WHAT SCHOOL COUNSELORS SHOULD KNOW ABOUT SELF INJURY AMONG ADOLESCENTS: A LITERATURE REVIEW

by

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ABSTRACT

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The purpose of this paper is to examine the research about self-injury and compile it in a format that illustrates the importance of professional awareness of this problem. School counselors need to be aware of self-injurious behavior because they are in daily contact with children and adolescents The literature indicates that adolescence is the period in which self-injuring is likely to begin. This paper will discuss aspects of self-injury including the historical perspectives on self-injury, causes and treatment of such behavior, the role of the professional in treating people who self-injure, and the importance of professional understanding of self-injurious behavior. Upon conclusion of

the literature review, recommendations were made as to how school counselors can be prepared to help students who self-injure.

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CHAPTER I: INTRODUCTION

Rationale

The act of taking a knife and slicing through your thigh, watching the skin part and the blood form a clean line, is something that many people can not imagine doing. But there is a growing population of individuals who engage in this behavior. This behavior is known as self-injury. It can include a wide variety of acts. Some examples are cutting, burning, scratching, picking, banging, and bruising. While these behaviors do harm the individual and bring pain, they are not intended to cause death, and therefore self-injury is a distinct category than suicide.

It is only within the recent past that this disorder has been explored by researchers. Books like "A Bright Red Scream: Self-Mutilation and the Language of Pain," by Merilee Strong (1998), and "Bodily Harm: The Breakthrough Healing Program for Self-Injurers," by Karen Conterio and Wendy Lader (1998) have been written to illuminate this troubling, yet not uncommon behavior of self-injury. These books intend to help both the individual who self-injures and the people who are trying to help that individual. Journals in the fields of psychology, mental health, school counseling, and the medical fields have also begun publishing studies addressing self-injurious behavior.

There are numerous sources that identify the differences between self-injurious behavior and suicidal behavior. Walsh and Rosen (1988, cited in Warm, Murray & Fox, 2003) define self-injurious behavior as deliberate and self-inflicted harm that is not socially acceptable, but distinguish it from suicide in that it is not life-threatening. Pattison and Kahan (1983, cited in Jeffrey & Warm, 2002) define self-injurious behavior as being both repetitive and self-inflicted but with a low lethality. Jeffrey and Warm

(2002) define self-injurious behavior as direct, purposeful injury inflected on oneself. These three definitions identify the subtle yet but important distinction between self-injurious behavior and suicidal behavior, which is that the self-injurer does not intend to end his or her life. This distinction is crucial for understanding self-injurious behavior.

Recently, self-injurious behavior has become known to the general public. For example, in 2003, the *New York Times* reviewed the movie "In My Skin," written and directed by Marina de Van, which tells the story of a businesswoman who engages in self-injurious cutting behaviors. Self-injury has now been introduced into our culture through popular media, and the concept of self-injury is becoming more public. Therefore, a sound understanding of this behavior and its treatments is crucial.

Nowhere is this more important than it is for those individuals who might be working in a professional setting trying to help individuals who self-injure. Those individuals might include doctors, nurses, mental health practitioners, school psychologists, and school counselors. Previous studies indicate that there is a lack of understanding about self-injurious behavior in the medical fields, and that this lack of understanding can impede the treatment that those who engage in self-injurious behavior receive from medical personnel. Jeffery and Warm (2002) outlined this lack of medical understanding of self-injurious behavior in their study of how well psychiatrists and medical personal self-injurious behavior. They found that these two groups professionals, doctors and nurses, did not have an adequate understanding of self-injury, and that medical personnel needed further training in order to effectively work with individuals who self-injure.

Because school counselors work with many types of individuals on a daily basis, the chances that they might need to work with someone who engages in self-injurious behavior is higher than that of many professions. Because of this likelihood, the author believes it is important to educate school counselors so that they have an adequate understanding of self-injurious behavior, if, like some medical staff, they need more training to best serve the self-injurious population. This information is crucial because the counseling field is constantly changing, and school counselors need to stay current in their understanding of problems in order to be relevant. Without an understanding of current problems that students may face, school counselors lose their relevance in the school, lose respect from the student, and lose their effectiveness as counselors.

Statement of the Problem

The purpose of this study is to review the significant literature regarding self-injurious behavior and compile a document that shows the importance of making sure that school counselors have an understanding of such behavior.

Purpose of the Study

In this study, the author will review the literature about self-injurious behavior. The author will compile a document that outlines the historical aspects of self-injury, the causes and treatment of self-injury, and the role that professionals play in treating self-injurious behavior. This document will show the importance of training school counselors at the graduate level in working with a self-injurious population.

Definition of Terms

In order to understand this study, the terms that need to be understood are:

Self-Injury – For the purpose of this study, self-injury is defined as the act of deliberately causing harm to one's own body without the intent of dying. Self-injury includes a wide variety of behaviors which include cutting one's own flesh, burning one's own flesh, picking or scratching at one's own flesh, pulling out one's own hair, and reopening healing wounds on one's body.

Methodology

For this study, the author will conduct research to find previously published resources on self-injurious behavior. The author will consult scholarly journals, books, newspapers, popular culture resources, and theses. The author will then compile the research from these sources into an user-friendly document to illustrate aspects relevant to self-injury in order to promote a professional understanding of such behavior on the part of school counselors.

CHAPTER II: LITERATURE REVIEW

This chapter will consider the literature and research relevant to self-harm. It will cover the definition of self-injury, the history of self-injury, give examples of self-injurious behavior and personal stories of people who self-injure, discuss the causes of self-injurious behavior, discuss the population and prevalence of people who self-injure, discuss treatment and the role of the professional in treating people who self-injure, and show the importance of understanding self-injurious behavior.

Definition of Self-Injury

There is no one widely agreed upon definition of self-injury. The S.A.F.E. website (Lader, n.d.) defines self-injury as an action that is done impulsively, deliberately, and repetitively in order to hurt one's own body in a non-lethal manner. Warm, Murray and Fox (2003) use a definition from Walsh and Rosen from 1988, defining self-injury as a non-lethal action that is deliberate in order to harm or disfigure one's own body. Walsh and Rosen also add that self-injury is socially unacceptable. In her book on self-injury, Strong (1998) defers to Favazza's definition. Strong describes three types of self-injury: major self-mutilation, stereotypic self-injury, and moderate/superficial self-mutilation. Furthermore, the terms self-injury, self-mutilation and self-harm are often used interchangeably in the literature.

Major self-mutilation is defined as doing significant, irreversible damage to a major organ, such as cutting off a leg or taking out an eye (Strong, 1998). This type of self-injury is usually done by individuals who are experiencing a stage of psychosis. Stereotypic self-injury is less severe but much more repetitive (Strong, 1998). This type of self-injury usually involves a repetitive behavior such as banging one's head against

the floor. Individuals who engage in this type of self-injury often suffer from a neurological disorder such as Autism or Tourette Syndrome. The third type of self-injury, moderate/superficial self-mutilation, is described by Strong (1998) as being the most common type of self-injury. Moderate/superficial self-mutilation will be the focus of this literature review. There are three sub-types of this type of self-injury. These three sub-types are episodic, repetitive and compulsive. Compulsive self-injury is similar in nature to a psychological disorder like Obsessive-Compulsive Disorder. It is more subconscious than the other two sub-types and is not done as much as a release but more of as a compulsion. Episodic and repetitive self-injury vary in one main way. They both occur in episodes where the self-injury will manifest itself more at specific times. However, the difference is that individuals who are described as participating in repetitive moderate/superficial self-mutilation view the fact that they self-injure as a crucial part of their identity and in fact develop who they are around that self-injury.

History of Self-Injury

There is a long history of self-injurious behavior worldwide. Strong (1998) pointed out that the first published reference about self-injury in the Gospel of Mark in the New Testament of the Bible. Self-injury has also been present in other religions and races. Strong (1998) states that Egyptian mummies have been shown to have tattoos and scarification. She also points to war heroes like the Scot William Wallace, who dyed his skin blue and carved patterns in his skin in order to frighten his enemies in battle. According to Conterio, Lader and Bloom (1998), humans have a long history of using their skin as a method to communicate. This history includes the Hindu, where women wear a red dot on their forehead, the Native Americans, where cuttings and decorating the

face are used in rituals, and some African people who use scarification and tattooing in certain circumstances. Conterio et al. also mentioned how in American society, behaviors such as tattooing, body piercing, and scarification are ways used to communicate through the body. These methods of using the skin as canvas for communication are less harmful methods of self-injurious behavior, but are similar to self-injury in that the body is altered .

Historically, in the context of mental health, deliberate self-harm, particularly cutting, has been viewed as a sort of weak suicidal behavior (Strong & Favazza, 1998). The first case of self-injury in the psychological literature is referenced in the nineteenth century, but most of the cases of that time were extreme acts usually done either for religious purposes or in a state of psychosis (Strong, 1998). Strong also noted that it has only been since the 1940's that self-injurious behaviors like cutting have been recognized by psychologists and psychiatrists as a coping behavior instead of a masochistic or suicidal behavior.

More recently, self-injury has moved into the public eye and popular culture. Strong (1998) pointed also to a 1993 London fashion show where supermodels Naomi Campbell and Christy Turlington walked down the runway showing off their new naval piercings. Strong noted that while this was also a fashion trend, it was the beginning of piercings and body modification as socially acceptable norms. These norms come close to the line of self-injury. Deliberate self-harm in the form of cutting was given a very visible face in 1995 when Princess Diana (of Wales) admitted to her problems with cutting to deal with emotional pain (Conterio et al., 1998). Today's movie stars like Angelina Jolie and Johnny Depp have publicly discussed their history of self-injury.

Strong (1998) pointed to a magazine interview with Depp in which he showed scars on his forearm and stated that he made them to mark important events in his life. In 2003, Holden reviewed a movie for the *New York Times* whose entire plot revolved around a woman who engaged in self-injurious behavior in the form of cutting. Today's tattoo parlors offer not just tattoos, but advertise such services as body piercing and scarification in bright neon window lights.

In ways such as these, self-injurious behavior, particularly in the form of cutting, has become a more accepted practice in American culture. This becomes a problem, because as Strong (1998) (cited in Poppe, 2001) pointed out, young people who engage in self-injurious behavior often learn about it from one of their peers. With self-injurious behavior more in the public eye, it is crucial that professionals are adequately prepared to both prevent such behaviors and to help those who engage in them.

Prevelance of Self-Injury

While there is no definitive data on the prevalence of deliberate self-harm, most people who study deliberate self-harm agree that the incidence has been increasing. Conterio, Lader and Bloom (1998) reported that when they first started their clinic for people who engaged in deliberate self-harm in the 1980's, they could hardly find enough people to fill the clinic. Today, they reported, they have to turn people away and the problem has become more mainstream. According to a study by Tantam and Whittaker (1992, cited in Warm, Murray & Fox 2003) at least 1 out of every 600 people seek treatment at a hospital as the result of deliberate self-harm. Favazza and Conterio (1989) estimated that about 750 per 100,000 people engage in deliberate self-harm every year

(Haines, cited in Jeffery & Warm, 2002). Strong and Favazza (1998), meanwhile, estimated that at least two million Americans engaged in deliberate self-harm every year.

Population Who Self-Injure

There are a wide variety of individuals who engage in self-injurious behavior. The literature has defined the characteristics of a self-injurer in different ways. Strong (1998) used the definition of Graff and Mallin, who described the typical person who engages in self-injury as young, female, and very intelligent. Strong also found that the profile of a self-injurer would be someone who would fall likely prey to alcohol and drug abuse and painful, unsuccessful relationships. Furthermore, they found that the typical self-injurer had a painful or traumatic childhood. In a survey conducted on a website and given to individuals who identified themselves as self-injurers, Warm, Murray and Fox (2002) found that the respondents reported higher than average levels of either physical or sexual abuse, as well as high levels of eating disorders. In addition, Warm et al found that of the respondents, 33% reported engaging in theft, 17% considered themselves alcoholics and 15% were drug abusers. S.A.F.E. Alternatives (Lader, n.d.), a treatment center for individuals who self-injure, also found that the average self-injurer is of upper or upper-middle class and intelligent. In addition, they found that the majority of individuals who engage in self-injurious behavior have low self-esteem, and that 90% were discouraged from showing or sharing emotions while they were growing up, and 50% were victims of either physical or sexual abuse at a young age. S.A.F.E. Alternatives (Lader, n.d.) also found that a higher percentage of females engage in self-injury than males, and that self-injurious behavior tends to start at puberty and lasts an average of 5-10 years, which would mean that most individuals who do self-injure would

do so at some time during their high school careers – an important fact for school counselors to keep in mind.

Examples of Self-Injury

There are a variety of methods that individuals utilize in order to self-injure. S.A.F.E. Alternatives (Lader, n.d.) includes in their list of self-injurious behaviors the following behaviors: punching things (like walls to hurt yourself), hair pulling (also known as trichotillomania), cutting, scratching, picking at scabs, purposefully infecting oneself, bruising bones or skin, and breaking your own bones. They also point out that most self-injurers use more than one method, although the most common form of self-injury in cutting yourself on either your legs or arms.

Causes of Self-Injury

There is no one exact cause of self-injurious behavior pointed to by the literature about self-injury. Rather, most of the literature points to a number of similar causes. According to Allen (1995), there are three main reasons that individuals self-injure. These reasons are to manage moods or overwhelming feelings, as a response to either thoughts or beliefs, or to better manage their relationships. Allen points out that it is important to recognized the difference between self-injurious actions and suicidal actions because the reasons behind the actions are completely different. Strong (1998) found that the main reason people self-injure is that they use their skin as a way to alter their mood. She found that while engaging in self-injury, most individuals experienced a sense of dissociation, or that they felt that their body was separate from their self. Other feelings while self-injuring, according to Strong, included a loss of control over self and numbness. She further recognized the causes in greater detail, stating that individuals

self-injure in order to get rid on anger, to gain a sense of control or self-control, to alleviate tensions, and to end a feeling of emotional numbness. Strong pointed out that there are often other diseases present along with self-injury, including post-traumatic stress disorder (PTSD), depressions, personality disorders, and dissociative disorders. As Allen did, Strong (1998) emphasized the fact that self-injury and suicide do not serve the same purpose. S.A.F.E. Alternatives (Lader, n.d.) noted that the main causes of self-injury include the inability to express strong emotions, an empty feeling, a feeling that you are alone or no one understands you, and a history of feeling scared, either through past relationships or while growing up. Lader also stated that possible causes or co-morbids with self-injury could be Borderline Personality Disorder, Bipolar Disorder, Major Depression, or Anxiety Disorders. Hawton, Rodham, Evans and Weatherall (2002) found that while there is no definite cause of self-injury, there are increased cases of self-injurious behavior under certain circumstances in the case of adolescents. These circumstances were when cigarettes, alcohol, or drugs were in use, when there were identity problems around sexual orientation, when females were aware of friends who were self-injuring, when individuals suffered from low self-esteem, and when depression and anxiety problems were present. These behaviors represent risks or warning signs for adolescents who are at risk for self-injury.

Personal Accounts of Self-Injury

While there are similarities in the causes of self-injury, each story of a person who self-injures is unique and uniquely disturbing. Conterio and Lader (1998) provided a number of examples in their book. They tell the story of Leila, a privileged young woman who was a star at music and a perfectionist. Leila began cutting while in college,

progressing from her arms to her legs to her chest. Leila seemed to have everything going for her, but still engaged in self-injury. Conterio and Lader (1998) also told the story of Ashley, a successful high school student who attended church, volunteered on weekends, held a part time job, had good peer relationships, and spent nights in her bathroom cutting lines into her forearm with a razor blade. Strong (1998) provided a number of personal examples of individuals who engage in self-injury. She told the story of Camryn, an Australian nineteen-year-old who had been raped. Camryn also used sex and heroin to deal with her unresolved anger about the rape before she turned to cutting, and found that cutting was the most rewarding in terms of fulfilling her needs. Strong also gave us the example of Liz, a college freshman who grew up in a physically abusive household and began to self-injure while in junior high school. Liz has used a variety of methods to self-injure, including trying to break her own foot and severely burning her hand. But perhaps the best voice that Strong gave us of a personal account of self-injury is that of Andrew. She opened the book with Andrew, speaking in his own words:

> It's that feeling again. You wake up and see blood stains on your sheets and on your carpet. Books and bits of paper strewn all over your room. Broken furniture. That familiar sting on your arms, on your torso. Your face is smeared red. You were doing so well too – thirteen days since the last time. You feel numb, dazed, hung over, stupid….Just what are you trying to prove? The maid comes in and sees red-stained tissues on the floor, looks at you, not too sure what to make of it. You try to piece together exactly what happened last night….It feels like any minute you're going to explode. Your eyes become watery, you start crying. The crying becomes shouts, yells, screams. You try and hold

> yourself down. Start kicking the door….You dig your nails into the skin on your wrist. Can't feel anything. It's like you're watching a film of someone, this isn't you. You take your shirt off, look in the mirror. Hate, disgust, frustration, anger, regret. Almost like a ritual, without even thinking what you're doing, you pick up a razor blade….blood dripping down. Rub in some antiseptic, do it again, do it again until you're calm, you're satisfied….How do you feel? Alive. Real. Numb. Calm. Satisfied. (Strong, p. 1).

Andrew's story of injuring himself gives voice to the act of self-injury. His story, and other examples like this, allow us to see inside of what a person who self-injures is thinking, which in turn allows us better understanding of the behavior.

Treatment of Self-Injurious Behavior

It is important that the causes of self-injury are explored in order to further understand which treatments may work in helping individuals who engage in self-injurious behavior. Part of the history of self-injury is that it has been misdiagnosed as suicidal behavior, and therefore treated as you would treat a person who is suicidal. Allen (1995) pointed out that historically, individuals who self-injure have been tossed about in the mental health system, passed along from one clinician to another because no one either wants to or knows how to effectively treat self-injury. More recently, therapists have begun to use a variety of treatment methods to help those who self-injure. Allen (1995) noted that some successful therapy techniques to use with a population who self-injure include helping them to learn to express their emotions and fears, give them something else to be successful at and have control over, and use behavioral therapy techniques to alter their behavior. Strong (1998) stated that the most successful

techniques to use were small groups, family therapy, and individual therapy. She also stressed the importance of using alternative outlets for emotions such as art, drama, and dance. She pointed out that while a small percentage of those who self-injure may stop of their own will, most will need professional help during treatment. S.A.F.E. Alternatives (Lader, n.d.) described the most effective treatment method to be a combination of medication to treat co-morbid disorders such as anxiety or depression used along with Cognitive-Behavioral therapy (like journals, logs, and behavioral contracts) and interpersonal therapy (to develop a stronger sense of self and develop strong relationships). Lader also noted that treatment for individuals who self-injure is likely to be long-lasting and aftercare is needed if it is going to be successful. Strong (1998) agreed that if treatment is to be successful, it needs to be long term. Overall, the literature agreed that a multi-modal approach is most successful when working with individuals who engage in self-injury.

Role of the Professional in Treatment

While the literature varies somewhat on what type of therapeutic approach is recommended for use with an individual who engages in self-injury, it is unanimous that it is crucial to have a trained professional involved in the treatment process. According to Allen (1995), a professional who is untrained in helping those who self-injure can end up doing more harm than good. An untrained professional might be tempted to make sophisticated coping habits (which self-injury is at times) stop abruptly, or might open up old unhealed wounds without the ability to help the client work through those hurts. Strong (1998) noted that the role of the professional is crucial because the most important aspect of treatment is that there is a safe and trusting relationship between

the client and the therapist. S.A.F.E. Alternatives (Lader, n.d.) stressed that a licensed psychiatric professional must evaluate the client and diagnose self-injury in order to be sure that it is really the condition that needs to be treated.

Importance of Professional Understanding of Self-Injury

As shown, the role of the professional is crucial in treating individuals who engage in self-injurious behavior. As Hawton, Rodham, Evans and Weatherall (2002) noted, it is important that professional counselors gather as much accurate information as possible about self-injury so as not only to treat self-injury, but also recognize individuals who may be at risk for self-injurious behaviors and prevent those behaviors from occurring. But, as Allen (1995) stated, most basic psychological texts make no mention about the issue of self-injury. This may explain what Warm, Murray and Fox (2002) found when reviewing studies of those who were supposed to be helping individuals who self-injure. They found that professionals, when confronted with a patient who has engaged in self-injury, tend to take one of two viewpoints: they either think that self-injury is a waste of their time to treat, or they believe they are incapable of treating self-injury because of a lack of understanding about the behavior. Perhaps this is why, as Hawton et al. (2002) found that only 12.6% of the population they identified that engage in self-injury reported to a medical facility or hospital for help after self-injuring. Statistics such as these only emphasize the importance of a universal professional understanding of self-injurious behavior.

CHAPTER III: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The literature reviewed for this paper found compelling evidence that self-injury is a problem that counseling professionals must not only be aware of, but be trained specifically in treating.

The history of self-injury is long and complex, but the problem is present and still complex in our world today. Because self-injury is becoming more visible to the general public, it may increase in frequency since having friends who self-injure is a risk factor. Body piercings and scarification are current popular trends, and are behaviors that are close to crossing the line of self-injurious behavior.

Multi-modal forms of therapy are most effective when treating individuals who engage in self-injury, but only when done by a well trained professional. A non-trained professional may actually hurt when trying to treat an individual who self-injures by providing an ineffective type of treatment. Interactions with poorly trained professionals may actually turn individuals who self-injure away from seeking medical and psychological treatment. Because of this fact, medical personnel and counselors need more training at the graduate level in working with the self-injurious population.

Self-injury is not the problem of just one gender, race, age, or class, but rather transcends such boundaries and affects virtually all types of people. It is the job of counselors and other professionals to help all types of people. As the population of self-injurious individuals grows, so grows the need for specialized training in treating self-injury.

Recommendations

After reviewing the literature surrounding the issue of self-injury, it is clearly apparent that self-injury needs to be better addressed in graduate coursework required for those planning to enter the helping professions, such as school counselors. As school counselors, perhaps we should not be specifically trained to treat self-injury, but we should be better made aware of its existence, especially since the majority of those who engage in self-injury begin doing so in their adolescence. Self-injury should be addressed alongside other mental disorders that affect adolescents in school counseling coursework. In addition, it is apparent that medical professionals need professional training in order to both act and feel competent when treating individuals who have engaged in self-injury for wounds which they may go to the hospital. Overall, the issue of self-injury needs to be better addressed in all areas relevant to mental health.

Because most of the literature relevant to self-injurious behavior is relatively recent, further study is crucial in order to develop a firm understanding of this behavior. The author recommends that interventions taken to treat self-injury by a variety of professionals are studied in order to discover an effective comprehensive treatment method. The professionals studied should include medical personnel, school counselors, psychiatrists, psychologists, and social workers. Once more research on this area is conducted, a stronger method for working with the self-injurious population can be discovered. One specific resource school counselors could use is the S.A.F.E. Alternatives website – www.selfinjury.com – which provides information for individuals who self-injure as well as their parents. It would also be helpful for school counselors to attend conferences or in-services specifically related to the topic of self-injurious

behavior in order to be more effective immediately when working with students who self-injure.

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