adapt to the requirements of these different roles. One moment the child knows to reach out timidly to receive the food and the equally desired hugs from the parent. A few minutes later, when the abuse begins, very different survival skills are required. Since it is difficult for the child’s mind to integrate the two experiences, and since there is no time to think about it in the fight for survival, it seems best to forget about what happened before.

_Traumatic amnesia_ can occur after any traumatic event, and has been documented in combat veterans, crime and accident victims, and child abuse survivors. Amnesia is also a common feature in a normal hypnotic trance. Partial amnesia and full amnesia are important features of the development of the dissociative child. The ability to forget allows the child to go to school, study, play with friends, and pretend that everything is all right at home. Although the ability to forget may make it difficult to remember things like lessons and homework, the child is sometimes able to create an illusion of safety by dissociating again and again.

As the child repeatedly dissociates, she or he may automatically learn to split single memories into pieces – separating the _knowledge_ of what happened from the memory of the _behavioral actions_ that occurred, from the _emotions_ attached to them, from all of the _physical sensations_ experienced during the abuse. These memory fragments seem to be more easily scattered than the more unified memories.9

When memories are fragmented in this fashion, the survivor may be unable to speak about them in other than a confused fashion, in which the memories are revealed and then taken back at the same time. The following is a quotation from a survivor with DID during the first months of treatment:

> What did I tell you before? I don’t remember anything about my childhood. I do think about some weird things, but I keep thinking that I made them up or that I dreamed them. And some of them are really sick. I never tell anybody ’cause I guess, I’m sure, they didn’t really happen. If I found out they did happen, I’d just die. I don’t like to think about those things, ’cause I think they may have
Dissociation thus supports denial (in both the survivor and the abuser) of the reality of the abuse. If the different alters (or self-states) evolve with very different traits, they can split up a wide array of normal feelings and behaviors that were not allowed by the abusers. The natural response of the severely abused child is to be filled with an intense mixture of emotions, such as rage, fear, and sadness. These feelings cannot be expressed, however, because the child could be punished for doing so. While the abusers continue to be pleased at the child’s abilities to cope with their demands, the emotions that are considered unacceptable to the abusers are split off and placed behind dissociative barriers – sometimes emerging with little warning, in inappropriate settings, or with little provocation. Survivors may be alarmed by the intensity of these emotional expressions. Although they may seek help for another reason, such as domestic violence, they often fear that their own angry alters will behave violently or otherwise inappropriately if they ever lose control of them.

Common Misunderstandings about DID

It is important to understand that all coping efforts that succeed in maintaining the splitting and severing of associations are valued by the DID survivor. For example, early in therapy, when different alters hold onto different abuse memories – and when they refuse to share these memories because they decide that they “cannot stand each other” and “will never agree to work together” – this is one effective way to defend against the horror. The abused child fears she will not survive if she faces both the reality of the enormity of the abuse and the trauma of the abandonment. This fear remains strong in the dissociative adult survivor, who continues to defend against the painful knowledge of what happened. One survivor wrote that her DID was like a war machine: “My struggle now is to dismantle the war machine, now that the war is over.”

People who have not had experience working with DID sometimes find role-playing of the alters difficult to accept. They misinterpret the “acting” as a simple ploy to gain attention. In fact, the better the dissociative child is at role-playing the different alters, the more the child can maintain the conviction that they are, indeed, separate people. This is considered essential to someone with DID, because it helps the child continue to believe that the many abusive experiences could not possibly have happened to her or him alone.

Alters typically are not stable in structure; their behavior is influenced by the social interaction in which they are placed, and amnesia barriers between them are not consistent over time. Information constantly leaks back and forth between alters. The system could not function if certain necessary information did not somehow get shared. Just as dreams are forgotten upon waking, when too much upsetting information leaks across the boundaries from alter to alter – in other words, when too much knowledge gets.
“put together” or “associated” – dissociative survivors have ways to dissociate the material again, and just as the alters originally came into being to placate or please someone, so they can continue to change their behavior in response to their interactions with others.12

The Experience of DID before Diagnosis

Prior to diagnosis, survivors may be nearly as much in the dark about their dependence on their dissociative coping style as are their friends, family and coworkers. Typically, at least one of the alters who comes to counseling suffers from time loss, blackouts, or “grayouts.” Survivors may feel that some of their thoughts and feelings are not their own; they may experience intense struggles within themselves and may “hear” the voices of one or more of their alters or parts. These voices may command survivors to hurt themselves, while other voices may console them. Their behavioral changes may make them seem moody to others, and they may sometimes appear to act like small children. More overt evidence of switching is usually not revealed publicly – as alters have learned how to “behave” in order to look “normal.”

Survivors with DID, prior to identification by a helping professional, are usually not able to put things together or self-diagnose. As adolescents, they are likely to have convinced themselves that everyone is like them. As adults, they may experience multiplicity more directly, but they may not reveal their symptoms to others because of fears of being labeled “crazy” or “schizophrenic.”

During adolescence, DID survivors may display behavior that either is stormy, showing a high-risk behavior profile, or withdrawn.13 They are most likely to seek help in adulthood – for “panic attacks,” depression, eating disorders, somatic (physical) problems, or a suicide attempt, or because of rape or domestic violence.

Undiagnosed DID survivors tend to become skilled at covering up for their switching and time loss during childhood, but they often do so at a high price. Making up stories to account for behavior they do not remember sometimes leads to the reputation of being a liar. Dependence on alcohol and drugs to justify their perplexing blackouts and inconsistent behaviors can lead to serious medical, psychological, and interpersonal consequences.

Some DID survivors become perpetrators as well as victims. This is why therapy specifically targeted at DID survivors is important in stopping trans-generational transmission of violence. If subject to extensive amnesia, dissociative survivors often do not know to what extent they may have perpetrated and are fearful that, in entering treatment for DID, they will find out that they have done “terrible things.” For some survivors, facing their abuse history and getting to know alters of whom they may be afraid, make entering treatment a courageous act.
Rape Crisis Intervention for the DID Survivor

Survivors who come for assistance may demonstrate various signs of dissociation, such as pauses, breaks in continuity in conversations, confusion, or disorientation. They may seem to space in and out. They may switch alters, which may or may not be obvious to the observer. After switching, they may not know what was talked about with the previous alter who was “out.” Under great stress, some DID clients experience rapid switching and may appear quite confused. Survivors may also pause before answering, because they are listening to internal voices. They may feel compelled to say or do something because of internal pressure from another alter, while that alter remains inside. Thus, either face-to-face or on the telephone, when the rape crisis counselor suspects that the survivor might be highly dissociative, it is helpful to allow for pauses, repeat statements as necessary, and be calm and understanding of any disorganized and unconventional behavior.

If a person seeking assistance provides information that she has been diagnosed with a dissociative disorder and has been in treatment for it, this should alert the counselor to seek supervision. While doing crisis intervention with the survivor, more successful outcomes may be achieved when all parts of the system are invited to problem-solve. If very experienced and trained working with DID, a counselor could say to a survivor:

- Any and all parts (or alters) inside are welcome to listen.
- Are there parts (or alters) who can talk with me for a while about taking steps for your safety?
- Perhaps some of your parts (or alters) can begin with me now to make a safety plan.

A word of caution is necessary. If a survivor has never been spoken to by a helping professional in this way, she may feel panicky if “everyone” is invited to listen. Although it may not seem so, this can be very powerful intervention for a dissociative survivor who is unused to it, as she or he may fear losing control of parts inside who generally stay inside. In all cases it is essential to seek supervision, and in this situation, it may be advisable not to talk to alters.

Advocacy when the DID Survivor Reports Sexual Assault

Various studies have documented high rates of rape and other forms of repeat victimization during adulthood in both male and female DID survivors. One investigation reported a high rate of dissociative symptoms in victims of two or more separate rape attempts.

The DID survivor may first seek counseling after she suffers a sexual assault during adulthood. Due to a tendency to experience dangerous situations as familiar and to dissociate in the face of danger cues, such survivors appear to be at higher risk for sexual assault. Sometimes an alter accidentally or deliberately “sets up” another alter to be in an
at-risk situation, and then leaves the “victim” alter to experience the assault. Such situations may be a way of reliving the childhood abuse experiences, in an attempt to master them. The survivor who is able to access ongoing therapy can learn to stop this cycle of repeated victimization.

Often when undiagnosed DID survivors report rape, they attempt to cover for their dissociation. Like other rape survivors, they may blame themselves for the assault, despite the fact they may have complete or partial amnesia about it. When reporting the rape, they may attribute their lack of memory about the incident(s) to being intoxicated, whether or not they recall using alcohol or drugs. Highly dissociative survivors may make up some of the details in order to be able to present a coherent story, although they may have only fragmented memories of the assault.

The increased stress of a rape may cause the voices (of other alters) in the survivor’s head to increase, or alters to flee inside the mind because they have trouble dealing with the situation. While giving her account, the DID survivor may hear voices of alters giving different versions of what happened during the rape, each from her own perspective. Conversely, the mind may go completely blank; alters with the memories of the rape can block each other out or simply shut down. Unless specifically asked about these experiences, survivors may share none of the complexity of their inner experiences with their counselors.

**Referring the Dissociative Survivor for Treatment**

The discovery of DID and its partial forms is relatively recent, and the study of modes of treatment continues. However, certain approaches have been identified as more successful than others. The modern treatment of DID involves three general stages:

- **Stabilization**, in which the client learns to communicate between alters and practices a range of skills with which to cope with the stress of the next stage;
- **Memory Processing**, in which trauma memories are shared between alters and are worked through; and
- **Integration and Post-Integration Self-Development**

Some techniques such as “re-parenting” have been tried with survivors but currently are being reconsidered. Extended hospitalization which may include scheduled work on memory processing, was tried during the 1980s and early 1990s in an attempt to shorten the length of therapy while ensuring safety; these now have been, for the most part, abandoned as a treatment approach.

The current thinking among DID experts is to provide long-term outpatient treatment, several years at a frequency of two to three times a week (although once a week may be acceptable during less active phases or with some clients). This treatment typically is provided by an experienced therapist, trained in working with complex dissociative trauma survivors (See Chapter 26: Further Support for Healing).
Hospitalization of up to two weeks for stabilization and safety may be necessary and can be useful. Other recommended approaches include use of expressive therapies such as art and movement therapies, and expressive modes such as keeping a journal. Medications to treat some of the symptoms related to depression and anxiety are sometimes prescribed to ease the suffering of some survivors as they undergo therapy.

1 F. Putnam, *Diagnosis and Treatment of Multiple Personality Disorder* (New York, 1989).
5 Ibid.
7 Ibid.
15 Putnam, op .cit.
B. Eating Disorders

Sexual trauma survivors have been found to have a high incidence of eating disorders. Many classic descriptions of dissociative identity disorder and incest victimization contain accounts of “disordered eating behaviors.”[1] “Proponents of the ‘specific link’ hypothesis describe complex, multiple mediating mechanisms between sexual abuse and disordered eating. They emphasize the adverse effects of sexual abuse on body esteem, self-regulation, identity, and interpersonal functioning.”[2] It is important to note here that the current research findings linking sexual abuse and eating disorders do not support the idea that the abuse causes eating disorders, but rather that there is a correlation between the two.[3] While sexual abuse is not the only correlative of eating disorders, it has become increasingly clear that this abuse – particularly in childhood – is a very significant issue with this population.[4] “One fundamental reason is that eating is often associated with family meals, nurturing and proof that parents care for children. Thus, feeding and then abusing the child are incongruent, confusing, and difficult to assimilate and integrate.”[5]

The three most commonly seen categories of eating disorders are bulimia, anorexia and compulsive eating. They can be understood as follows:

- **Bulimia** is characterized by binge eating or eating normal amounts and then purging the food from the body by vomiting, abusing laxatives, fasting, or compulsive exercising. Many people with bulimia are within normal weight range. Following the binge episode, many suffer from overwhelming feelings of guilt, depression, or self-disgust. Purge behavior can relieve many of these feelings temporarily and can become an end in itself.[6]

- **Anorexia** is characterized by depriving oneself of food to the point of weighing less than 85 percent of normal body weight, and often includes some of the features of bulimia. The medical risks are numerous, including amenorrhea, or the lack of menstrual periods, growth of excess body hair, and even self-starvation. Anorexia is one of the few psychiatric illnesses that is often potentially fatal to the sufferer. In addition to these physical characteristics, anorexics may demonstrate psychological characteristics of the starving. They may be depressed, irritable, pessimistic, and/or nearly always preoccupied with food.[7]

- **Compulsive Overeating** usually involves bingeing in secret and rapidly ingesting large quantities of high-caloric food, or eating continuously all day long. This can lead to many medical risks and low self-esteem due to resulting obesity.[8]

Other eating problems for rape survivors include variations of these three common disorders, as well as avoidance of foods of certain textures or foods that might trigger traumatic memories.
Eating Disorders as a Coping Mechanism

After so much has seemed beyond their control, some survivors – in an attempt to gain control of their lives – rigidly regulate their food intake, as in anorexia, or plan secret rituals of bingeing and purging. Eating disorder symptoms can serve adaptive functions for survivors of sexual abuse, such as:

- Comfort/nurturing
- Numbing
- Distraction
- Sedation
- Rebellion
- Cry for help
- Discharge of anger
- Control and power
- Predictability and structure
- Establishment of psychological space
- Unconscious reenactment of abuse
- Self-punishment
- Self-purification
- An attempt to disappear (as in anorexia)
- Creating a large or small body for protection
- Avoidance of intimacy

A survivor of childhood sexual abuse has noted, “Trying to physically change their body image to mask sexuality is typical of many teen and adult survivors and can set off a lifelong pattern of either anorexia or compulsive overeating.” Some survivors believe that by gaining weight and increasing their body size, they can reduce their attractiveness and thereby, in their minds, reduce the probability that they will be abused again. This may be based in part on the myth that only “sexually attractive” persons are raped and/or that rape equals sex. For other survivors, “the body becomes the only reason a man would approach since they feel internally damaged. Making the body attractive (i.e., thin) becomes an obsession, the only way to escape being alone.”

Some sexual abuse and rape survivors “use repetitive eating behaviors and obsessive thinking about food to alter their mood.” While engaging in binging and/or purging, they are absorbed with the behavior and therefore avoid unpleasant or painful feelings. Survivors may use rituals with food or the avoidance of food to make themselves feel better. According to one expert on the subject:

*While they are totally involved with eating, shoveling spoonful after spoonful of ice cream into their mouths, other pains, fears, and hungers recede. Compulsive eating is an escape. Although you may hate yourself in an hour, you get relief in the moment. If you are hurting, eating compulsively may be the only way you know to nurture yourself.*
Other authorities have observed, “Purging, particularly vomiting, can be a symbolic attempt to cleanse oneself of a rape or sexual assault experience. . . . The purging is also a release. Some bulimics describe their vomiting as violent and visualize the abuser while vomiting.”15

**Body Image and Eating Disorders**

“Our feelings and attitudes toward our body – ultimately how we form our body image – are built on the interest, caring, and respect that others, particularly our caregivers, give our body when we are growing up.”16 “In sexual abuse the child’s body is not only violated, but, in a sense, is used as a weapon against her.”17 Two frequently noted aftereffects of sexual abuse or rape are low self-esteem and poor body image. Victims tend to see themselves in negative ways in all or most areas of their lives, often focusing on body image. To quote one survivor:

> He always used to say how beautiful and sexy I was, what a great body I had . . . how he just couldn’t help himself. But I never felt pretty or believed anybody liked me. I felt ugly and repulsive. I hated my body. It was like the ugliness of the incest got transferred to my feelings about myself. . . .18

Survivors often develop distorted perceptions of their bodies; they believe they are heavier than they really are, or that they are overweight when they are actually normal weight or underweight. Some survivors may have learned to see themselves as ugly, bad, and unlovable. Other survivors of sexual exploitation see their body as their only asset. This causes them to believe they must use their body as a source of power, thus putting themselves at high risk for eating disorders as they attempt to achieve the “perfect” body.

**The Medical Risks and Counseling the Survivor**

Counselors and survivors should be aware of the medical risks involved with major eating disorders. Excessive vomiting can cause damage to the esophagus and take the enamel off teeth. Nutritional deficits eventually cause damage to the body if this behavior is left untreated. Overuse of laxatives results in dependence, causing the bowel to become “lazy” and stop working on its own; this also leads to nutritional deficits by robbing the body of much-needed vitamins and minerals. Both bulimia and anorexia can cause imbalances of the body’s electrolytes and ketones as well as weakness and fainting spells. Heart problems and death can also result from eating disorders. Overeating can cause high blood pressure, diabetes, heart problems, high cholesterol, and other medical risks.19

Sometimes, in addition to sexual abuse, the survivor was physically abused and/or neglected – as in the case of battered women, incest survivors, or survivors of ritual abuse. Some were not fed or nurtured adequately. Others were force-fed, punished with
food, deprived of food, or had their food intake over-controlled. Those who were neglected as children may not have been fed properly or taught proper nutrition and eating habits, and therefore may not have learned to take care of themselves in these areas.

The person with an eating disorder may be totally unaware of some of the unpleasant and long-lasting effects of nutritional deficiencies. Often these survivors have kept both their eating disorder and their sexual abuse secrets from everyone. It is therapeutic for them to tell someone their secret and not be judged so the rape counselor’s role is very important.

As a rape crisis counselor, you may be in a position to recognize the signs of an eating disorder. It is not appropriate for you to provide treatment or diagnosis of this coping mechanism. Instead, seek supervision and make appropriate referrals for the eating disorder as you continue to work with the survivor on issues related to the assault or abuse.

Survivors disclosing an eating disorder need to be supported and reassured that having this coping behavior is by no means their fault, and that they deserve to get help. They should be empowered to seek treatment because they want to help themselves and feel better about themselves. These individuals should understand that they are not alone: eating disorders are common among survivors and many other people, especially women. They also must be told that this way of coping is dangerous to their health. The counselor should be able to provide referrals to doctors and therapists who are sensitive to eating disorders and sexual abuse, and who have demonstrated expertise in treating both issues.

4 L. Landray, Recovering from Rape, second edition (New York, 1994).
7 M. Pipher, Reviving Ophelia: Saving the Selves of Adolescent Girls (New York, 1994).
8 Ibid.
11 Schwartz and Cohn, op. cit.
12 Ibid.
13 Zraly and Swift.
17 Ibid.
18 Kunzman, op. cit.
19 Kaplan and Sadock, op. cit.
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C. Substance Abuse

Sexual assault survivors are at high risk for developing difficulties with alcohol and other drugs. Their problems may fall anywhere along a continuum from an isolated episode with binge use/abuse following a traumatic event, to full-blown addiction that may ultimately be life-threatening. The importance of the relationship between the two problems is that they are not just coexisting but synergistic – meaning that each makes the other worse.1

Mood-altering substances can act like anesthesia by creating a state of mind very close to that of a trance or dissociative state. This state of mind can quickly and very effectively help the survivor escape both physical and emotional pain. While intoxicated or high, memories of traumatic events can be blocked out and feelings numbed. While it is an illusion that lasts only as long as the effect of the alcohol or other drug, the survivor temporarily feels better by creating a sense of control and well-being. Use of substances may start out as a social activity, but physical or emotional isolation is a likely outcome of prolonged use.

Abusable substances include:

- Alcohol
- Street drugs (heroin, cocaine, marijuana, acid, etc.)
- Prescription medications that also may be purchased on the street, including: anti-anxiety medications (Valium, Ativan, Klonopin, Xanax); sedatives that contain barbiturates (Phenobarbital, Nembutal, Seconal); narcotic painkillers (Codeine, Morphine, Demerol, Percocet, Fiorecet, Darvon)
- Inhalants and other household/industrial substances

Survivors and Substance Abuse

Like sexual assault, substance abuse cuts across all socioeconomic, cultural, and ethnic groups. Men and women, regardless of their sexual orientation, are both affected. With alcohol and other drugs readily available to all, survivors are most likely to turn to whichever substance is most accessible or socially sanctioned.

There are similar dynamics in sexual assault and substance abuse. People who experience either problem are likely to feel stigmatized by their family, friends, or community. They also tend to initially use denial to avoid confronting their problems, and to minimize the seriousness of their situation or emotional distress. While neither problem actually causes the other, they can intensify the risks and consequences for each other. Sexual abuse trauma often occurs at times when alcohol or other drugs are also involved. Although survivors clearly use substances as a coping strategy, the possibility also exists that they had a preexisting problem with these that may or may not have already been identified or treated.
Issues related to both the sexual assault trauma and substance abuse must be addressed for healing to occur. Leaving either problem untreated will result in ongoing symptoms – either inability to process feelings and memories of the trauma, or inability to stay clean and sober. Although it is essential to stabilize crisis symptoms as they occur, substance abuse must be addressed as well as the sexual assault before the survivor is able to effectively do the emotional and cognitive work necessary for healing.

Survivors who are victimized by family members are particularly at risk for substance abuse. If the related perpetrator is addicted to alcohol and/or other drugs, the survivor may have a genetic predisposition for addiction – a possibility now established through research. In addition, individuals from families where there are addictions are at greater risk for sexual abuse and other forms of violence either by family members or outsiders. Addicted parents may have impaired ability to provide nurturing and adequate care for children; this can set the stage for sexual or physical trauma.2

Childhood sexual and physical abuse has been linked to later substance abuse in a variety of studies. One study found that sexually abused women seeking services from a crisis center had 10 times the likelihood of drug addiction history and more than twice the likelihood of an alcoholism history, compared to women seeking services who had not been sexually abused as children.3

One authority on the subject has noted:

Only recently have addiction professionals recognized the association between addictions and incest. Research confirms it. Lasting addiction recovery is often elusive unless survivors face the truth about sexual trauma and its resulting feelings. . . .

The high rate of addictions among incest survivors occurs for two reasons. First, for incest survivors, chemical use/abuse/addiction serves a survival purpose. It numbs pain, and creates a sense of aliveness or excitement for one who may feel “dead” inside. . . . The other reason for this frequency is that incest occurs frequently in alcoholic families, and [children of alcoholics] are several times more likely to become addicted or to be become involved with an addict.4

Studies and clinical experience further suggest that a substantial number of men seeking treatment for substance abuse also have histories of physical or sexual abuse. Because there has been little support for men to verbally express their emotions, male survivors have likely learned to suppress their feelings. This has created a group of survivors who are at exceptionally high risk for alcohol and other drug abuse.5 (See Chapter 13: Male Survivors of Sexual Assault.)
What is Substance Abuse?

Substance abuse – which always involves a loss of control and negative consequences – includes misuse of substances, chemical abuse, and chemical dependence. (The specific criteria used to diagnose abuse and dependence can be found in the *Diagnostic and Statistical Manual of Mental Disorders*.)

Use becomes *misuse* when the purpose is to avoid thoughts, memories, or feelings. This is a warning sign that the person is at risk for more serious problems. Since any use of a substance may create problems for the survivor, an inability to set aside alcohol, street drugs, and/or prescription drugs may be an indication of larger problems. (Some people can recognize the pattern of their behavior at this point and modify their substance use without treatment or difficulty.)

**Chemical abuse** involves impairment of a person’s ability to function in any area of life. She or he may be unable to meet responsibilities at home, school, or work and begin to have increasing social or interpersonal difficulties. Abusing alcohol and other drugs may result in physically dangerous situations such as drunk driving, or there may be arrests for public disorderliness, fights, or theft. These are warning signs of the potential for addiction.

**Chemical dependence** is a chronic and progressive disorder that is debilitating and potentially life-threatening. The use of alcohol or other drugs cannot be controlled for more than short periods of time, if at all, and the person becomes obsessed with obtaining and using the substance. There is increased *tolerance*, meaning that the person needs to use more and more to get the same effect. Withdrawal symptoms begin to appear when the person is unable to use the drug. Treatment is available and, with assistance, the condition can be controlled.

Indications of addiction may include escalation of problems in daily life and loss of control. The person may begin to experience *blackouts* – periods when she or he appears to be alert and functioning normally, but has no memory of what happened during the blackouts. For sexual assault survivors, this must be distinguished from dissociative episodes during which there also is no recall. (See *Chapter 22A: Coping Patterns of Sexual Assault Survivors – Dissociation*.) Finally, this is a “disease of denial.” Denial or defensiveness about patterns of using alcohol or other drugs may indicate that the person is already in the process of addiction.

Chemical dependence is a disease with a progression of addictive behaviors that can be described in early, middle, and late stages. While the course of each person’s illness is individually determined, the following characteristics are usual:

**Early Stage**
- Sneaks drinks/drugs
- Preoccupied with alcohol/drugs
- Avoids references to alcohol/drug use
Chapter 22C: Coping Patterns of Sexual Assault Survivors – Substance Abuse

- Increased tolerance
- Relief from drinking/drugs
- Drinks or uses before and after social use/drinking
- Memory blackouts

**Middle Stage**
- Beginning of loss of control
- Dishonesty about use
- Attempts periods of forced abstinence
- Hides or protects supply
- Commits thinking errors about substances
- Feels guilty about use
- Quits or loses job
- Drinks or uses alone
- Neglects physical health and nutrition

**Late Stage**
- Experiences tremors or shakes
- Early morning use
- Binge use
- Loses tolerance for substance due to medical problems
- Unable to work
- Loses friends and family

One expert on the subject has noted that addictive episodes “. . . can be broken down into five parts: fleeting idea, mental attention, planning/obsession, acting it out, and the hangover involving shame, guilt, remorse, or physical withdrawal.”

Some gender differences are important to note. Women are more likely than men to become addicted in response to a crisis, such as rape or other trauma, and to have multiple addictions. Women generally become addicted more quickly, develop medical complications faster, and are likelier to abuse prescription medications. Finally, women are likelier to use alcohol or other drugs in isolation and develop hidden addictions. Women in the throes of addiction are less able to care for themselves and their families, putting their traditional responsibilities at risk; they thus are more apt to experience guilt, shame, and fear around these issues that relate to failure and responsibility, particularly if they are pregnant or parenting.

**Talking about Substance Abuse with the Survivor**

Substance abuse can be a difficult and overwhelming subject to address. Counselors may have unresolved personal experiences with alcohol and other drugs and may not understand that dependence is an illness that requires treatment, rather than a moral issue or a matter of will power. Counselors also may feel that they do not have enough
knowledge or information, or that the problem will go away once the rape trauma is addressed.

It is important to confront a survivor’s substance abuse as soon as you suspect the problem. You do not need “proof,” as long as your approach is respectful, caring, and nonjudgmental. Bring up the matter when your client is not high or intoxicated, and mention specific behaviors and problems when expressing your concern. Providing education about addiction as a disease may be helpful in motivating the individual to seek help or accept a referral. You need realistic goals for counseling a substance-abusing client. The recovery process is slow and often includes relapses, especially for sexual assault survivors.

In *The Recovery Book*, Dr. Al J. Mooney notes:

> **Self-deception is a front-line symptom of the disease of alcoholism/addiction. It helps the drinker/user escape from unpleasant reality and is rarely a conscious lie.** Denial is what is known in psychiatric jargon as a defense mechanism. **It is a primitive mechanism – a self-deception useful for a short time but destructive over the long term. For the alcoholic/addict, stubborn denial can be fatal.**

Because of denial, the survivor may become angry or avoid contact with you. But it is not helpful to the survivor if you ignore the substance abuse in order to maintain the counseling relationship. It supports the natural denial of the disease in the survivor and contributes to the feeling that life is so out of control that not even counseling can help. In confronting the substance abuse, the counselor can guide the survivor in thinking about options and beginning the recovery process. Avoidance of the subject only creates an illusion that the survivor is healing.

It is not helpful to try to provide crisis intervention or counseling to someone who is currently drunk or high. You may need to set limits with a survivor who is abusing alcohol or other drugs. Gently but firmly explain that you will not work with a survivor while she or he is under the influence, but that you remain available to help overall. This counteracts the denial that the survivor may be experiencing.

The following questions from *The Recovery Book* provide a useful guide to the types of issues that are relevant to assessing whether substance abuse might be an issue. A guideline is that three “yes” answers to these questions suggest the possibility of substance abuse.

- Have you ever felt you should cut down on, or tried to control, successfully or not, your drinking or drug use?
- Have you ever felt bad or guilty about your drinking or drug use?
- Do you ever take a morning eye-opener to steady your nerves or get rid of a hangover?
Do you use drugs daily or weekly? Do you use prescription drugs more often than prescribed? Have you ever asked more than one doctor to prescribe a drug for you?

Are alcohol or drugs sometimes more important than other things in your life—family, job, school, values? Is drinking with your buddies more important than seeing your child in a school play? Is snorting coke more important than visiting your mom on her birthday? Is smoking pot all weekend more important than the makeup course you need to graduate?

Do you find yourself lying to your spouse, kids, friends, employer—to cover up your drinking or drug use?

Have you ever switched from one kind of drink to another in the hope that this would keep you from getting drunk? Or from one drug to another to prove that you’re not addicted?

Have you ever had problems connected with drinking or drug use (such as traffic violations, lost work or school days, missed appointments, failed exams, financial problems, auto or other accidents)?

Has your substance use caused trouble at home or at work? Are those around you annoyed by or concerned about it? Are you annoyed by their concern? Do you become defensive?

Do you need to resort to chemical assistance to do something (start the day, work, or have sex, for example); to change how you feel (sad, scared, anxious, or angry); to banish shyness or bolster confidence?

The Process of Recovery from Substance Abuse

Recovery from substance abuse is possible once there is understanding and acceptance of the purpose substances serve, their current function, and the ways they no longer serve the person well. Recovery begins with the identification that the alcohol, street drug, or prescription drug is causing a problem in the person’s life. This awareness can come from an internal or external source.

Becoming clean and sober is important. Treatment for the disease of alcoholism/addiction is, in fact, unique in that it not only eliminates the symptoms of the illness but also has the potential to make life better than it has ever been before. It takes time, patience, and hard work—but with solid recovery, the survivor can:

- Regain the freedom to make choices.
- Begin to find pleasure in friends, family, nature, art, music, and work.
- Rediscover peace of mind, or discover it for the first time.
- Escape from fears—of people, new experiences, and financial insecurity.
- Benefit from a new honesty in relationship.
- Stop self-pity and start caring about others.
- Achieve liberation by giving up the need to control people, places, and things.
- Become comfortable with self and others.
• Learn to solve life’s problems with thoughtful actions instead of blotting them out with chemicals.
• Break the intergenerational cycle of addiction, so that it will not be passed down to another generation.9

Until the survivor achieves abstinence, little can change. Once the assessment is made that there is a substance abuse problem, the initial goal is to stop using the substance(s).10 Then, it is important to proceed with treatment that will provide the survivor with an appropriate focus. A process called “The Spiral of Change” offers a useful concept.11 It has five distinct phases.

The first phase, pre-contemplation, begins with identifying the alcohol or other drug as a problem. The survivor is actively using the substance in this stage, which results in increased isolation and narrowing of the world. The focus is on control of the use. The survivor is likely to respond to the identification of alcohol or other drugs as a problem with denial, anger, or sense of hopelessness. Since any misuse of substances during recovery from sexual assault is dangerous for the survivor and will interfere with trauma treatment, the survivor needs to recognize the importance of abstinence. The stronger the defenses of denial and anger at this stage, the likelier the survivor is depending on alcohol or other drugs for managing the trauma. It is important for the counselor to explore this area with the client in a nonjudgmental way, recognizing that the survivor is utilizing substance(s) to feel better.

The next step is contemplation. The survivor begins to recognize there is a problem, but may not be ready to change or give up the habit. A shift in beliefs begins to occur – from faith in the ability to control the use of the substance to acknowledgment of the loss of control. During this process, the survivor is likely to have intermittent periods of sobriety until there is a true acceptance of loss of control. It will be important for the survivor to learn other coping strategies to strengthen her or his ability to remain substance-free.

Preparation is the third step in the change process. Survivors may have strong ambivalence about giving up substances that have sustained a major coping pattern. The counselor needs to be aware of the loss issues and help the survivor to grieve and find substitute activities. Self-help groups can be integral pieces of this process, as they provide a source of stability, hope, and security. The survivor’s world-view expands and changes unconsciously. At the end of this stage, there is a commitment to change.

The action stage is recognized by continued movement into abstinence. Ambivalence diminishes, and the survivor moves from a strong defensive position to a more vulnerable, defenseless position. The counselor must be aware of the need for support and empathy. This phase may be very threatening for the sexual abuse survivor, who already feels defenseless and vulnerable. The focus of work at this phase is on education and support.

Maintenance is the phase to engage the survivor in “relapse prevention.” During this ongoing recovery, the survivor becomes interdependent and develops sharing
relationships. Exploration of earlier losses and issues can occur as they emerge. The focus is on helping the survivor find healthy ways to cope with conflicts.

Individuals who suffer from trauma issues are at high risk for relapse, since feelings related to trauma can be triggers for substance abuse. Education, honesty, and information are necessary at every stage to prevent relapse. Each survivor will have a unique set of warning signs that need to be identified; then she or he needs to develop healthy coping strategies. Keeping a daily journal and monitoring for relapse signs can be useful tools.

Treatment Resources

The combination of professional treatment and self-help groups can aid the survivor in keeping recovery on track. The numerous possibilities underscore how important it is for the counselor to maintain good working relationships with local substance abuse treatment providers, to be able to refer appropriately.

For an individual who wants to recover from addiction, self-help groups offer support and understanding from others in recovery. These include: Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Women for Sobriety, Rational Recovery, and specialized groups for professionals (physicians, lawyers, nurses, etc.). The classic “12-step programs” as well as other types of self-help groups may provide survivors with a safety net at all stages of recovery.

Inpatient programs in a freestanding detoxification or hospital setting provide short-term treatment, with the focus on a medically safe detoxification from the drug of choice. These programs can be very useful in providing medical management and psychological safety while undergoing detoxification. The survivor can learn about the disease of addiction and be referred to community resources when discharged.

Residential programs – such as sober houses and halfway houses – can offer a safe, supportive, structured environment while a survivor is learning to live substance-free. An individual can typically stay in a residential program from three months to a year. During treatment, survivors learn how to cope with daily living, possibly with employment, and may become active in 12-step programs. A residential program has a counseling staff and group meetings focused on recovery issues.

Outpatient treatment can be as limited as individual counseling on a monthly basis, or as intensive as daily groups in a structured day-treatment program. Many survivors combine individual counseling, groups, and a self-help program. For individuals who are unable to maintain an opiate-free life, Methadone maintenance programs can be useful; by providing daily doses of Methadone, along with counseling, these programs reduce high-risk behaviors involved in drug abuse.
A further resource for program information is the Massachusetts Department of Public Health’s toll-free Statewide Information and Referral Number. There are programs that accept pregnant women and women with their children; the Coalition on Addiction, Pregnancy, and Parenting can assist in identifying appropriate placement for women survivors.

5 Adrienne Crowder, Opening the Door: A Treatment Model for Therapy with Male Survivors of Sexual Abuse (1990).
7 Blume, op. cit.
9 Mooney, op. cit.
10 Blume, op. cit.
D. Self-Inflicted Violence

Self-inflicted violence or self-injury is the intermittent deliberate hurting of one’s own body. Self-inflicted violence is frequently encountered in adolescent and adult survivors of childhood sexual abuse, physical abuse, and neglect – particularly when that abuse was repetitive, severe, and began early in life (before age seven). Self-injury is a coping strategy on which some sexual assault survivors regularly rely.

Self-inflicted violence is frequently difficult for others to understand, because it runs counter to the observation that human behavior is more often pleasure-seeking or, at least, pain-avoiding. Although self-injury appears to run contrary to logic, it is unfortunate that these behaviors have, in the past, been labeled “masochistic” or “manipulative.” Such labels are misleading and simplistic, serving to further victimize survivors of severe abuse.

Because some self-injurious behaviors can seem repugnant or bizarre, it is easy to react by distancing ourselves from the survivor, labeling the individual who self-injures as “wrong,” “bad,” or “sick.” Another way of distancing from the survivor is to become focused on, or even fascinated by, the self-mutilation behaviors themselves, while losing touch with the survivor as a human being. Such responses reinforce the survivor’s own sense of loss of contact with self and loss of contact with others.

Forms of Self-Inflicted Violence

Self-inflicted violence covers a wide variety of behaviors. These include: scratching and cutting with razor blades, glass or knives; burning with cigarettes, matches, or caustic substances, such as oven cleaner; head and body banging; striking hard objects (such as a wall) with a fist. There are other forms of self-inflicted violence: scratching with fingernails or biting the skin until a wound is created; pulling out hair, eyelashes, or eyebrows; inserting sharp objects into the vagina or rectum; using caustic substances as douches or enemas. Purging and laxative abuse fall into the category of self-inflicted violence, as they damage the body and cause pain.

Common sites for injury are wrists, forearms, legs, and genitals. Some survivors tend to self-injure in places that can be seen, such as on the hands and wrists; others tend to keep marks left by their violence concealed under clothing. Some depend on a single form of self-inflicted violence, while others do not.

In general, self-inflicted violence has been more commonly reported in women than men. Although coping through this behavior appears to have increased dramatically since the 1960s, it may be that such actions were simply more hidden in the past. Self-inflicted violence may still be seriously underreported, due to social stigma.
A number of authors have documented the frequency of self-inflicted violence among sexual abuse survivors. One study found that 62 percent of self-injurers reported histories of childhood physical and/or sexual abuse. Another found that childhood sexual abuse was correlated more with later self-inflicted violence than was physical abuse. Research also has uncovered high rates of self-injury in adolescents and in adults with dissociative symptoms. One study found self-injury in 83 percent of their group of individuals with dissociative identity disorder (DID) and 78 percent in a group with partial DID.

For some survivors, other types of behavior can be considered self-inflicted violence, depending on the circumstances. These include more indirect forms of self-harm, such as excessive dieting, poor nutrition, or not obtaining needed medical care. Body alterations, such as body piercing, tattoos, or cosmetic surgery sometimes can be considered forms of self-inflicted violence (but are frequently carried out for other reasons). Eating disorders and drug abuse also can be viewed as self-inflicted abuse. (See Chapter 22B: Coping Patterns of Sexual Assault Survivors – Eating Disorders and Chapter 22C: Coping Patterns of Sexual Assault Survivors – Substance Abuse.)

Distinguishing Self-Inflicted Violence from Suicidal Behavior

Individuals who self-injure also may have thoughts about suicide and be at risk to make an attempt or even complete a suicide. Suicide attempts generally can be distinguished from self-inflicted violence as a coping pattern. (See Chapter 24: Suicide Prevention.) There are similarities, however, that have led to confusion, even in health settings. For example, episodes of superficial cutting of the arms have frequently been labeled as “suicide gestures” or “suicide attempts” by hospital emergency room staff, without exploring the meanings of the behavior with the patient.

Both suicidal and self-inflicted violent behaviors:

- Are directed against the self.
- Result in physical harm.
- Occur after a period of frustration.
- May involve an attempt to reach out to another person to get them to do something or feel a certain way.

However, suicide attempts are distinguished from self-inflicted violence as a coping pattern in a number of key respects. The usual stimulus for suicide is unendurable and unrelenting psychological pain – which leads to hopelessness and the conviction that there is little point in continuing to struggle. For the suicidal individual, suicide is an act meant to solve ongoing problems by seeking a state of unconsciousness. Thus, suicide can be thought of as an attempt to escape. Suicidal ideation is often characterized by all-or-nothing thinking or tunnel vision, in which rational alternatives to suicide are not considered.6
In contrast, the intent of self-inflicted violence is to change an emotional state, or to modulate or regulate tension. Individuals who self-injure usually do not suffer from severe, ongoing depression, but rather from intermittent periods of intense distress. Survivors locked into common patterns of self-inflicted violence often report periods of gradual buildups of psychological pain and tension, sometimes accompanied by feelings of depersonalization (such as a sense of numbness, being unreal or like an automaton, parts of the body feeling disconnected, or observing the self from the outside).

When the urge to self-injure is acted on, there is often no experience of pain, at least at first. Similar to using chemicals to alter one’s emotional state, survivors describe entering altered states of consciousness moments before or during their acts of self-inflicted violence. Thoughts may become confused before the act. Survivors who self-injure are usually aware that they will feel better afterwards. They self-injure to “pull themselves together,” or to reconnect with themselves and others. Their thinking is narrowed only in the sense that they believe that the self-mutilating acts are the best means of relief. After the act, there typically is a significant relief of tension and a return to a normal state.

**Dynamics in Self-Injury for Survivors of Childhood Abuse**

Discovering the origin of self-inflicted violence in the past can help a survivor to understand – and take action to lessen dependence on – these actions. Even in professional psychotherapy sessions, understanding the role of self-injury for a particular survivor can take time, since the reasons for the behavior may be extremely complex or difficult to untangle. And, for the same survivor, the same self-injurious behaviors may be triggered by a variety of cues at different times.

It is not necessary for the rape crisis counselor to fully understand or “treat” the complexities to be effective. The information in this section is presented to create sensitivity to the nature of self-inflicted violence, so you can relate in an open and supportive way with your client.

Engaging in self-inflicted violence can be a means of distraction from painful emotions by inducing physical pain to replace the unbearable emotional pain. Self-injurious behaviors can also be reenactments of childhood physical and/or sexual assaults that survivors may not remember, may only vaguely remember, or may be unable to talk about because to do so would be overwhelming or because they are still “keeping a secret.”

Self-inflicted violence can be a way of making the outside of the body look like what the inside feels like, or of showing oneself or others what that emotional pain is like. The physical scars can be powerful images or metaphors for the pain, anger, and grief that the survivor is reluctant to express openly. The survivor may really wish to cry out, in the process of re-experiencing the trauma, that she felt cut off from all affection and kindness.
at home, or that her spirit was crippled, or that parts of her felt as though they “died” with acts of incest. (See *Chapter 17: Adult Survivors of Incest*.)

Growing up, an abuse survivor may learn that the open expression of normal feelings of rage and sadness at being exploited will not be tolerated and must be suppressed or dissociated. Later, when she or he is given “permission” to express these emotions directly, the survivor may continue to rely on those ways that helped to release the feelings before. Self-inflicted violence may feel like the most comfortable and familiar way to express feelings, even while the survivor is beginning to heal in other ways.

Self-injury also can be a means to deal with ongoing abuse, by practicing ways to feel and cope with pain. The survivor can experience a measure of control in choosing the time and type of injury, even knowing that pain is inevitable.

Self-injury may regulate the levels of certain chemicals in the brain. These chemicals – the endogenous opioids or endorphins responsible for the so-called “runner’s high” – can cause feelings of well-being, or even a euphoric state, after injuring themselves. It has been speculated that people may develop an addiction to this endorphin release and may self-injure in order to receive a chemical “fix.”

In some survivors, self-inflicted violence may be related to being in a hypnotic trance. People can enter such a trance state in three ways: when a hypnotherapist guides the individual through a trance experience; self-hypnosis, where a trained person guides herself or himself; and spontaneous trance, in which the individual enters and leaves trance states without deliberately intending to do either. Self-inflicted violence may be a way to use a trance to make painful memories go away, or to help escape a trance in which the survivor is experiencing a flashback. Self-injury can “ground” a survivor who is “spaced out” (or in a trance), by allowing greater awareness of the body and surroundings. Sometimes seeing blood can help the self-injuring survivor feel “real.” It may also speed up a flashback by going straight to the final part of the memory where the physical pain was felt.7

Survivors frequently feel powerless to impress upon others the severity of their emotional pain and frustration, or to influence others on their behalf. Self-inflicted violence can be used in the context of an interpersonal relationship, by providing a measure of power and control. For example, the survivor may self-injure to gain nurturing from others or to shock them into paying attention. The individual experiences some restoration of personal power as the self-injurious behavior results in similar feelings of helplessness and frustration in others. This mechanism, sometimes referred to as projective identification, allows the survivor to transfer overwhelming emotions to another person, partly to learn how someone else would handle similar feelings.

The experience of abuse naturally and inevitably leads to a great deal of anger in a survivor. The expression of anger is a critically important part of the healing process. Anger can be an enormous source of energy that can be used productively toward getting well. However, since perpetrators often act angry during their abusive behavior,
survivors may be afraid of their own anger. And since perpetrators may have abused a child when she or he reacted with anger, the survivor was taught that expressing anger was “bad.” Thus, survivors often turn their anger at the only “safe” target – themselves.

Self-inflicted violence can be felt as punishment for things survivors feel they have done wrong in the distant or recent past. It can be an attempt to attack (or “get rid of” or “punish”) a particular part of the body that the abuser favored or that the survivor blames for the abuse.

Survivors of severe, repetitive child abuse may suffer from DID. (See Chapter 22A: Coping Patterns of Sexual Assault Survivors – Dissociation.) They may self-injure for reasons related to internal conflicts between alter personalities. For example, one alter may injure the body as a warning to another alter not to reveal more information to a friend, therapist, or law enforcement official about the abuse. Or one alter who feels isolated may carve a message or symbol as an attempt to communicate other specific information to other alters. Such survivors may feel quite pessimistic that the parts inside them will ever understand each other.

Some survivors report that they self-injure because they were taught, more or less specifically, to do so in response to certain feelings – such as anger, shame, or sexual arousal. Some were taught, in the context of ritualistic abuse, to self-injure at specific times of year, or as part of certain rituals. (See Chapter 23: Ritual Abuse.) When “triggered” by cues, they report having strong urges to self-injure in prescribed ways. Survivors may believe a perpetrator’s claim to be able to read their mind, or to be always watching them. Although these survivors may realize that their perpetrators will not know whether they self-injure according to instructions, they may feel a compulsion to do so, “just in case.”

Survivors of sadistic abuse have reported being repeatedly labeled by their perpetrators as “bad” or “containing evil.” While these survivors differ in the degree to which they believe in this “badness,” they frequently report that self-inflicted violence – such as cutting or purging – can be a way of attempting to get rid of this perceived sense of evil.

Exploring Healthy, Self-Affirming Alternatives

Survivors have discovered a variety of alternatives to self-inflicted violence. As the reasons for the violence vary, so do successful strategies for replacing it. For example, one survivor might find that drawing on her arm with a red marker or ketchup circumvents a strongly felt need to cut her arm; another might find that this only escalates the internal pressure to cut herself.

A sampling of strategies is as follows:

- **Distraction** techniques can be helpful, particularly when these lead to a mood change. Playing favorite music, watching a movie, reading, working on a hobby,
or talking with a friend are possible alternatives. When self-inflicted violence behaviors are associated with a particular place in the home, such as a bathroom or bedroom, changing the environment is sometimes helpful.

- **Self-soothing and nurturing** strategies include petting a pet, walking along the beach, hugging a stuffed animal, listening to a tape with nurturing or soothing imagery, or imagining being in a completely safe, protected place.

- When self-injurious behavior involves an attempt to show others something about the pain inside or the abuse memories, strategies involving self-expression can be helpful. These include: writing about what happened and/or the feelings of pain; calling a trusted person to talk about what happened and subsequent feelings; making an audiotape to give a friend or therapist.11

- When the self-injury is related to communication between alters in a survivor with DID, much can be done over time to increase internal communication and cooperation between alters, especially with the aid of a therapist trained in working with dissociation. Different alters can be encouraged to write or draw their thoughts and feelings. (While it is not up to a rape crisis counselor to initiate this work, you might consider referring your client to a professional therapist.)

- When survivors are about to self-injure because they feel “spaced out,” “not real,” or disconnected from their bodies, they can be encouraged toward actions that reconnect them, such as: remembering a time when they did feel connected; stroking their face or arm to feel the sensation of skin touching skin; rubbing an ice-cube on these areas; or drink a hot beverage or a very cold drink.12

- When the self-inflicted violence seems like a physical addiction, survivors can seek the help of a trauma-oriented psychiatrist experienced in using medications. Some survivors find that vigorous physical exercise leads to similar state changes. Various self-help or 12-step programs for addictions can be used, as well as peer support groups for those who self-injure. (See Chapter 22C: Coping Patterns of Sexual Assault Survivors – Substance Abuse.)

- When feeling overwhelmed, some survivors are able to learn (often with the aid of hypnotic suggestions by a trained therapist) to place in “containers” within the mind their overwhelming feelings, flashbacks, body memories, and tensions. These containers – visualized as bank vaults, locked chests, trash bags, videotapes, or compact discs – can be brought out again to remember and review in the service of healing.

- With the rape crisis counselor (or other helping person), survivors can discuss why they blame themselves (or parts of their bodies) for the abuse. They can practice ways to ask for attention from others in a direct fashion. They can try to talk over feelings of helplessness and horror, instead of watching for emotional reactions from the helping person when they report their self-inflicted violence.
There are many strategies for expressing, exploring, and directing anger into healing. Expressing anger can be done physically – by activities such as ripping up an old book, or throwing eggs into a bathtub and watching them smash. Hypnotic techniques, such as imagining cutting into a large rock with a hammer, are sometimes helpful. Some survivors like to draw, write, or talk about what they would like to do to their perpetrators. Some find that joining groups to educate others about child abuse or to change social policy can be a good long-term strategy for working through their anger.

Working on issues of sexuality, alone or with a sensitive partner, can be helpful. When sexual experiences in the present trigger memories, shame, and self-inflicted violence, survivors sometimes decide to put such experiences on hold awhile. Many find that talking with a therapist about sexual feelings, including the pairing of sexual feelings and pain, is very valuable.

Different Views on Therapy for Self-Inflicted Violence

As therapists gain increased understanding of the role of self-inflicted violence in the lives of survivors of sexual and other repetitive childhood abuse, they continue to explore approaches that will assist survivors. Most experts agree that a solid, ongoing, helping relationship is important. Survivors find they can resist self-inflicted violence more easily when they are in long-term therapy, because such therapy leads to increased feelings of safety, and attachment or connection with another person. Other safe, ongoing relationships have similar positive effects. When these relationships undergo stresses or disruptions, as when the therapist is away, the pressures to self-injure frequently increase.

There is a difference of opinion about how therapists should react to self-inflicted violence. Most clinicians hold the view that survivors should be encouraged to strive to gradually decrease the frequency and degree of self-injury – with the goals of fewer episodes and less damage to body tissue over time. Contracts may be set up between therapist and client that help limit the amount of self-inflicted violence. As a last resort, brief hospitalization for safety is used.

A few clinicians report achieving more success with a “no-tolerance policy,” in which the client is referred to a hospital or another therapist if self-injury continues. They define self-inflicted violence behaviors for the client as showing extreme disrespect for the body and person of the survivor – which, as therapists, they cannot condone. They take the position that all self-abuse must stop without delay, in order for the work of healing to begin. Many survivors say they would be unable to give up self-inflicted violence so suddenly and completely, and others reject the notion that therapists should set such limits on their behaviors. However, clinicians supporting this policy have reported that many survivors do well with this firm approach, when it is combined with a positive helping relationship and respect for the capacity of survivors to heal.
Ways of Helping the Self-Injuring Survivor

As the rape crisis counselor, you may experience a variety of strong or disturbing emotions in:

- Encountering the self-injurious behaviors.
- Learning the extent of sexual, physical, and emotional abuse and neglect that typically leads to self-inflicted violence as a coping pattern.
- Perceiving the underlying emotional pain that these behaviors cover over (yet, at the same time, so eloquently express).

The usual emotional responses of helping a survivor may intensify if the counselor becomes preoccupied with preventing self-inflicted violence. In the face of such pressure, it is important for you to recall that your own strong reactions are normal and result from the intensity of the issues involved. Self-awareness and self-acceptance enable the counselor to assist the survivor. (See Chapter 27: Taking Care of Ourselves.)

The characteristics of the counselor’s attitude that tend to be most helpful with the self-injuring survivor are:

- Concern for the survivor’s physical safety, even when she or he is not able to be concerned.
- A nonjudgmental attitude toward the self-injurious behaviors.
- A calming presence that can “contain” the strong emotions of the survivor.
- Respect for the survivor as the expert on her or his own experience.
- Interest in the survivor as a human being.
- Maintenance of the appropriate distance, being neither under- nor over-involved.
- Belief that the survivor possesses considerable strengths that can be mobilized in the service of healing.
- Recognition of your own limitations in the role of a rape crisis counselor, and offering appropriate referrals.

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3 Van der Kolk, op. cit.
5 S. Boon and N. Draijer, Multiple Personality in the Netherlands: A Study on Reliability and Validity of the Diagnosis (Amsterdam, 1993).
6 B. Walsh and P. Rosen, Self-Mutilation: Theory, Research and Treatment.

9 Sakheim, unpublished paper.

10 Sakheim, unpublished paper.

11 Sakheim, unpublished paper


13 Sakheim, unpublished paper.
