Understanding and Responding to People in the Criminal Justice System Who Live with Self-Inflicted Violence

Written by Ruta Mazelis

Introduction

Every day, every hour, inmates in jails, prisons, and juvenile detention centers are bleeding, burning, and bruising themselves. These actions, known as Self-Inflicted Violence (SIV), are often considered to be the behaviors of the highly disturbed or pathologically manipulative, yet they are actually the most effective coping mechanisms many people have to manage their lives in the moment. When understood, the cuts, bruises, and blisters of SIV can guide us to better understand incarcerated individuals. They also provide us with ideas to stimulate healing and change not only for those individuals, but for our criminal justice system as well.

SIV is the intentional injuring of one's body as a means of coping with severe emotional and/or psychic stressors. It is used most commonly to manage the aftereffects of earlier trauma, especially experiences of childhood physical, sexual, and emotional abuse or severe neglect. Because the majority of persons who are incarcerated in correctional or psychiatric facilities have histories of trauma, staff in these facilities—both clinical staff and line staff—will work with people who self-injure and should have a clear understanding of:

- what self-injury is,
- who does it,
- why people do it, and
- what staff can/should do about it.

What is self-inflicted violence?

Clinically, SIV has been referred to by many terms, including "self-mutilation," "delicate skin cutting," and "parasuicidality." While commonly used, all of these labels misrepresent the behavior and meanings of SIV. Mutilation is not a goal of someone who self-injures, and some forms of SIV leave no scars. While cutting is one of the most prevalent methods of SIV, other common forms of self-inflicted violence used are punching, hitting, burning, bruising, head-banging, picking, or scalding the body. Each of these serves its own purpose and these different methods are not often interchangeable.

Many myths abound regarding SIV. One of the most prevalent is that the behavior is a failed, minimal suicide attempt, known as "parasuicidality." In fact, the opposite is actually true. SIV is often used to manage the strong emotions that lead one to consider

dying, and it often serves to avert suicide attempts. Practices that seek to eliminate SIV (including physical and chemical restraints, seclusion, constant observation, and intervention) actually increase the risk of successful suicide by removing an effective coping strategy that acts as an alternative to ending one's life.

Who self-injures?

Currently, attention to SIV by the media and the mental health field has focused on youth, particularly adolescent girls. While use of SIV often begins in childhood or adolescence, it is not uncommon among men and women of all ages. Therefore, while SIV is an important issue in the juvenile justice system, it is equally important that it be understood in the adult system as well. Other assumptions regarding people who live with SIV are that they are white and of middle or higher socioeconomic class. This is inaccurate. SIV is utilized by men and women of all classes, races, and cultures. The common denominator amongst people who live with SIV is a history of some form of trauma. Research shows that the vast majority of incarcerated people have known histories of childhood trauma, especially childhood abuse. For example, a recent study of men incarcerated in a county jail reported that 59% of them acknowledged some form of sexual abuse occurring before the age of 13.[1] A history of abuse, as well as other forms of trauma, is especially likely for people in the criminal justice system who struggle with mental health and/or substance abuse problems. Rates of prior trauma are as high or higher for individuals in the criminal justice system as for individuals in the mental health system.[2]

Childhood trauma often has profound repercussions in later life and can greatly impact a person's physical, emotional, and spiritual being. As reported by NYCASA, a 1999 study of female inmates at Bedford Hills Correctional Facility in New York found that over 80% had a history of childhood physical and sexual abuse, and more than 90% had experienced battering or sexual assault during their lifetime.[3] In a study of inmates on death row, 100% had histories of family violence and more than 87% were victims of severe physical and/or sexual abuse and met criteria for Post Traumatic Stress Disorder.[4]

A history of abuse does not excuse criminal behavior, but it may help explain it. For example, the use of alcohol and other substances is an effective method of "self-medicating," commonly used by traumatized people to "numb-out" or escape from intrusive thoughts and emotional pain. The use of illegal substances, and the behaviors necessary to access such drugs, often results in criminal behavior and incarceration. Similarly, most of the people (male and female) who work in the sex trade are victims of childhood sexual abuse. People who learn as children that sex is the most effective currency for maintaining relationships and feeling valued (not to mention making money) find as adults that sex work still meets these needs. The vast majority of incarcerated women have been arrested on charges of solicitation, drug offenses, or both.

Childhood trauma can take many forms, including experiences of:

- early loss and separation, especially of a parent /caregiver or sibling due to
    - illness

    - death
    - divorce/separation
    - drug and/or alcohol abuse
    - incarceration
    - neglect
- poverty and deprivation
- severe illness, hospitalization, surgery
- war
- racism
- childhood abuses, including
    - sexual assault, including incest
    - physical assault
    - emotional abuse
    - witnessing domestic violence, and
    - neglect.(emotional and/or physical)

These same traumatic events or conditions during childhood are the antecedents of SIV.

> *. . . the age at which their abuse and/or neglect had occurred played an important role in both the severity of their self-destructive behavior and the form it took: The earlier the abuse, the more self-directed the aggression. Abuse during early childhood and latency was strongly correlated with suicide attempts, self-mutilation, and other self-injurious behaviors. . . .Histories of sexual abuse, in particular, predicted continued suicide attempts, self-mutilation, and other self-destructive acts. Severity of neglect scores predicted continued suicide attempts, self-mutilation, and other self-destructive behaviors. During this period, the subjects with the most severe separation and neglect histories were the most self-destructive.*
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> —Bessel A. van der Kolk, M.D.[5]

Acts of SIV often lead to psychiatric interventions. By far, the most common psychiatric label given to those who self-injure, especially women, is Borderline Personality Disorder. This diagnosis, while now acknowledged to be strongly correlated with childhood trauma, often elicits intensely judgmental and punitive treatment from clinical staff, both in psychiatric hospitals and in corrections facilities. While the most common accurate diagnoses given to childhood trauma survivors are Post Traumatic Stress Disorder and any of the Dissociative Disorders (and the recognition that anxiety, depression, extreme mood swings and hearing voices are not uncommon amongst trauma survivors), these are not usually applied to people who live with self-injury. Also, recent research has identified that people with psychiatric diagnoses not previously considered to be related to childhood trauma, such as schizophrenia and obsessive-compulsive disorder, do have a very high prevalence of childhood trauma and that the trauma might be related to the development of those disorders.[6]

All too often, the result of psychiatric diagnosis is to stigmatize certain people as dishonest, unlikable, and, worst of all, hopeless. Nowhere are these iatrogenic (harm caused by treatment) effects of diagnosis more pernicious than in the criminal justice system, and no diagnosis hurts more than that of a personality disorder. . . people who are so described are treated as if their disruptive and self-destructive acts are simply evidence of moral weakness, dishonor, and perhaps evil.

—Joel Dvoskin, Ph.D., A.B.P.P.[7]

Why do people deliberately cut, punch, or burn themselves?

Just as the substance use and sex work (described above) serve a purpose and solve a problem for survivors of childhood trauma, so too does SIV (and most other trauma-related behaviors) serve a functional purpose for those who do it. Typically, SIV is driven by the underlying need for self-regulation and serves as a means of grounding, a way of managing highly dissociative states that impinge and impair functioning. It helps the person manage intense, seemingly overwhelming feelings, memories, and experiences. It is best understood as an act of self-defense, defending oneself from being consumed by the overwhelming distress of despair, numbness, or the re-experiencing of abuse. When asked how SIV helps, those who live with it say it helps them to:

- feel real, get a sense of their physical boundaries
- diminish intense emotions such as despair, terror, grief, self-hate, rage, shame, or helplessness
- facilitate dissociation, to disconnect from their sense of self when overwhelmed
- diminish dissociation, when the sense of disconnection is unwanted; SIV serves as "grounding"
- symbolize internal pain through an external expression
- remember without consciously knowing; re-enacting of previous abuse as an attempt to gain mastery
- communicate what cannot be said verbally
- express anger at someone else by directing it at their own body; i.e. punching themselves to avoid violence towards another
- stop or diminish flashbacks of abuse
- communicate between personalities in those with Dissociative Identity Disorder (formerly known as Multiple Personality Disorder)
- symbolize spiritual beliefs

Many people who self-injure feel no physical pain at the time of the acts of SIV. While some clinicians believe that this is a result of certain naturally produced brain chemicals (endogenous opioids known as endorphins), this theory is flawed. The wounds of SIV are often minimal. Many require little or no medical attention. They are no different from many minor wounds that are the results of accidents, and these do not cause any sort of chemically induced relief. The absence of pain from self-injury is much more likely

related to the depth of the psychological disconnection (or dissociation) the self-injuring person is experiencing at the time. Also, as SIV is often used as a release for profound emotional pain, persons who self-injure report that the emotional pain is so overwhelming it makes the less intense physical pain from the self-injury irrelevant. Many people who cut themselves do so as an act of expression and release of deep and very difficult emotions. As a poet once wrote: "I hurt so much, I bleed."[8] People who have survived traumatic childhoods often struggle with dissociation, which is the sense of having one's thoughts, feelings, and identity separate from one's body. Dissociation is often described as a sense of "extreme spaciness." While an effective form of self-preservation, dissociation leads to feelings of disconnection and/or unreality and thus interferes with learning new ways of being in, and interacting with, the world. For some people it may be a preferable state of being when overwhelmed; at other times dissociation is unwanted or frightening. SIV is often used as a tool to manage dissociation, either to increase it or to decrease it. As a result, SIV serves as an "all-purpose tool" for many institutionalized or incarcerated people.

Persons with histories of severe abuse who experience emotional numbness often turn to SIV to "feel something." This is particularly poignant for those who are kept in isolation most of the time. Inmates in highly restrictive environments who have no hope for change in their situations not only tend to self-injure, but often do so with escalating severity as their helplessness and hopelessness increase. For these people the SIV serves as a way of feeling "something" in the midst of continued intolerable emotional and experiential numbness.

> *Many of the most violent men in prisons mutilate themselves at least as viciously as they mutilate their victims (that is to say, very viciously. . . . The things these men do to themselves are the most common, "everyday" events in the world of maximum-security prisons. . . . At the least violent of the self-mutilative spectrum, these men cut their wrists or forearms or other areas of their bodies. . . . On the other hand, I have also known prison inmates who have cut off their own penis and testicles, others who have torn out their own toenails, and others who have blinded themselves. When these various forms of self-mutilation no longer bring feeling, many of these men come to realize that the only way to kill the pain in their souls is to kill the whole body. For these men, their living death is an intolerable, zombie-like existence.*
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> —James Gilligan, M.D.[9]

Abuse survivors, especially those who disconnect from themselves and others through dissociation, often struggle with a fluid sense of personal boundaries. Because their personal physical and emotional integrity have been repeatedly violated they may literally not know where they end and "other" begins. Sometimes the sight of a cut and the presence of one's own blood help a person literally understand his/her own physical boundary. It is a way of experiencing that "what is bleeding is me, it is where I begin."

Abuse survivors' struggle with identifying and exercising personal boundaries is especially difficult when they are housed in facilities that are unsafe or overcrowded, or when they are kept in isolation (isolation of someone who self-injures is a very common institutional reaction to SIV). The need to manage strong feelings (or absence of feeling anything) in these settings contributes to the use of SIV. This is especially true in the face of ongoing sexual and physical violence and intimidation while incarcerated, when the inmates' options are so very limited.

Violence in correctional facilities, especially sexual assault, is remarkably common. Research in seven Midwestern prison facilities showed that over 20% of male inmates experienced pressured, coerced, or forced sexual contact, both by other inmates and by staff.[10] Women in correctional facilities also face threats and acts of violence and sexual abuse. For many the experience of sexual abuse and objectification is a continuation of their childhood and adolescent lives. "Women prisoners report experiencing routine sexual harassment once incarcerated. In addition, many women in prisons and jails across the U.S. report they are victims of sexual abuse by staff. Reported incidents include male guards touching women's breasts and genitals when conducting searches, watching prisoners while they shower and dress, and raping prisoners."[11]

What can staff do to stop people from injuring themselves?

Typically, interventions for self-injury focus on the immediate prevention or stopping of acts of SIV. While this seems logical, it generally results in an escalation of SIV rather than diminishing it. The reason for this is simple: coercion, even if intended to "prevent harm to self" is inherently retraumatizing. It reenacts or mimics previous trauma, with its resultant loss of control, helplessness, fear, outrage, and overwhelmed coping.

> *I have been in prison for the last five years. Three years ago I tried to kill myself. I cut my throat. It was serious. They put me in solitary confinement for 14 months. I didn't talk to anyone. I had a really hard time in there. I got extremely depressed.*
>
> *I just cut myself an hour ago. Now I do it in the shower. I don't tell the prison shrink that I do this. It's too risky. I cut my thighs, stomach, or breasts so I can hide it. I bandage myself with toilet paper and scotch tape. I will be released in two months. Until then I pray I don't get strip-searched for anything.*
>
> *I don't want anyone to "help me" ever again.*
>
> —d.t.[12]

"Doing nothing" actually leads to better outcomes than coercive measures, especially those that involve restraint, seclusion/isolation, and/or forced medication (chemical restraint). Unfortunately many psychiatric and criminal justice practices and policies promote revictimization. However, as awareness of the impact of trauma on mental (and

physical) health increases, more clinicians, judges, and wardens are reconsidering the use of interventions that ultimately cause more harm than good. While interventions that directly address trauma and its impacts are very useful, what might be even more significant for healing is the creation of a trauma-informed environment. Such an environment promotes collaboration between staff and inmate to identify what is both helpful and hurtful when struggling with the urge to self-injure. People who have survived trauma have experienced frightening helplessness and need as much control over their lives as possible. This includes making decisions about SIV. All staff can be taught skills to promote collaboration, insight, and communication even while focused on the maintenance of security and safety.

> *Many who self-harm have limited ability to modulate or tolerate emotional responses to the world, and often do not have a very concrete sense of self. I have often found that although it may be the anxiety that surfaces first and can trigger the self-harm, that as individuals learn to sit with that anxiety for longer and longer periods of time (delaying the self-harm) these people often discover another emotion that is below the anxiety, be it sadness, fear, anger, abandonment, etc. I have also seen where memories are beginning to surface and the self-harm can push that back down. What I have seen as very powerful is beginning to see their self-harm as a language, as saying "I am overwhelmed" or "I am scared" or "this feels too familiar," in combination with learning that they can at first delay the act for a few moments (which then allows them to try a few more moments, and so on and so on), and the behaviors slowly begin to lessen. As they begin to experience some intense emotions and then see that these emotions can lessen by experiencing them, they begin to lessen the behaviors. My work the last 7–9 years with incarcerated females has really opened my eyes to these behaviors. We see some of the most extreme: massive cutting with objects inserted into cuts, both eyes blackened, head banging to the point of a laceration. These women have some of the most severe abuse histories and are some of the most unattached. Many have histories of torture by families with many generations of extremely sick individuals.*
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> —Dr. Maggie Zinman, Ph.D.[13]

Systemic Change

To reduce SIV and to promote recovery from other sequelae of trauma, violence between inmates or between staff and inmates must ultimately be addressed. Healing can rarely occur when physical and/or emotional safety is threatened. Correctional facilities in which this is a problem must strive to create, implement, and enforce policies to end the ongoing violence, rape, molestation, or intimidation within the institutional setting. This pertains to actions between inmates as well as between corrections staff and inmates. As this current violence decreases, so will the need for SIV to cope with the repercussions of unsafe environments. The most successful approach to decreasing violence, intimidation,

and misunderstanding is to provide staff and inmates with information about the prevalence and repercussions of severe childhood trauma, to facilitate the creation of trauma-informed environments, and to promote the development of trauma-informed practices and policies. For example, when corrections officers receive trauma training they often learn to perceive inmate behavior from a different, less personal and inciting perspective. This attitudinal shift often results in decreased reactivity towards the inmates, which then influences inmate responses to staff as well. The establishment of trauma-informed criminal justice facilities requires a philosophical shift in the culture of the facility.

> *. . . I've just spent almost three weeks locked in a filthy little box for cutting myself. Twelve of those days were spent naked while being viewed, by anyone who entered the office, via closed circuit TV. It was awful. I wished for death many times. . . .*
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> *The guards violated my rights to confidentiality by ripping the pages out of my journal and art therapy book, passed them around amongst themselves, then punished m by sentencing me to solitary confinement— because they didn't like what I had said. . . . I'm not ashamed to say that I'm afraid to go to confinement— because of the hostility displayed towards me by various guards. Confinement has always been a notorious place to be beaten up and otherwise abused, without any witnesses anywhere. I was severely brutalized down there seven years ago and I wear a brace on my leg as a result, and will for the rest of my life.*
>
> *I am fighting the desire to slash my entire body open.*
>
> CeCe[14]

Individual Action

To successfully help a person to stop using SIV, it is necessary to consider several questions:

- Is the inmate educated about trauma and, specifically, about the relationship between trauma and SIV?
- Does the inmate have a desire to address SIV?
- How does SIV help the inmate?
- What problems is SIV meant to solve?
- What does the inmate believe might be helpful to her/him to promote healing?

The answers can be determined by discussing the meaning and usefulness of the behavior with the inmate. Working together with the person, that knowledge can be used to develop alternative coping strategies that are effective solutions for managing the triggers that lead to SIV. Not only will this exchange serve to develop a customized approach to minimize the use of SIV, but it will build trust and model a way of solving problems without using self-directed or other-directed violence. An attitude of respect promotes integrity.

Although the choices of alternatives to SIV may be more limited in correctional systems than outside, self-abusive inmates can address the emotional and situational triggers of self-injury by:

- Exercising (whether by doing pushups in one's cell or walking in the yard), to provide physical release for intense emotions or psychic stress
- Speaking with someone who is able to listen compassionately and not overreact to the idea of SIV; this may be a mental health professional or a peer
- Meditating or using progressive muscle relaxation and grounding techniques to facilitate calm and manage dissociation
- Writing, drawing, or using music and other creative pursuits, which are often helpful in facilitating expression of feelings that cannot be verbalized, and
- Learning about the impacts of trauma and healing, as such information can contextualize SIV for that person. Many trauma survivors, especially those who experienced abuse in early childhood, are unaware of the profound and ongoing impact that the trauma has on their adult lives.

People living with SIV can benefit from the following health, mental health, and support programs that can be conducted effectively in corrections settings. In addition to specific skills, these programs provide a sense of connection and meaningful activities. What is most important is providing a space, place, and opportunity for the learning of self-respect, boundaries, communication, and emotional expression.

- Education regarding
    - self-injury, especially as it relates to a history of trauma
    - harm-reduction principles
    - strategies to create alternative behaviors
- Group therapy and support groups to
    - identify and address the sequelae of trauma
    - explore the meanings of SIV
    - develop and practice alternative choices for managing the triggers that lead to SIV
    - practice mutually supportive, healthy relationships amongst peers. Inmates with trauma histories report that peer support is the greatest single factor in changing self-perceptions and the need to self-harm.
- Purposeful, community betterment, self-improvement, and support programs such as
    - mentoring
    - gardening
    - animal training
    - job training
    - parenting

I am a 40 year-old woman recovering from SIV. Since coming here (to prison) with a life sentence in 1997 I've grown beyond the need to self-injure, though the impulse still arises in highly stressful or painful circumstances. The healing I've found was self-motivated, not due to being

> *treated for the disorder while property of the Department of Corrections. Their method of dealing with inmates who self-harm is not much different than some outside ones. Inmates who hurt themselves are punished for it by being stripped and confined for up to 3 weeks in a small bare cell. Of course this is done under the guise of protecting that inmate from themselves. . . . I found strength by forming my own support group consisting of people who were doing positive things for themselves. Some of those had self-harmed in the past and found other ways to deal with life. As I grew I began reaching out to people who were actively harming themselves, passing on what I had learned. I also took steps to begin healing from my past trauma, sexual abuse issues. I believe my healing there, the self-forgiveness I found, were the biggest achievements in no longer having the need to harm myself.*
>
> Darlene D.[15]

Helping an inmate look at the strengths that he or she has within is more productive than focusing on what are often considered to be pathological or manipulative acts. Acts of SIV often trigger intense feelings (such as disgust or anger) in those who work with people who self-harm. It may be easier to not "take it personally" if staff can reframe their thinking about "manipulative" behavior in terms of an inmate's attempt to *indirectly* communicate his/her story. For the person living with SIV, the self-injury is an act of self-preservation and self-help. It is not useful to punish a person who is attempting to manage the pain of profound emotional and spiritual wounding. Remembering the following may make it easier to be patient with a self-injuring inmate:

- Acts of SIV are helpful as well as harmful; people with histories of trauma, often severe, turn to SIV as a way of managing what feels unmanageable any other way.
- The wounds of self-injury are seldom life-threatening; SIV is often used to avert suicide in people who are considering suicide. Mandating the elimination of SIV increases the likelihood of suicide.
- Behavior change takes time.

Trauma-Informed Correctional Systems

Education about the consequences of childhood trauma is crucial for staff and inmates alike. Training provides staff with the most effective approaches for intervening with persons who self-injure, as well as for all inmates who live with other sequelae of trauma, while increasing the safety of everyone concerned. These trauma-informed interventions equip officers and other staff to "provide a respectful human encounter, to facilitate medical treatment if it is needed, to help begin or advance the process of understanding self-injury as an adaptation or reaction."[16] As a criminal justice facility becomes trauma-informed, incidents of violence towards self, staff, and other inmates will decrease. This provides a safer environment for staff and inmates alike, and reduces recidivism in the long run. For people who have lived lives in which violence is the norm, it is crucial to provide opportunities for understanding of their history and instilling hope for personal

change. With such support, even inmates with life sentences, and those on death row, have transformed themselves.

> *I use my cutting as a way to hide my anguish, sadness, and guilt. If I use violence against myself I can typically hide all the negative feelings, appearing quite happy and content to those who don't know me. This decreases the questions and the prying. . . .The most help I have received has been provided by those with no psychological training, the other people who are housed here with me. The ones I have allowed close enough to get to know the real me. . . .When people aren't afraid of me or the fact that I may cut this helps me to feel "normal," which helps the desire decrease. Being in prison is in no way helpful to the sickness that thrives on hatred, loneliness and guilt. . . .What it all comes down to is yes, I am a felon, a murderer, a cutter. . . . But I am a sister, an aunt, a daughter, a granddaughter, friend, and lover. I am . . . a young woman who has survived herself.*
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> —Stephanie Sara Timothy[17]

Change needs to occur on multiple levels, from policy development to individual interventions. Stopping retraumatization is crucial. As of 2002, fourteen states had no law prohibiting sexual relations between inmates and correctional staff.[18] Education of corrections staff regarding the prevalence of trauma histories in the people they work with is also critical. Staff can learn how these histories impact the lives of the inmates that they work with and can facilitate environments that permit greater personal dignity and respect. As wardens increasingly become aware of the benefits of trauma-informed facilities, specific staff educational programs are being developed. Mental health care providers who are experienced in the dynamics of abuse and the process of recovery are developing trauma care strategies that address inmate needs. Peer-driven activities that promote harm reduction and healing from SIV and trauma are inarguably meaningful. Progress in these areas is not only possible but has already begun. Judges, wardens, corrections staff, mental health professionals, and former inmates are leading the shift toward a trauma-informed criminal justice system. Guides now exist to facilitate the launch of peer support groups for trauma survivors. The greatest hope for profound change will come in the collaboration between all stakeholders in the criminal justice system, including former prisoners and providers who have lived with SIV.

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