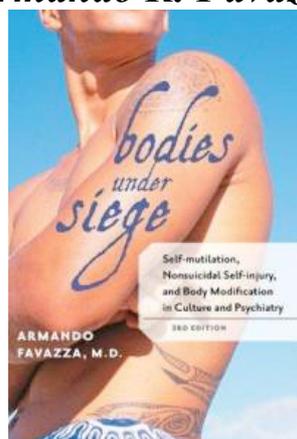


Interview

Bodies under siege
Armando R. Favazza



Interviewed by *Sabrina Di Cioccio*

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Sabrina Di Cioccio Dr Favazza, in May 2011 the Johns Hopkins University Press has published the 3rd edition of “*Bodies under siege: self-mutilation, nonsuicidal self-injury, and body modification in culture and psychiatry*”, that since 1987 it is regarded as the most important work on self-injurious behaviours and body modification practices, explored in their complexity by cultural and clinical perspectives, paying attention to the relationship with the contemporary context.

Could you explain why many years ago, you took interest in self mutilation and decided to dedicate yourself to the research on its meaning?

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Armando R. Favazza I was fortunate to study under the famous anthropologist, Margaret Mead, and so my professional identity is that of a cultural psychiatrist who is interested in the interface between clinical psychiatry and cultural anthropology. In the late 1970s, at the beginning of my career, I mainly wrote a series of articles in an attempt to establish the field of cultural psychiatry in the United States e.g. my article “*The foundations of cultural psychiatry*” was the cover article in the *American Journal of Psychiatry* [135: 293-303, 1978]. My colleagues in the field worked mainly with various ethnic groups but my university is located in an area of Missouri with a homogeneous population. I decided that I needed to find an area of interest demonstrating the importance of culture in mainstream psychiatry. At a clinical conference in 1980 at my university I was asked to comment on a presentation by a psychiatry resident. The case for discussion was a 17 year old young woman who had cut herself hundreds of times. At that time the usual formulation was that her cutting represented a type of attenuated suicide. This did not make sense to me because she was intelligent and knew how to kill herself if she wanted too. I reviewed the literature but found nothing very helpful. In just so happened that I was reading an anthropology book about a group of Moroccan Sufi Muslim healers. Their method of healing was to bring together a group of ill patients while a small band of musicians played songs that helped the healers perform a trance dance. The healers then gashed open their heads, dipped bits of bread into their blood, and then gave them to the patients to eat. The healers believed that their blood possessed a healing power. This totally surprised me because in Western culture patients, and not healers, cut themselves. I also then stumbled upon a passage from the Bible in the Gospel of Mark when Jesus came to the land of the Gadarenes. He was presented with a disturbed person who was kept chained in a cemetery where he cut himself, night and day, with small stones. Jesus diagnosed demon possession and then exorcised the demons who immediately left the man but attacked a group of pigs who plunged into a river and drowned. I interpreted this story to mean that the man may have had self-destructive tendencies but, by cutting himself, he avoided suicide. These two stories got me to thinking that perhaps deliberate self-injury served a positive purpose. I then began the long journey of trying to strip away the mysterious aura and to understand deliberate self-harm which culminated in the publication of the 1st edition of “*Bodies Under Siege*” in 1987 and has continued with the publication of a 3rd edition in 2011. I should note that the terminology has changed over the years. Non-Suicidal Self-Injury [NSSI] has replaced the older terms such as SIB (Self-Injurious Behaviour), deliberate self-harm, and self-mutilation (although I still use this term when referring to Major acts of NSSI such as self-castration and eye enucleation).

SDC *Self-Injurious Behaviours are not suicidal attempts: you have well explained in your researches, why SIB itself is considered a morbid form of self-help that provides temporary relief from a host of painful symptoms such as anxiety, depersonalization and desperation, making possible to feel itself real, to establish a sense of personal order, to maintain equilibrium.*

Could you explain why these behaviours are not considered destructive acts? And how this experience of the injurious symptom as a morbid form of self- help, put back the beginning of a treatment?

ARF By definition, NSSI refers to the pathological, direct and deliberate destruction or modification of healthy body tissue without true suicidal intent. This definition excludes drug overdoses and ingesting foreign substances (although this distinction is not made in England and Australia and has resulted in problems in comparing statistics and studies). NSSI differs from culturally sanctioned body modification because it is often impulsive or compulsive and driven by morbid motives that are usually (but not always) associated with a diagnosable mental illness ranging from psychotic conditions to personality disorders to profound mental retardation to anxiety disorders. It is destructive because it harms body tissue but it also is a form of self-help and a pathological approach to emotional dysregulation and distress tolerance that for most persons provides rapid, temporary relief from a variety of disturbing mental symptoms such as mounting anxiety, depression, and depersonalization. My studies of rituals that go back to the earliest days of humankind has revealed that body modification is most commonly associated with attempts to achieve spirituality, to heal physical

illnesses, and to preserve the social order. Thus, destroying and modifying healthy body tissue are integral components of the human condition. From this perspective NSSI can be understood as a means of obtaining short term relief from troubling symptoms as well as an ageless way to attain spiritual benefits, better health, and acceptance into an orderly, adult communal life. Prior to the publication of my book NSSI was understood only as a horrible and senseless act that, according to a famous American psychiatrist, left therapists feeling “helpless, horrified, guilty, furious, betrayed, disgusted, and sad.” After the publication of my book the study of NSSI was deemed “worthy” of academic study and the literature on treatment has changed its focus from countertransference to some optimism. My work has allowed self-injurers to express their thoughts and feelings both to the public and to mental health professionals and this has made a tremendous difference in the way that self-injurers are perceived and treated.

SDC *Thus Self-Injurious Behaviours represent a pathological solution, used by the subject as a coping mechanism. It is very interesting to note how in the last years it was observed an increase of this pathology that often is observed in association with eating disorders.*

Do you think it is possible to say that in this case, the structuring of the harming symptom that is not guided by a destructive intent and don't hush up the body but realize to keep in touch with it, is an embryonic attempt of the subject to affirm his will to live, meanwhile the eating disorder persists the denial of the body, of its sensations, of its physiological needs felt as distressing, hushing up the body and so confirming its self destructive nature?

ARF I have written extensively, although perhaps not totally successfully, on the comorbidity of NSSI and eating disorders, especially bulimia nervosa. I have proposed the existence of a NSSI syndrome as a Disorder of Impulse Control. The syndrome is characterized by repeated acts of NSSI such as skin cutting and burning (often described as addictive) and interspersed periods of other impulsive behaviors such as eating disorders, alcohol/substance abuse, and kleptomania. Usually one symptom may predominate at any given time, but multiple impulsive behaviors may coexist. The syndrome typically starts in early adolescence and may last for 10-15 years without treatment. Person with the syndrome are at high risk for drug overdoses due to demoralization over their inability to control their behaviours. The dynamics of bulimia and NSSI are often similar. Sustained anorexia nervosa is only partially related to NSSI because it is not an impulsive method of self-harm.

SDC *The retirement from the social life is one of the consequences of feeling ashamed of a body pock marked. SIB communities offer a virtual place in which the pathological and “secret” identity can be confessed and at the same time, the anonymity is guaranteed and that social retirement necessary to make the act, is preserved.*

What do you think about the risk of this need of secrecy, and the reticence of seeking a professional help, for a pathology that implies an experience of addiction?

ARF The social morbidity associated with extensive cutting is very high. The presence of virtual communities on the internet does allow for the sharing of experiences and for support but such internet sites need to be monitored closely. Graphic descriptions of NSSI, for example, may serve as triggers for continued NSSI. I recommend certain sites in my book but I am unfamiliar with the situation in Italy.

SDC *You maintain that: “the Bill of Rights for self-injurers is a significant and important first step in bringing this problem into public consciousness and in addressing therapeutic considerations”.*

How is changed in these years, the attention to this pathology? How the importance to approach deviant self-mutilation from differing perspectives, helps clinicians to treat it?

ARF At least in English speaking countries the “Bill of Rights,” my numerous presentations to professional audiences and the pioneering informational presentations of persons such as Karen Conterio have resulted in increased professional and lay understanding of NSSI. Newspaper and magazine articles, a host of books on the topic, popular songs, films, and internet sites have really changed the climate regarding NSSI. It no longer is regarded as a senseless and horrific behavior. It still is unsettling but most people are no longer afraid of it, and self-injurers are now being treated with more compassion.

SDC *Dr Favazza, a last question before of concluding our interview: When self-injurers seek professional help, what type of treatment should they receive?*

ARF I have classified pathological NSSI into 4 descriptive types that are clinically useful and require different treatment approaches. A general statement is that psychotherapy is the most efficacious type of treatment and that, since the biological underpinnings or causes of NSSI (including the role of endogenous opioids) are unclear, studies have failed to demonstrate either specific benefits or consistent efficacy for medications. No medications have an American FDA [Food and Drug Administration] indication for NSSI but they can be helpful in managing self-injurious patients although treatment recommendations are primarily based on clinical experience.

Major NSSI, such as eye enucleation and amputation of body parts, is associated primarily with psychosis [75%], alcohol/drug intoxications, transsexualism, and the rare, newly described body-integrity identity disorder. Prevention is central and full doses of antipsychotic should be used in psychotic patients who are preoccupied with religion, the Bible, and sexuality as well as those who dramatically and suddenly change their appearance by cutting off their hair, engaging in extreme body modification practices, or wearing bizarre clothing. Agitated patients who have committed an act of Major NSSI are at high risk for a second episode; they should be appropriately medicated and hospitalized until their agitation is controlled.

Stereotypic NSSI, such as repetitive head banging, eye gouging, biting lips, tongues, cheeks and fingers, and face and head slapping, are prevalent in persons with severe mental retardation and also occur in disorders such as autism, Tourette's, de Lange, and Lesch-Nyhan syndromes, and hereditary neuropathy. Since many such patients cannot articulate what is bothering them, assessment must include input from caretakers e.g., the behavior may be a reaction to pain. Check for infections such as otitis media. Selecting a useful medication is problematic because some patients respond to some medications some of the time. I start out with an SSRI, then slowly add an atypical antipsychotic, followed by a mood stabilizer, then clonidine, then a beta-blocker. A trial of naltrexone is worth a try. Behavior therapy is the major form of treatment.

Compulsive NSSI, such as repetitive and severe skin scratching, nail biting, trichotillomania, and skin digging (delusional parasitosis), is usually treated first by dermatologists and family physicians. The literature on psychiatric treatment is limited but SSRIs, lithium, benzodiazepines, and atypical antipsychotics (for delusional parasitosis) may be somewhat effective. N-acetylcysteine may help with trichotillomania. Treatment should include psychotherapy.

Impulsive NSSI, such as skin cutting, burning, and carving, and inserting objects into the skin, may be episodic or repetitive; the highest prevalence rates are found in adolescents and emerging adults. Many impulsive self-injurers have a co-morbid mental illness such as generalized anxiety, post-traumatic stress disorder, and depression which should be treated with medications and psychotherapy. Do not automatically diagnose borderline personality disorder. Patients whose Impulsive NSSI is repetitive and out of control may have what I have described as the repetitive NSSI syndrome. This syndrome typically begins in adolescence and may last for 10-15 years during which many impulsive behaviors (such as bulimia, kleptomania, and alcohol/substance abuse) may become manifest. SSRIs may help to control impulsivity and mood stabilizers and atypical antipsychotics may help with emotional dysregulation. Psychotherapy is vital, especially dialectic behavior therapy. Cognitive behavioral and interpersonal therapies are also effective as, to a lesser extent, is psychodynamic therapy. Treatment

may last for years. For some patients the syndrome may end fairly abruptly. Facial cutting is a negative prognostic sign while a willingness to see a plastic surgeon to have scars minimized is a favorable prognostic sign.

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