

Self Mutilation and the Legal and Ethical Implications It Has Upon Schools

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**ABSTRACT**

The purpose of this study was to look at the research surrounding the topic of self-harm. Today, more and more students are engaging in self-harm, typically beginning in early to late adolescence. It affects everyone within a school population, as well as the student engaging in the behavior and his/her family. Educators are faced with a great deal of gray-area regarding how to help a student who may be engaging in this behavior. There are many ethical considerations, as well as different methods of treatment. Also, school counselors can provide a great deal of assistance to students, their families, as well as colleagues within the school building.

This research examined the causes and prevalence of self-harm, possible treatment methods, legal and ethical considerations, and the role a school counselor can play in the treatment of self-harm. Recommendations were also made to provide direction in the field of school counseling.

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## Chapter I: Introduction

Self injurious behavior, also known as self-mutilation, is becoming much more common among adolescents in today's society. There are many different types of self-harming behavior and it is common in both males and females. It is typically seen more within the adolescent population in the United States.

Some people feel that self-mutilation is a pre-cursor to suicide. Others feel that it is due to behavioral disorders, depression, or anxiety. It can also be seen as an attempt to escape life's situations for a moment.

Rates of suicide have risen in young males in many countries since the 1970s, and despite a slight downward trend in recent years, suicide is now the second or third most frequent cause of death among 15- to 24-year-olds in several countries Worldwide, nonfatal, deliberate self-harm is usually most common in young people, especially young females (Evans, 2004, p. 576).

Studies of adolescents who have deliberately harmed themselves and presented to general hospitals have demonstrated that their behavior is often impulsive, in terms of involving little premeditation and usually being precipitated by relationship problems with family or friends, difficulties with schoolwork, or disciplinary crises, but in many cases it also occurs in the context of depressive, anxiety, and behavioral disorders (Evans, 2004, p. 576).

There is no one common reason for self-mutilation. The reasons vary from individual to individual. An article by Best (2006) discussed self-mutilation in an institutional setting. He explained,

In some professional settings, such as secure units for young offenders, psychiatric wards, hospital accident and emergency (A&E) departments and prisons, it may be considered to be predictable and understandable as either a

symptom of a mental health problem or a function of experience within a particular institutional culture” (Best, 2006, p. 162).

But, adolescents who self-injure are not only found in institutions, but anywhere, including our schools. The number of students who choose to do this is rising. In Best’s article, he states “...the indications are that self-harm amongst school pupils takes many forms and is by no means an isolated occurrence” (Best, 2006, p. 165).

A 1995 study estimates “The incidence of self-mutilation in adolescents and young adults (ages 15–35) has been estimated at 1,800 per 100,000 compared to estimates of 14 to 750 per 100,000 in the general population” (Sueymoto, 1995, p. 162). It is becoming an epidemic that counselors must focus on because so many of students are touched by it.

Stereotypes show that many of those students experimenting with self-mutilation are female. In fact, in many studies, authors feel that the most common population who self mutilate is actually female adolescents who are single, from a middle- to upper-class background, and intelligent. (Sueymoto, 1995, p.162)

There are many kinds of self-harm and they are seen in many different environments. In schools, teachers may see acts such as cutting of the skin, scratching, burning of the skin, ingesting chemicals, picking at sores, swallowing items, and much more. Bulimia and anorexia are also considered to be types of self-harm, a trend that is growing at an alarming rate. Self-harm can also include binge drinking, drug use and putting oneself at risk for sexual abuse.

There are many implications that self-mutilation has on school counselors. Counselors need to advocate for their students, aid in maximizing their potential, and helping students succeed. It is also the job of a counselor to help protect their students to the best of their ability. When a student is self-mutilating, it is virtually impossible to know what to do. A counselor has

an obligation to their students to protect confidentiality as much as possible. Students come to counselors to discuss very private matters, and trust their counselors to keep their secrets. However, the line is blurred when a student is harming themselves because the counselor also has to protect the student. The American School Counseling Association (ASCA) National Standards section A.2b states that a counselor

“Keeps information confidential unless disclosure is required to prevent clear and imminent danger to the student or others or when legal requirements demand that confidential information be revealed. Counselors will consult with appropriate professionals when in doubt as to the validity of an exception” (ASCA standard A. 2b).

Here, there is a clear discrepancy about what the counselor should do if they learn that a student is engaging in self-mutilation. On one hand, counselors are urged to keep information private, on the other they need to disclose harm to an individual. If the student is not at risk for suicide, the decision is whether or not to reveal the self-abuse.

### *Purpose of the Study*

The purpose of this study is to examine self-injurious behavior. It is to document the prevalence of adolescents who self injure and to discuss the legal and ethical implications this behavior has on guidance counselors and schools.

### *Research Objectives*

- To discuss self-harm and its dangers among adolescents.
- To research the prevalence of self-harm among males and females.

- To discuss the legal and ethical implications that self-harm may have upon guidance counselors and schools.

### *Definitions*

*Confidentiality.* This is defined by American School Counselor Association as the protection of “information received in the counseling relationship as specified by federal and state laws, written policies and applicable ethical standards. Such information is only to be revealed to others with the informed consent of the student, consistent with the counselor’s ethical obligation” (ASCA Standard A.2.f).

*“Cutting.”* This is best defined as slicing one’s own skin with a sharp object.

*Self-mutilation.* This is best defined as a direct, socially unacceptable behavior that causes physical injury where the individual is not attempting suicide but is in a psychologically disturbed state.

*“NSSI.”* This is defined as Non-Suicidal Self Injury.

### *Limitations*

- In studies based on self-report, researchers may not have been given accurate information from the subjects questioned.

## Chapter II: Literature Review

This chapter includes a discussion on the prevalence of self-mutilation and its demographics, followed by potential causes and treatment plans, and legal and ethical implications that self-mutilation has upon schools. The chapter concludes with the role a counselor plays in cases of self-harm.

### *Prevalence of Self-Mutilation*

Self-injurious behavior is a very important issue in today's society. It is becoming a bigger problem than it ever has been, especially in a school setting. An article by Stone and Sias stated that "the majority of our society sees self-mutilation as a very deviant behavior. Part of this negativity stems from the fact that self-mutilation continues to be poorly understood" (Stone and Sias, 2003, p. 119). Their article also states that "most self-injurers feel very alone and unable to share their pain with others. Many wear long sleeves and pants at all times and are careful to cover their scars while in public. If they reveal the scars or explain the behavior, they risk rejection and social ostracism" (Stone and Sias, 2003, p.119).

There are many reasons why people self injure, and there also many different methods. Burning skin, picking at scabs, head-banging, body-banging, biting one's skin, and cutting skin are all types of self-mutilation. Often, we see self-mutilation in individuals with mental retardation. In a study conducted by Hyman et.al, of the 97 subjects being treated for self-injurious behavior, mental retardation was found in 82.5%. Most of those who engaged in self-mutilation in this study displayed more than one type of self-injurious behavior. They were head-banging, head-hitting, body-hitting, and biting. While self-mutilation is very common in

those with some type of cognitive disability, the behavior is not limited to those with disability (Hyman, Oliver, & Hall, 2002, p. 146).

There are also different categories of self-harm. Favazza breaks self-harm down into three different types, including major, stereotypic, and superficial. Major self-harm includes acts in which a significant amount of tissue damage is sustained. This is typically found in psychotic clients, stemming from some type of delusions. It may include eye-gauging or castration (as cited in Stone and Sias, 2003, p. 114).

Stereotypic self-harm often takes place in a pattern and does not have any psychotic ideation involved. The client may engage in self-harm in the presence of others, and is often associated with neurological and psychiatric disorders, such as Autism or Tourette syndrome. Typical self-harm may include head-banging, biting fingers, hitting themselves, etc (as cited in Stone and Sias, 2003, p. 114).

Superficial self harm can be further categorized, according to Favazza. Some superficial self-harm may be Compulsive Superficial. This often occurs several times per day, and is often ritualistic in nature. Another category is Episodic, in which the person occasionally engages in the behavior. Most often, this is found to be “cutting”, burning skin, or picking at scabs so they do not heal. The third category is known as Repetitive self-harm. This is when the episodic self-harm becomes an overwhelming preoccupation for the client. This also may mean that the client has developed an identity based on their preoccupations. They may be known as a “cutter” (as cited in Stone and Sias, 2003, p. 115).

In a study by Hilt, Cha, and Nolen-Hoeksema (2000), adolescent girls from various backgrounds were surveyed to assess the frequency of self-harm. This included ethnicity,

socioeconomic status, and education level. The population used is significant because self-harm is not often studied in diverse backgrounds. Ninety-four girls, ranging in ages 10-14 participated in this study. The participants did a self-report on their frequency of self harm, internal distress, peer victimization, and quality of peer communication. Researchers found that more than half of the sample had engaged in self-harm in their lifetime. Thirty-six percent of them had engaged in self-harm in the past year. However, 92% of those who did engage in self-harm reported no suicidal intent. The study also found that there were no significant differences among the different ethnicities.

Favazza has developed a profile of someone who engages in self-harm.

“A typical self-injurer is a female, in her mid-20s to early 30s, who has been hurting herself since her teens. She tends to be middle or upper-middle class, intelligent, well educated, and from a background of physical or sexual abuse or from a home with at least one alcoholic parent. She tends to be emotionally inarticulate and emotionally imperceptive, lacking a language for emotional expression. In addition, she may suffer from borderline, histrionic, antisocial, obsessive-compulsive disorder, or multiple personality disorder (as cited in Stone and Sias, 2003, p.116).

However, Sias and Stone articulate that while this may typically be the case, the type of self-harm is at a much lower, superficial grade than males, who engage in more major acts of self-harm. Roberts-Dobie and Donatelle state that, “Females are the focus of almost all self-injury research, although one report estimates that males may account for as many as 40% of self-injurers. It may be, however, that their injuries (cuts and bruises) are overlooked as a product of

adolescent "macho outbursts" such as fighting or sports injuries" (Roberts-Dobie and Donatelle, 2007, p. 258). They also believe that onset typically is the freshman year of high school, subsiding around age 18.

Commonly in schools, we hear about "cutting" Many people who self-mutilate engage in this form of abuse, often using razors, scissors, safety pins, or other objects. Often, we associate this behavior with adolescent females. Brumberg cites an earlier study suggesting the higher prevalence of female "cutters".

"A 1995 report in the Journal of the American Academy of Child and Adolescent Psychiatry indicates that cutting exists primarily among "popular" high-school girls who perform well academically. Many observers suggest that cutting and eating disorders often exist in tandem, casting both as diseases of the rich and pampered" (Brumberg, 2006, p.6).

This behavior is also growing more popular at the university level. In a recent study by Whitlock, 3,096 students at Princeton University and Cornell were surveyed about self-mutilation. The data showed that 17% of students who responded had engaged in self-mutilation. Of those students, 75% had done so numerous times. Whitlock also found that both men and women engage in self-mutilation, however, women outnumbered men (Whitlock, 2006, p. 1939). When we think about self-mutilation, we often think of women. However, an article by Jeni L. Hohlfelder summarizes some reasons why more women are diagnosed with self-mutilation than men. She suggests that men are less likely to seek help, which would lead to a smaller diagnosis of the population, even though some males are engaging in self-mutilation. She also suggested that typically, women tend to internalize their emotions, which sometimes

leads to dangerous behavior, such as cutting, etc. She referenced an article by Conterio and Lader, stating “males tend to avoid emotional expression and instead turn their emotions outward through violence and aggression” (as cited in Hohlfelder, 2004, p.8).

Data from Whitlock’s 2006 study also showed that there was no correlation between self-mutilation and social class as some would expect. The study shows that while more women engage in this type of behavior, self-mutilation is not only for the low-income female as stereotypes often suggest (Whitlock, 2006, p.1941).

### *Causes of Self-Mutilation*

Self harm, especially cutting, is becoming a growing problem, but one that is no longer seen as “taboo”. Brumberg (2006) gives the example of a student who talks to her as if her cutting is not a big deal. While healthcare professionals consider it to be a very serious matter, teenagers and college students often see it as a coping mechanism.

Sias and Stone (2003) found that there may be a predisposition to self-harm for many individuals.

Predisposing factors for self-harming behavior include physical or sexual abuse in childhood, caregiver neglect and early history of surgical procedures or illness, parental alcoholism or depression, residence in a total-care institution, proneness to accidents, perfectionist tendencies, an inability to tolerate and express feelings, and dissatisfaction with body shape or sexual organs, and distorted body image (Sias & Stone, 2003, p. 115).

Self-mutilation is often an impulsive behavior that helps one deal with the difficulties of life.

‘Cutting is not as pathological as it once was,’ explained Bonnie Lambourn-Kavcic, a clinical psychologist at a counseling center. Part of its new "normality" is the growing understanding among clinicians that repetitive self-injury is not usually suicidal and that it can be a short-term response to unhappiness, stress, and depersonalization” (Brumburg, 2006, p.8).

Self-Mutilation happens for many different reasons, depending on the individual who is engaging in it. It can be a psychological relief from all of the frustration, anxiety, and anger in the person’s life

Himber (1994) found specific reasons for self-mutilation including induction of a pleasurable state, tension release, discharge of anger, communication, expiation, self-purification, self-punishment and enhancement of self-esteem. Other reasons include affect regulation, self-medication, coping mechanism, sexual gratification, religious and societal beliefs, and symbolism (As cited in Hohlfelder, 2004, p. 20).

Many of the above causes involve gratification and reflect feelings of anxiety and frustration. While these are not specific to every individual who self-mutilates, they are all equally alarming. There are better solutions for all of these causes, but people often don’t know where to turn or how to access them. School counselors could be great resources for these individuals and could provide a wealth of knowledge concerning coping skills and the need for support.

Self-mutilation is often considered by some to be an indicator of suicidal ideation. But, some experts feel that it is anti-suicide. They feel that self-mutilators engage in their destructive behavior to avoid committing suicide, and to feel some relief from the pain they are experiencing in their lives. While this may be a comforting idea to some, one needs to be careful not to assume that someone engaging in self-mutilation would never commit suicide. Hohlfelder's article demonstrates how different expert opinions can be.

Crowe and Bunclark (2000) agreed that the goal in self-mutilation is usually to reduce tension rather than to end life. While a strong case has been made on differentiating self-mutilation and suicide, one should not be mistaken in thinking that self-mutilation is an anti-suicide indicator (As cited in Hohlfelder, 2004, p 16).

Also, some who engage in self-harm have had suicidal thoughts, and have possibly attempted suicide in the past. In the event of self-harm in a school setting, a counselor could be utilized in finding out whether the student has thoughts of suicide.

As previously discussed, a majority of the time, self-harm is not an indicator of suicide. Non- Suicidal Self Injury (NSSI) is defined as "direct, deliberate destruction of one's own body tissue without suicidal intent" (Hilt, Cha,& Nolen-Hoeksema, 2008, p.63). The level of distress often raises in the time of adolescence, especially for teenage girls. An article by Hankin, et. al. explains that typically, rates of depression and psychological distress rise in girls, but not boys. This may explain why a majority of those who self-harm are female (Hankin, et.al. 1998, p.136-137).

In 2004, Nock and Prinstein proposed a model of NSSI. They believe that NSSI has both automatic functions, such as emotion regulation, and social functions such as interpersonal functions. Their model explains that “NSSI can be maintained by either positive reinforcement (i.e., followed by the presentation of a favorable stimulus) or negative reinforcement (i.e., followed by the removal of an aversive stimulus) (As cited in Hilt, 2008, p.63). The two factors then branch out into four functions of Non-suicidal Self-Injury:

The emotion-regulation functions involve automatic negative reinforcement, in which individuals engage in NSSI to avoid negative affective states (e.g., “To stop bad feelings”), and automatic positive reinforcement, in which individuals engage in self-harm to attain a desired physiological state (e.g., “To feel something, even if it was pain”). The interpersonal functions comprise social negative reinforcement, in which individuals engage in NSSI to avoid interpersonal task demands (e.g., “To avoid punishment from others”), and social positive reinforcement, in which individuals engage in NSSI to gain attention or access to other people (e.g., “To get attention”) (Hilt, 2008, p. 63).

A 2006 article by Chapman, et.al, suggests that many engage in self-harm “in order to avoid unwanted emotional states” (Chapman, Gratz, & Brown, 2006, p. 374). This then leads to self-harm in order to regulate distress and creates automatic negative reinforcement by stopping the bad feelings. Hilt’s article also suggests that self-harm creates positive reinforcement for those who engage in the behavior. “In addition, research related to the automatic positive reinforcement aspect of NSSI has shown that those engaging in NSSI may experience a lack of emotional feeling preceding NSSI and have a higher threshold for physical feeling or pain” (Hilt, 2008, p.64). And, “These findings suggest that individuals who are distressed by a lack of

feeling may engage in NSSI for automatic positive reinforcement (e.g., to feel something, even if it is pain)” (Hilt, 2008, p.64).

Peer interpersonal relationships also affect adolescent girls more than boys. “Starting in middle childhood, girls report greater interpersonal sensitivity and concern about peer evaluation compared with boys” (Hilt, 2008, p.64). Victimization that often occurs in middle school negatively affects girls’ self-esteem and feelings of self-worth. Many times they are victimized on the issues of weight, clothing, peer group, looks, economic status, etc. All of these things influence personal distress in adolescent girls.

In a 2008 article by Nock and Berry-Mendes, it is suggested that another cause of self-harm is poor problem-solving skills. Prior research shows that deficits in social-problem solving skills are related to suicidal ideation in adults, adolescents, and children (Nock & Berry-Mendes, 2008, p. 29). For example, “suicidal individuals generate fewer and less effective solutions to social problems than those who are non-suicidal and that these differences are not explained by IQ or the presence of other psychological disorders, such as depression” (Nock & Berry-Mendes, 2008, p. 30).

“...regardless of the solutions generated, it may be that self-injurers select less effective responses from among those generated. In other words, they may, in fact, be able to generate numerous and effective solutions but then select less adaptive responses for behavioral enactment. The decision about which solution is selected and performed may be influenced by self-injurers' beliefs about their self-efficacy for effectively performing an adaptive solution” (Nock & Berry-Mendes 2008, p. 30).

In the research study conducted by Nock and Berry-Mendes, the participants were provided with cards that had scenarios. They then had to develop solutions to the problems presented. Those who self-harm presented the same number of solutions to the problems and self-critical attributions as those who did not self-injure. However, research indicated that those who self-harm chose an increased amount of negative solutions and also rated their self-efficacy as lower. The overall results of the study indicate that those who self-injure possess a lack of problem-solving ability. Those who self-harm tend to be impulsive people, often looking for instant gratification. The overall findings in this particular article indicate that when “given time to think about a problem, self-injurers can produce effective solutions at the same level as non-injurers. However, self-injurers selected more maladaptive responses from those generated and reported lower self-efficacy for performing adaptive solutions...” (Nock & Berry-Mendes, 2008, p. 30). This indicates a deficit in coping skills and heightened impulsivity than those who do not self-injure. In this case, a counselor could be utilized to aid in teaching appropriate coping skills in attempts to reduce the frequency of self-harm in their students.

Research shows that many times, self-mutilation can be prevented or even influenced by the role of the parents, teachers, and friends in the mutilator’s life. A 2003 article by Yip, Ngam, & Lam suggests that self-mutilation can happen as a result of conflicts, frustrations, and the feelings of emptiness in one’s life. The article also suggests that, rejecting parents may be a source of frustration that leads to mutilation. Parents can play a big role in either preventing or provoking the child’s self-mutilation. This suggests that self-mutilation may be prevented in the lives of some children. If parents are a source of support for the child, the child may be less likely to self-mutilate. The presence of a family structure provides a great deal of support, and an environment that provides the tools a child needs to be successful. Supportive families often

teach coping skills and communicate in a way that allows members to discuss anger in a productive way. The presence of a family structure can greatly reduce the chances that a child will self-mutilate (Yip, Ngam, and Lam, 2003, p. 406).

One more underlying cause of self-harm may be a psychopathology. Research suggests that many of the commonly known personality disorders harbor a self-harm component. Self-harm happens to be one of the diagnostic criteria of Borderline Personality Disorder. According to a 2007 article by Shevlin, et al., Borderline Personality Disorder is the most commonly diagnosed personality disorder. It generally occurs in 15-25% of all personality disorders (Shevlin, Dorahy, Adamson, and Murphy, 2006, 273). Borderline Personality is commonly characterized as “a severe disturbance in the characterological condition and behavioural tendencies of the individual” (World Health Organization, 1992). The DSM IV indicates that Borderline Personality Disorder is a pattern of instability in interpersonal relationships, self-image, and affect and marked impulsivity. The affected person would need to display five of nine characteristics, two of which could be identified as self harm. These are a person acting “Impulsively in two or more areas that are self damaging. These may include abuse, sex, spending, eating, driving reckless, or etc.” It also indicates that the person engages in “Recurrent gestures, self mutilation, suicidal behavior, or threats” (Shevlin, Dorahy, Adamson, and Murphy, 2006, p. 275).

#### *How is self-harm treated?*

An article by Wester and Trepal states that it is difficult to work with students who self-harm. One reason is that self-harm may get worse before it gets better for the student. The underlying issues are painful and difficult for the student to deal with and harming themselves is their attempt at coping. Addressing these issues may actually cause the student to harm

him/herself. Self-harm can also provide a feeling of control in a time when the student has none. However, if they are being forced to give up their coping mechanism or work on issues they don't want to, they may feel the need to harm themselves (Wester and Trepal, 2005, p.82).

Self-harming behavior is very serious, even addictive for some. For others, their actions may be part of a greater illness. A 2005 article by Skegg, states "Studies of self-harmers who present to hospitals that used standard diagnostic criteria have shown that more than 90% of these people had at least one psychiatric disorder, most commonly depression, followed by substance abuse and anxiety disorders" (Skegg, 2005, p. 1475). Skegg also points out that comorbidity is common. This means that there is more than one psychiatric disorder occurring at the same time. One of the most common is Borderline Personality Disorder. Other common disorders associated with self-harm are Post-Traumatic Stress Disorder, eating disorders, and schizophrenia. Some would suggest that treating the bigger psychiatric disorder would "fix" the need to self-harm. In many cases it would. In treating eating disorders or Post-Traumatic Stress Disorder, the need to self-harm may be significantly reduced. In other cases, prescribing antidepressants or anti-anxiety medications may help the client feel better in a way that would stop them from hurting themselves. But, it is not always that simple. Not every student who comes into the counseling office has PTSD, schizophrenia, or an eating disorder. In fact, those who are adolescents normally don't. They, too, need to be treated in an effective way.

Skegg states that "self-harm is a behavior, not an illness" (Skegg, 2005, p.1478). Management of self-harm "is highly dependent on the underlying problems, which could range from psychosis with intense continuing suicidal urges requiring psychiatric admission, to an impulsive over-reaction to a stressful event that rapidly resolves with family support" (Skegg, 2005, p. 1479). Skegg suggests a number of responses to self-harm:

- Monitor patient for further suicidal or self-harm thoughts
- Identify support available in a crisis
- Come to a shared understanding of the meaning of the behaviour and the patient's needs
- Treat psychiatric illness vigorously
- Attend to substance abuse
- Help patient to identify and work towards solving problems
- Enlist support of family and friends where possible
- Encourage adaptive expression of emotion
- Avoid prescribing quantities of medication that could be lethal in overdose
- Assertive follow-up in an empathic relationship
- Affirm the values of hope and of caring for oneself (Skeeg, 2005, p. 1479).

Many of the suggested techniques are things that a school counselor is able to do. They should be able to talk to their client and monitor their suicidal ideations. Counselors can also meet with the client on a weekly basis to work together and figure out what the underlying problems are that make them feel like they need to self-harm. School counselors can also provide follow up and an empathetic relationship. The student may need support and guidance to stop harming themselves. They may also need to feel that they are special and important individuals. Counselors can work with clients to find their positive attributes and strengths. More importantly, counselors can work with their students to teach appropriate coping skills.

Counselors can also provide students and their families with resources who offer treatment, such as individual counseling, family counseling, health-care providers, and support groups.

Stone and Sias (2003) propose using a bi-modal approach to treatment of self-harm behaviors. Cognitive behavioral strategies are utilized in an effort to change faulty thinking and also to stress that self-harm is not an appropriate way to cope with problems. They also propose using behavior modification to block self-harm behavior and establish more appropriate means of relief for the client (Stone and Sias, 2003, p. 120). Their treatment involves the individual and also the family system of the client. It includes "helping the client clarify underlying issues, recognize SIB patterns, acquire alternative coping skills, track behaviors, restore daily functioning, and enhance interpersonal skills" (Stone and Sias, 2003, p. 120). It is suggested that the client keep a journal to figure out what is important to them. They can also keep track of their self-harm pattern, and try to understand the underlying reasons for harming themselves. It is also important not to isolate the client engaging in self-harm as this may be when they are more inclined to hurt themselves. The process may take time, with the client slowly letting go of their destructive behaviors and learning new more appropriate responses to problems and also learning new communication skills. The family is also used to positively reinforce appropriate responses and help the client develop new coping techniques.

Wester and Trepal suggest finding alternatives to self-harm. Alternatives to self-harm are "safer methods that a client might use to receive a similar type of feeling or sensation without causing tissue damage" (Wester and Trepal, 2007, p. 183). They also feel that "Alternative behaviors should be matched to clients' reactions and emotions, what they need at a specific point in time to cope, or to the emotions or feelings they typically have prior to self-injuring" (Wester and Trepal, 2007, p.183) The suggested course of treatment is to assess the client in

every aspect of their self-harm, including what type it is, frequency, duration, intensity, and medical history. Then, it is recommended to assess the reasons for the self-harm. Once that has been done, it is important to identify the client's point at which self-harm has fulfilled its purpose, provide appropriate alternatives, and identifying continuing treatment (Wester and Trepal, 2007, p.183).

Once the client can provide reasons for their self-harm and the point in which they no longer need it, they can be provided with appropriate alternatives. This study provides alternatives to a number of different reasons for self-harm. An example would be if a student harms his/herself due to a feeling of overwhelming anger and/or aggression. They might engage in "cutting", head-banging, or slashing skin. The client could then engage in alternatives to release aggression. The therapist/counselor would encourage the students to hit a pillow, rip paper, throw eggs, etc. to release their aggression.

### *Legal and Ethical Implications*

There are legal and ethical issues that are associated with self-mutilation. Confidentiality, right to privacy, and mandated reporting are all concerns. The Preamble of the American School Counselor Association's Ethical Standards for School Counselors states, "Each person has the right to privacy and thereby the right to expect the counselor-counselee relationship to comply with all laws, policies, and ethical standards pertaining to confidentiality" (ASCA Ethical Guidelines, 1998). ASCA ethical guidelines also say that students have a "certain expectation of privacy in their communications with their school counselors" (Reinardy, 2002, p. 9).

School Counselors also have to follow the code of ethics, which says that counselors must maintain confidentiality; meaning that they will not tell others what they talk about in a particular meeting with a student, unless that student says that it is okay. However, this can be confusing to students, counselors, and school districts because counselors are also mandated reporters. In this case, if a counselor is alerted to the fact that the student is causing harm to themselves or others, the counselor must report the situation. This idea can be confusing to professionals because they never want to do the wrong thing for their students. A 2005 article by Werth and Rogers, highlights the court case of Tarasoff Vs. the California Board of Regents and other related cases which result in an uncertainty in what types of information can be released about a particular client. The authors feel that these cases “result in inconsistent applications across mental health professionals as well as across the various situations that could lead to death” (Werth and Rodgers, 2005, p. 9). What is a counselor to do? Werth and Rogers indicate that counselors have a duty to protect. In ethical obligations, “the duty to protect does not apply only when there is concern that the client will die by suicide but also in other instances involving potential harm-to-self, including other actions the client may take that could lead to death” (Werth and Rogers, 2005, p. 9). Yet, this is still vague because it doesn’t indicate proper procedure. The authors believe that in a clinical sense,

The guiding factor associated with the duty to protect when a client is at risk of self-harm would seem to be that an individual is engaging in a behavior (including the refusal to take protective action) that has a high probability of leading to significant harm to her- or himself (i.e. serious physical and/or mental impairment) or to death in a reasonably short period of time (e.g. 2 – 3 weeks) (Werth and Rogers, 2005, p. 10).

However, they also make that point that in this definition, the reason for the behavior is not addressed.

A client may engage in a potentially life-threatening behavior to escape or avoid psychological pain or social humiliation, while another may engage in the same behavior as a means to escape physical pain or to exert control over death. Similarly, one person may engage in a potentially life-threatening behavior such as cutting with the intent to die, while a different individual may engage in the same behavior intending to communicate distress, but with no intent to die. In theory, all four of these people would appear to engender the duty to protect (Werth & Rogers, 2005, p. 10).

The authors of this article advocate for a specific system that should be in place across the board for health-care professionals that would eliminate confusion about whether to act. They state “the way to make the duty to protect consistent is to have it be triggered if the potential outcome of the behavior (remember that refusing to do something, such as eating, is still a behavior) is that the person is placing himself or herself at risk of serious injury or death within a reasonably short period of time (e.g. 2 – 3 weeks)” (Werth & Rogers, 2005, p. 15). They believe that the system would then include “cutting” because the person is making an obvious attempt at self-harm. Once the counselor knows this is happening, then they are obligated to take action to help the client in an appropriate way. The authors also state that the counselor does not need to break confidentiality, but they do need to do something in order to keep the client from self-harming again. Werth and Rogers suggest contracting with the client, which means making a written agreement that the client will not self-harm. They also suggest increasing the amount of sessions or the length of sessions for the client, and social advocacy (Werth and Rogers, 2005, p.16).

In the case of Self-Mutilation, informed consent should be discussed. Informed consent means that “in order for a student to consent to school counseling services, s/he must be informed of the purpose and expected outcomes of those services” (Werth and Rogers, 2006, 16). In addition, the counselor must tell the student that there are certain types of information, if disclosed to a school counselor, that s/he is required by law (and by professional ethics) to report” (Reinardy, 2002, p.13). To make sure that there is a clear understanding between the counselor and the student, they must explain this in a way that a child of the particular age can understand. If a counselor is unsure of the need to report self-mutilation, ASCA standard A.2(b) states “counselors should keep information confidential unless disclosure is required to prevent clear and imminent danger to the counselee or others or when legal requirements demand that confidential information be revealed. Counselors will consult with other professionals when in doubt as to the validity of an exception.” (ASCA Ethical Guidelines, 1998).

Self-mutilation has many different meanings and often it has nothing to do with suicide. If the child is not at risk for suicide, what should a counselor or the district do? In this case, it would be important to notify the parents so that there is some idea of what is going on.

Also, if the student is a minor (under the age of 18) in the State of Wisconsin, “counselors have an ethical obligation of privacy to minor clients, and a legal obligation to the parents or legal guardians of those same minor clients to keep their children safe” (Reinardy, 2002, p. 9). The law states that minors “do not have the ability to make informed, voluntary decisions about the counseling services and the rights and limitations of confidentiality. Because the privacy rights of minor children legally belong to or are vested in their parents or guardians, it is the parents or guardians who have the right to obtain information about and to give consent

to the counseling services, and to consent to the release of information to third parties” (Reinardy, 2002, p.9). Yet, the child still has the right to privacy in the relationship.

The ASCA standard A.7. states that the counselor is to “inform the appropriate authorities when the counselee’s condition indicates a clear and imminent danger to the counselee or others. This is done after careful deliberation and, where possible, after consultation with other counseling professionals. The counselor informs the counselee of actions to be taken so as to minimize his or her confusion and to clarify counselee and counselor expectations” (ASCA ethical guidelines, 1998. A.7). The ASCA standard guidelines do not provide a clear outline of exactly what a counselor should do in the case of self-harm. The counselor needs to make assessments as to the severity, intensity, duration, suicidality, etc. They need to take all of these things into consideration and make the decision that is the best for the student.

### *The Implications of Self-Harm on School Counselors*

When a student engages in self-harm, the school counselor is generally the staff-member who deals with the behavior. Questions arise as to the role of the counselor. Do counselors need to report the known behavior? Do counselors take on the responsibility of treating the student or should they refer to outside sources? Counselors can recognize the signs of self-harm, provide early identification and intervention. A 2004 article by White Kress, Gibson, and Reynolds reports that counselors play an important role in keeping students safe. Counselors also need to make sure that students have the resources they need to develop academically and personally (White Kress, Gibson, & Reynolds, 2004, p. 195). The article by White Kress, Gibson, and Reynolds quotes a secondary article by Remley, Hermann, and Huey state that “the extension of

privacy rights belongs to the parent (even in the cases when the child requests confidentiality), and judicial decisions have historically protected parental rights. The article continues to say that counselors should consider reporting self-injurious behavior even if they don't feel the student is in imminent danger.

The authors reference previous work by Favazza, who states that by definition, the "intent of the person who is engaging in self-injurious behavior is not of a suicidal nature." Many of the experts suggest completing a thorough suicide assessment to determine whether it is imperative to report the self-harm (As cited in White Kress, Gibson, and Reynolds, 2004, p.195).

In regards to confidentiality, the ASCA standards state that the "professional school counselor informs appropriate officials in accordance with school policy of conditions that may be potentially damaging to the school's mission, personnel and property while honoring the confidentiality between student and counselor". However, in order to do this, a counselor is able to consult with another counselor, not breaking confidentiality. They may also present hypothetical situations to their school principal, as long as they do not identify the student. If the counselor chooses to consult with parents in the matter, they must make sure to contact both parents. It would not be ethical for a counselor to talk to only one parent in the situation.

Can a counselor treat the student engaging in self-injurious behavior? ASCA standards require counselors to practice within their professional competence and that they accept the consequences of their actions. In this case, the counselor should assess their knowledge and skills and make the decision as to whether they can provide adequate treatment for the student. If the counselor does not feel that they are capable of treating the student, they need to refer the student to someone who can better serve their needs. The article by White Kress, Gibson, and

Reynolds makes a recommendation for counselors to be aware of community mental health professionals to use for student referrals. The article also suggests that the counselor keep in regular contact with the student's mental health provider and work collaboratively with the treatment goals they set. This may be in regards to developing a safety plan or list of self-harm alternatives and working with their student to achieve this. (White Kress, Gibson, & Reynolds, 2004, p.196)

White Kress, Gibson, and Reynolds also suggest that a counselor can create a no-harm contract with their student in order to keep them safe. The article states "the development of a no-harm contract that clearly specifies what behaviors will require the school counselor/faculty/staff to take what actions may be helpful in clarifying to the student, parents, and school personnel the boundaries associated with the self-injurious behavior" (White Kress, Gibson, & Reynolds, 2004, p.198). It also explains that in a no-harm contract, "a school counselor might specify that a student cannot bring sharp objects/cutting implement to school and if he or she does, certain actions will be taken by the school faculty/staff" (White Kress, Gibson, & Reynolds, 2004, p.198). The contracts may also be used to limit self-injurious behavior on school grounds, sharing of objects, or behaviors students can engage in when experiencing the need to harm themselves.

School Counselors have to adhere to certain ethical guidelines, such as protecting confidentiality, alerting school officials and parents when necessary and protecting their students to the best of their ability. They also need to evaluate if the situation is within the realm of their professional competencies. If they feel that they are able to adequately help the student, they may need to utilize appropriate strategies. White Kress, Gibson, and Reynolds (2004) suggest that an appropriate way for counselors to elicit information about student's self harm would be

ask questions in a non-threatening way. Examples of this could be “Could you say more about this?”, “What were you thinking or feeling prior to the activity?”, and “How did you feel after the activity?” (White Kress, Gibson, & Reynolds, 2004, p. 196).

The White Kress, Gibson, and Reynolds article also explains that a counselor can make the client feel that they are safe by providing an environment of structure and consistency. It is suggested that the counselor and the student develop a safety plan together. This includes identifying triggers, physical cues and reducers related to self-injury. This could also include identifying safe people and safe places to go when the student feels the urge to engage in self-harm behaviors (White Kress, Gibson, & Reynolds, 2004, p. 196).

White Kress, Gibson, and Reynolds’ research shows that two factors contribute to the cessation of self-harm. The first factor is “developing an ability to identify and express feelings verbally.” The second factor is learning to use alternatives to self-harm. Counselors should assess a number of things. To effectively treat a student, counselors should assess student’s depression, suicidal ideation, social support, family history of suicide, and recent stressors (White Kress, Gibson, & Reynolds, 2004, p. 198).

White Kress, Gibson, and Reynolds suggest that the counselor can also provide aftercare for the student. The counselor can help arrange home-tutoring for the student. They can also suggest modifications to the student’s schedule through the use of a 504 plan (White Kress, Gibson, & Reynolds, 2004, p. 198).

In a 2007 study by Roberts-Dobie and Donatelle, the authors note that therapists have seen a “significant increase in the number of clients seeking help for their self-injury. Explanations for the increase include the collapse of the extended family, the body-focused

culture, body alienation, emotional deprivation, abuse, and biology” (Roberts-Dobie & Donatelle, 2007, p. 258). They also report that none of these issues explain why there has been a rise in self-harm behavior. It has become a part of mainstream culture, with websites dedicated to the behavior of celebrities who have talked about their past self-harm behavior. Roberts-Dobie and Donatelle note that schools are in the position to help students who self-harm. They, similar to previous authors, believe that one of the most important duties of a counselor is to be a source of referral for the students. “Whether identifying symptoms, making referrals to an outside mental health therapist, briefing school staff on health information, or helping a self-injurer plan for academic success, counselors can and do play an important and unique role in the delivery of services to students who self-injure” (Roberts-Dobie & Donatelle, 2007, p. 259).

Roberts-Dobie and Donatelle sent out questionnaires to school counselors from across the country to examine the experience, knowledge and needs of a school counselor when working with students who engage in self-harm. They were asked about their confidence in helping students who engage in self-harm, their experience in the area, demographics they have noticed, and how they became aware of most students who self-harm. Five hundred and eighteen surveys were returned. Eighty-one percent of counselors surveyed said that they had worked with a student who self-injured. Many of those who participated said that most often, their referral sources were students and/or teachers. Ninety-one percent of those surveyed said that they were providing individual counseling for students who self-harm, in the area of assisting students in coping with a problem. However, the counselors also felt that referring to a psychiatrist was the proper way to handle the situation (Roberts-Dobie & Donatelle, 2007, p. 259).

One of the questions asked counselors to rate their level of efficacy when working with students who are self-harming. Counselors participating in the study rated their abilities highest

in the area of referring to outside sources and lowest in the area of providing group counseling to those students. On average, the counselors felt moderately competent in the areas of identifying students who are engaging in self-harm, counseling the friends of students who self harm, and providing information on self-harm to parents and school staff ( Roberts-Dobie and Donatelle, 2007,p. 261).

This research found that schools could be a place of support for students who self-harm. Counselors can be responsible for individual counseling and referring to outside sources. However, many counselors who responded to the survey reported that there were no policies or procedures that they should follow when working with a student who is engaging in self-harm. Many counselors either said there was no policy or that they didn't know what it was.

Roberts-Dobie and Donatelle suggest a number of things that school counselors can do if they do not feel confident in their abilities. School counselors can increase their knowledge base by attending conferences that have featured speakers and experts in the field. They can also attend in-service trainings in the areas of self-harm and suicide. Counselors can also use a particular program, such as SOAR. This program “incorporates activities to help counselors examine personal attitudes toward suicide, strengthens empathy and active listening skills, and develops crisis intervention skills through training to identify students at risk, counsel those students, document contacts, and appropriately refer students to outside mental health counseling” (Roberts-Dobie & Donatelle, 2007, p. 262). School counselors can also use their knowledge on the topic of self-harm to train members of the staff. Staff should be aware of the warning signs, causes and what to look for in students. They should also be aware that they should report their findings to counselors to ensure that the student will be contacted (Roberts-Dobie and Donnatelle, 2007, p. 263).

Counselors should also address the issue of self-harm among students. This could include presentations to health classes, school-wide assemblies, or even training a small group as gatekeepers.

It is also extremely important to develop school-family relationships. Roberts-Dobie and Donatelle stated that schools should inform families about educational activities that the school participates in regarding self-harm. They also state that it is important for schools to provide information to parents including possible causes, symptoms, contacts for treatment, as well as information on the counselor's role in the process. Informing parents and families is important because they are then provided with the tools to help their own children. They are able to notice self-harming behaviors in their own children. Providing information to parents also helps them know the appropriate steps to take if they do discover that their children are engaging in self-harming behaviors. It is also important for parents to know that the school is available for support (Roberts-Dobie and Donatelle, 2007, p. 264).

Counselors are able to provide a link for the student engaging in self-harm behaviors. They can aid the therapist in carrying out a safety plan or treatment plan. They can contact the teachers and help establish a 504 plan to better accommodate the student. They can also keep in touch with the parent to address how the student is doing in school and find out if there is anything else needed. They can also be a resource for the student in between therapy sessions. If they need to talk, or need a few minutes out of class, the counselor can help. The counselor can also facilitate a safer school by educating staff and encouraging them to report students who are harming themselves.

### Chapter III: Discussion, Conclusions, and Recommendations

This chapter includes a discussion of the literature reviewed. It also discusses conclusions drawn from the research. Also, recommendations are made concerning what can be done to battle the growing problem of self-mutilation.

#### *Discussion*

Research indicates that the frequency of self-harm is growing in the United States as well as the world. It also indicates that there are many different types of self-harm, ranging from skin picking to cutting to head-banging and so on. All research indicates that both males and females self-mutilate, but in many cases females are more likely to seek help. This simply indicates that females are more likely to report the behavior. Self-harm typically begins in adolescence, and may continue into early adulthood if not treated.

#### *Conclusions*

Self-harm is often utilized to cope with life, release anger, and feel a relief from pain. However, it often occurs in conjunction with another mental illness, including depression, Bipolar Disorder, Borderline Personality Disorder, and others. Students should be educated on coping methods in efforts to prevent self-harm. They should also be educated on warning signs so they will be more able to recognize this behavior in their friends. Schools should stress that they are a safe environment, and that students should feel comfortable talking to an adult if someone they know is engaging in self-harm. Also, mental health care needs to be more readily accessible to students with depression and other mental health illnesses in order to prevent self-harm among students. It is not the beginning to an eventual suicide, but a way to cope with everyday life.

### *Recommendations*

Self-harm is an extremely dangerous activity. One thing that can be done to try and lower the frequency in which it occurs is to educate students on the dangers and the impact it will have upon their lives. Recommendations to lower the frequency of self-harm in adolescents would be to include a more comprehensive guidance curriculum, including anger management, coping skills, life skills, and relaxation. Some sense of help needs to be provided for students engaging in self-harm.

There is a great deal of gray-area regarding the legal and ethical considerations of self-harm. It is really up to the professional judgment of the counselor to decide who needs to be informed when a student is engaging in self-harm. Some professionals recommend reporting to parents no matter what. Some recommend reporting only if they think the student is truly endangering his/her safety. The counselor needs to establish his/her own policy to determine what they need to do and they need to be consistent with each case. However, research indicates that reporting self-harm to parents may save trouble in the long run. Overall, it would be helpful to counselors and administrators to develop a set of guidelines that would be consistent from school to school.

This being said, counselors can provide a great deal of help to a student who is engaging in self-harm. They can be there to refer to outside sources, provide support groups, and individual counseling. Counselors can also work in conjunction with mental health professionals and parents to help a student stay on the right track during treatment and follow through with safety plans. Counselors can also teach coping skills to help students find better alternatives than self-harm.

### *Limitations*

Current self-harm literature has some limitations. Females are more likely to report their self-harm behavior, and research focuses more on girls. Some of the information provided could be biased to the idea that more females self-harm. Also, self-harm often occurs in conjunction with other mental health issues. Treatment plans can be established; however they might not be effective if other mental health issues are not addressed at the same time.

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