Cutting and self-mutilating behaviors among adolescent girls: a counselor's role in understanding and treatment

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Abstract
With the reported incidence of cutting and self-mutilating behaviors in adolescent girls on the rise, counselors need to take a look at the changing role they can play in helping these young girls understand the reasons underlying their self-destructive behaviors. The counselor can also help them find new ways to cope with the deep emotional trauma that precipitates the behavior. Understanding the causes and dynamics of this disorder will lead to better opportunities for effective treatment. This paper is intended to focus on the nature of the disorder and the role of counseling in bringing these young women back from the edge of darkness and teaching them how to form healthy coping skills, behaviors, and communications.

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Cutting And Self-Mutilating Behaviors Among Adolescent Girls:

A Counselor’s Role In Understanding And Treatment

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Carla C. Hughes

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With the reported incidence of cutting and self-mutilating behaviors in adolescent girls on the rise, counselors need to take a look at the changing role they can play in helping these young girls understand the reasons underlying their self-destructive behaviors. The counselor can also help them find new ways to cope with the deep emotional trauma that precipitates the behavior. Understanding the causes and dynamics of this disorder will lead to better opportunities for effective treatment. This paper is intended to focus on the nature of the disorder and the role of counseling in bringing these young women back from the edge of darkness and teaching them how to form healthy coping skills, behaviors, and communications.
The increasing incidence of cutting and other self-injurious behaviors in adolescent girls has alerted mental health professionals to better understand and treat the emotional turmoil underlying this disorder (Alderman, 1997; Levenkron, 1998; Strong, 1998). Just as anorexia and bulimia were relatively unknown and misunderstood conditions thirty years ago, self-mutilation is feared and misunderstood today (Alderman, 1997; Levenkron, 1998). Strong (1998) referred to cutting as the addiction of the '90s because hospitals, emergency rooms, psych wards, prisons, schools, and juvenile facilities have so widely reported the occurrence in the last decade.

The majority of self-mutilators are young adolescent women (Alderman, 1997; Autin & Kortum, 2004; Conterio & Lader, 1998; Favazza, 1996; Levenkron, 1998; Strong, 1998; Zila & Kiselica, 2001). This disorder is often associated with a history of childhood trauma (Alderman, 1997; Autin & Kortum, 2004; Conterio & Lader, 1998; Levenkron, 1998; Strong, 1998; Zila & Kiselica, 2001). These traumas include sexual abuse, neglect, physical abuse, and a failure in attachments and trust relationships (Autin & Kortum, 2004; Crowe & Bunclark, 2000; Kress, 2003; Levenkron, 1998; Strong, 1998). Eating disorders, obsessive-compulsive disorders, alcoholism, and drug dependence are other pathologies associated with the same childhood traumas (Autin & Kortum, 2004; Crowe & Bunclark, 2000; Levenkron, 1998; Strong, 1998). Other diagnoses that can be associated with cutting and self-mutilation include depression, bipolar disorder, posttraumatic

In order to understand how to treat self-mutilation, it is important to define what it is and what brings young women to this self-destructive act (Autin & Kortum, 2004; Levenkron, 1998). Defining self-mutilation is not simple because it is such a complex issue (Levenkron, 1998; Strong, 1998). At its most basic, it is the act of harming oneself, usually by cutting the skin with a sharp object such as a knife or razor blade, or scraping with bottle caps, scissors, or fingernails (Alderman, 1997; Autin & Kortum, 2004; Levenkron, 1998; Strong, 1998). It also includes burning the skin with cigarettes, chemicals or acids, and open flames (Alderman, 1997; Levenkron, 1998; Strong, 1998). Another method used by the self-mutilator causes bruises by hitting and gouging the skin (Alderman, 1997; Strong, 1998). In all cases physical pain is inflicted in order to escape deep emotional pain (Alderman, 1997). “Self-mutilating behavior means that the mind has slipped away from its ordinary context or perspective, losing sight of the immediate impracticality of pain and danger in order to commit an act that will bring an immediate solution (however unrealistic or temporary in nature) to emotional pain” (Levenkron, 1998, p.45).
The general reaction to the act of cutting and self-mutilation has been one of revulsion not only from the general population but also from helping professionals and members of the mental health community (Levenkron, 1998). It has been this revulsion and lack of understanding that has kept the self-mutilator from disclosing her behavior (Alderman, 1997).

The purpose of this paper is to define self-mutilation, examine the motivations behind self-mutilation, and shed some light on the causal factors leading to the disorder. Also addressed is the role of the counselor in facilitating better treatment by giving the counselor some understanding of the disorder.

What is Self-Mutilation?

Why would an adolescent girl intentionally harm herself by cutting, scraping, burning, or hitting parts of her own body (Autin & Kortum, 2004)? To the average individual, male or female the idea of self-mutilation seems sick or disgusting (Alderman, 1997; Autin & Kortum, 2004). For the young woman trying to escape the unbearable emotional pain brought on by physical or sexual abuse, neglect, and other traumas resulting in difficulty forming attachments, it is a profound relief when, if even for a short period of time, the emotional pain can be replaced (Alderman, 1997; Autin & Kortum, 2004; Favazza, 1996; Levenkron, 1998; Milia, 1996; Strong, 1998).

According to Levenkron (1998), the incidence of cutting and other self-mutilating behaviors, especially among adolescent females, follows a similar
pattern to that of anorexia and bulimia (Autin & Kortum, 2004; Levenkron, 1998). Because of limited empirical data, it has been difficult to determine the actual percentage of adolescent females engaged in self-mutilating behaviors, which may still be unknown (Levenkron, 1998). It is also unknown how many suicides have been accidental as a result of self-mutilation gone wrong (Alderman, 1997). Today, researchers such as Favazza, Alderman, Levenkron, and Strong have described the phenomenon of self-injury among teenagers as the deliberate destruction of one’s own body tissue with no suicidal intent (Strong, 1998). In actuality, death or serious physical impairment is the furthest thing from the mind of the self-mutilator (Alderman, 1997; Levenkron, 1998; Strong, 1998). “Although it may seem like a strange idea at first, SIV (self-inflicted violence) is actually a method of sustaining life and coping during an emotionally difficult time” (Alderman, 1997, p. 7).

Matthews and Wallis (2002) described three main categories to define the patterns of non-life threatening injury and psychopathology as; a) repetitive minor cuts and bruises; b) extreme and bizarre injuries; and c) repetitive movements such as head banging. Many repeating self-mutilators experience feelings of guilt and self-blame for behaviors that provide relief from tension with no suicidal intent (Crowe & Bunclark, 2002).
Prevalence of Self-Mutilation

Armando Favazza, a professor of psychiatry at the University of Missouri, Columbia, did extensive research on cutting and other self-mutilating behaviors and conducted a survey of 500 undergraduate psychology students (Strong, 1998). In his study, he found an amazing 12 percent, or one in eight students, had deliberately cut, burned, or physically harmed themselves in some way at least once in their lives (Strong, 1998). Further, within the previous six months he also conducted a random survey of the general population, finding four percent had admitted to intentionally causing bodily harm to themselves (Autin & Kortum, 2004; Favazza, 1996; Strong, 1998). That equates to approximately eight million Americans who may currently be engaging in self-mutilating behaviors (Autin & Kortum, 2004; Favazza, 1996; Strong, 1998).

The severity, frequency, and prevalence of self-mutilation was universally unheard of or ignored until 1996 (Autin & Kortum, 2004). It was at this time that Princess Diana of Great Britain stepped forward and publicly admitted to having problems with anorexia, bulimia, and cutting (Autin & Kortum, 2004). Princess Diana indicated in a BBC television interview that when a person has so much pain on the inside, there is a need for help which finds expression in hurting oneself on the outside (Autin & Kortum, 2004; Strong, 1998). The result of this BBC television interview was an increase in interest as well as a striving to understand a disorder that defies understanding (Autin & Kortum, 2004).
Autin & Kortum (2004) listed three major categories to define the acts of self-mutilation. These include: a) major self-injury in which permanent disfiguration occurs; b) stereotypical self-injury, which consists of head banging and biting; and c) superficial self-injury, which is the most common form of self-mutilation and includes cutting, burning, and hair-pulling. This should not be confused with normal adolescent fads and rituals such as tattooing, body piercing, and other, more extreme ritual body manipulation (Alderman, 1997; Autin & Kortum, 2004; Strong, 1998). Even though these activities appear to be self-destructive or have an injurious effect, they have been accepted, but not approved, in Western culture as adolescent fads (Alderman, 1997; Strong, 1998). The difference between fad and self-mutilation is in the intent (Alderman, 1997; Strong, 1998). The intent of tattooing, body piercing, plastic surgery, and ritual self-mutilation is to fit in and be socially accepted by one’s peers (Alderman, 1997; Strong, 1998). The intent of self-injury is to release tension and cope with overwhelming emotions that cannot be expressed verbally (Alderman, 1997; Autin & Kortum, 2004; Conterio & Lader, 1998; Levenkron, 1998; Strong, 1998; Zila & Kiselica, 2001).

While not all adolescents who have undergone trauma in their lives engage in self-mutilating behaviors, a majority of adolescents who self-injure have histories of trauma or abuse (Kress, 2003). It has been found that there is a strong correlation between a child who self-injures and a home that is lacking in adequate, healthy communication and nurturing (Conterio & Lader, 1998; Kress,
A teenager who has been the victim of neglect or abuse often has trouble expressing herself and will communicate much more directly and forcefully by actions rather than words (Autin & Kortum, 2004; Conterio & Lader, 1998; Levenkron, 1998). For most adolescents who self-injure, verbal communication is inadequate to represent the intense emotions that can find no other expression (Autin & Kortum, 2004; Levenkron, 1998; Strong, 1998). There appears to be no release of emotion comparable in words to express inner feelings the way cutting the flesh can provide (Alderman, 1997; Strong, 1998).

“There are many roots to cutting, but the single, most common causal factor is childhood sexual abuse” (Strong, 1998, p. 64). Experts such as Favazza, Levenkron, and Strong have recognized sexual abuse as the primary diagnosis of self-mutilators. Figures suggested that over half of all self-mutilating teenagers are the victims of childhood sexual abuse (Autin & Kortum, 2004). One of the inevitable outcomes to childhood sexual abuse is that the victim equates pain with love (Autin & Kortum, 2004). When a child is deprived of kindness and loving touch and is instead exposed to sexual attention from a beloved parent, pain and self-punishment seem familiar (Autin & Kortum, 2004; Conterio & Lader, 1998). It is also one of the only connections to her parents (Conterio & Lader, 1998; Strong, 1998). Abused children identify with the abusive parent, which seems better than to identify with the weak, powerless parent who is unable to do anything to protect them (Conterio & Lader, 1998; Strong, 1998). As bad as
the abuse may have been, it provided the child with the needed attention and contact with a parent (Conterio & Lader, 1998; Strong, 1998). Cutting is a way for the abuse victim to re-create the feelings of being connected through the pain but still maintain control of her own body (Conterio & Lader, 1998).

Common Characteristics

The majority of self-mutilators can be defined by common characteristics or traits that form a profile of those engaging in self-harming behaviors (Autin & Kortum, 2004). The typical cutter has been described as a young, highly intelligent white female from a middle to upper-middle class family who is prone to alcohol and drug abuse and who has a great deal of difficulty in her relationships (Autin & Kortum, 2004; Crowe & Buncclark, 2000; Kress, 2003; Levenkron, 1998; Strong, 1998; Zila & Kiselica, 2001). A large percentage of these young women endured early lives characterized by great instability including failure in close family relationships (Conterio & Lader, 1998). Most often, sexual and/or physical abuse occurred as well as placement outside the home (Conterio & Lader, 1998). Additionally, the typical self-mutilator grew up in a home in which the father was either sexually seductive toward his daughter(s) or was distant and hypercritical (Strong, 1998). Mothers of self-mutilators were most often cold, rejecting, punitive, and judgmental (Strong, 1998). According to Grunebaum & Klerman (1967), they felt worthless, as though they contained all the worthless features of their parents. These children grew up lacking caring.
There are also signs and symptoms associated with the profile of self-mutilators including perfectionist tendencies, a dislike of body or body shape, the inability to tolerate intense feelings, the inability to express emotional needs or experiences, feelings of helplessness, lack of control, and rapid and intense mood swings (Autin & Kortum, 2004; Strong, 1998). The psychological symptoms to look for are withdrawal, moodiness, and depression (Autin & Kortum, 2004). Walsh & Rosen (1988) found other variables when determining the symptoms and risk factors in self-mutilators. These include the loss of a parent, having another self-mutilating family member, a romantic breakup, intimacy problems, and peer conflicts (Autin & Kortum, 2004; Kehrberg, 1997; Walsh & Rosen, 1988). Alleviating stress and depression or dealing with the feelings of alienation from peers or family can lead the adolescent girl to cutting or other forms of self-mutilation (Froeschle & Moyer, 2004). In addition, cutting becomes a method of communicating what can’t be spoken and often becomes the re-enactment of a childhood trauma (Autin & Kortum, 2004; Levenkron, 1998).

In most cases, young women who self-mutilate don’t want anyone to know about these self-harming behaviors because of a sense of shame and the fear of discovery (Alderman, 1997). Levenkron (1998) suggested looking for signs such as a preference for wearing concealing clothing at all times, avoidance of
situations where more revealing clothing might be expected, and frequent complaints of accidental injury (Autin & Kortum, 2004).

Why Teenagers Engage In Self-Mutilation

Most adolescent girls who engage in self-mutilating behaviors probably could not tell anyone why they injure themselves (Alderman, 1997). In addition to the inability to recognize the motivations that lie behind the behaviors, they probably would be unable to tell anyone when their self-injurious behaviors began (Alderman, 1997). In other cases, the injuries were accidental, but the teenager found the release of blood soothing, which then led to further incidents of self-injury (Conterio & Lader, 1998). For the adolescent girl, it becomes a means of coping and of expressing intense emotions that can find no other outlet (Alderman, 1997; Conterio & Lader, 1998; Autin & Kortum, 2004; Levenkron, 1998). The adolescent self-injurer looks upon her actions as a temporary relief from such symptoms as anxiety, depersonalization, and racing thoughts (Strong, 1998). Levenkron (1998) compared it to the individual who becomes extremely angry or frustrated with no verbal outlet for the strong feelings and lashes out by knocking something over or throwing an object and breaking it. When the emotional pain is so overwhelming that none of these traditional outlets is sufficient, the person will push a fist through a wall or a window, bang her head against a wall, or as a last attempt, use a weapon against herself (Levenkron, 1998).
Causal Factors

Research by Walsh & Rosen (1988) found important indicators to be childhood or adolescent loss of a parent or placement outside the home, as well as serious childhood illness or surgery. Also, children that had witnessed domestic violence and other forms of destructive behaviors were more likely to inflict self-harm than those from environments void of severe trauma (Conterio & Lader, 1998; Kehrberg, 1997; Levenkron, 1998; Strong, 1998). Not only were these forms of negative attention prevalent in the early lives of self-mutilating adolescents, but there was also a strong sense that something was missing (Conterio & Lader, 1998). According to Conterio & Lader (1998) a bond between the child and her early caregivers was never formed, which resulted in a lack of early nurturing, touch, affection, and comfort.

Zila & Kiselica (2001) observed that children growing up with the absence of appropriate attachments and nurturing had a much higher likelihood of engaging in self-mutilating behaviors. These young girls were abused emotionally, sexually, physically, or through extreme neglect by parents who were themselves emotionally fragile, making it difficult for these girls to accept comfort from others (Himber, 1994; Zila & Kiselica, 2001). The abused child presents an example of a failure on the part of the caregiver (Conterio & Lader, 1998). As a result of the absence or neglect of an emotionally unavailable parent, the child was left to feel vulnerable and as though she was in a continuous state of danger.
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(Conterio & Lader, 1998). Too often, when a child was being physically or sexually abused by one parent or caregiver, the other caregiver permitted the abuse to continue by not intervening on behalf of the child (Conterio & Lader, 1998). To the child, this was evidence of betrayal on the part of someone she trusted (Conterio & Lader, 1998).

Simeon & Favazza (2001) referred to a number of states and motivations likely to lead the adolescent to engage in self-mutilating behaviors. Included are the following: releasing unbearable mounting tension; discharging rage directed at hated parts of the self; self-punishment; attempting to feel alive again by lifting depersonalization and emotional deadness; regaining a sense of control and omnipotence; self-soothing; reconfirming self-boundaries; communicating with or controlling others; experiencing sexual excitement, euphoria or titillation; relieving intolerable aloneness, alienation, hopelessness, or despair; combating any desperate affects or thoughts; and expressing conflicting, dissociative states (Autin & Kortum, 2004; Kress, 2003; Matthews & Wallis, 2002; Milia, 1996).

To those who do not cut or otherwise injure their own bodies, self-mutilation can appear to be unnecessarily self-destructive, masochistic, or simply irrational (Strong, 1998). Strong (1998) referred to cutting as having great meaning for those who practice this behavior. “It is like a secret code known only to those who speak its language, or those who take the time to listen carefully” (Strong, 1998, p. 36). Included among the clues to understanding cutting and other self-
injurious behaviors are coping as a survival tactic, loss of control, a sense of an internal split dissociation, and feelings of psychological pain (Alderman, 1997; Autin & Kortum, 2004; Levenkron, 1998; Strong, 1998).

**Defense Mechanisms**

Coping is a survival tactic used to get through a difficult situation by relieving stress and tension as easily as possible (Alderman, 1997). Self-mutilation is a negative, dangerous, and unhealthy coping strategy because it promotes the possibility of psychological difficulties as well as physical damage (Alderman, 1997). “As a coping mechanism, self-inflicted violence is unique in that it is one of the few methods that also causes physical injury. It makes little sense logically that physical injury can provide a sense of relief” (Alderman, 1997, p. 34). To the self-mutilator, feelings are dangerous and expressing emotions to other people is nearly impossible (Alderman, 1997). The self-mutilator has very little physical or emotional security and lacks emotional perceptiveness toward other people as well (Levenkron, 1998). Inflicting physical injury provided a way for the adolescent to express inner conflict when aggression was turned inwards (Crowe & Bunclark, 2000). For many adolescent girls, this type of coping mechanism was precipitated by an overwhelming need to gain or regain self-control (Froeschle & Moyer, 2004; Levenkron, 1998).

The issue of control is fundamental to the self-mutilator (Autin & Kortum, 2004). For many adolescent girls, a feeling of helplessness and a sense that there
is no one with whom they can place their trust is experienced (Autin & Kortum, 2004). The feelings of loneliness and fear are usually realistic stemming from real experiences based upon type of childhood trauma (Alderman, 1997; Autin & Kortum, 2004; Clery, 1998; Levenkron, 1998; Strong, 1998). The young girl feels so helpless and so completely overwhelmed by the intense mental anguish and chaos of these unmanageable feelings that the use of any sharp object against the skin gives her total control over her own body (Autin & Kortum, 2004). “Pain that is self-inflicted is pain over which a person has control” (Autin & Kortum, 2004, p. 517). It is basically a means by which the self-mutilating teenager can alter her mood state by putting the focus of her pain in a controllable area of the body (Autin & Kortum, 2004). The body becomes a substitute target for the adolescent girl’s anger and aggression (Milia, 1996). The most common areas to be targeted include the forearms and wrists, upper arms, thighs, abdomen, and occasionally, breasts and calves (Autin & Kortum, 2004; Milia, 1996). Even though her body is a vital piece of her identity, the self-mutilating adolescent views her body as an object (Conterio & Lader, 1998). If she had been sexually or physically abused, her body is also the cause of her suffering and pain (Conterio & Lader, 1998).

In most teenagers, as emotional and physical discomfort increase, a sense of being in control is lessened (Alderman, 1997). The act of cutting or other forms of self-mutilation may be perceived as a means of regaining control over one’s
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life and emotional states (Alderman, 1997). In addition to controlling the physical self, thoughts that are intrusive, obsessive, or unwanted can be controlled through self-mutilation (Alderman, 1997). Greater control over emotions, thoughts, body, and behaviors provided an effective mechanism for the perception of comfort and peace (Alderman, 1997).

A key element to the act of self-mutilation is the dissociative state (Levenkron, 1998). For many, cutting became an out of body experience which served to distract the cutter from problems, while bypassing the body’s defenses (Levenkron, 1998; Milia, 1996). It may also have functioned to deaden a painful memory, which had remained repressed (Milia, 1996). This dissociated state alters consciousness, causing a reduction or lack of physical pain during cutting in which the self-mutilator feels comfortable and calm (Alderman, 1997; Zila & Kiselica, 2001).

A Counselor’s Role In Treatment

There can be a great deal of pressure placed upon the therapist who is called upon to help a young woman who self-mutilates. Many mental health professionals find it difficult to talk in detail about self-mutilation with their clients because the professional may feel frightened, repulsed, or frustrated (Himber, 1994; Kress, 2003; Zila & Kiselica, 2001). Data gathered from 117 mental health professionals identified self-injury as the behavior most traumatizing to encounter as well as being the most distressing client behavior.
found in clinical practice (Deiter & Pearlman, 1998). Because some therapists may find self-mutilating behavior to be too upsetting or frightening to deal with, it is better that these individuals not counsel clients who engage in this type of behavior (Conterio & Lader, 1998). A therapist who is repulsed by the client’s behaviors will ultimately cause more harm than good in the counseling process (Conterio & Lader, 1998). It is important for the counselor to represent normative, non-abusive values and express compassion and understanding toward the self-mutilating client regardless of personal feelings (Autin & Kortum, 2004; Clery, 1998). Also of importance for the counselor is the monitoring of his/her own reactions and self-awareness while maintaining openness and respect for the client (Kress, 2003).

Counselor Traits

An effective counselor combines a set of personality traits and strategies to offer the self-mutilator a way out of her hurt, anger, and loneliness (Levenkron, 1998). An effective counselor needs to feel confident about his/her abilities to successfully treat the cutter (Levenkron, 1998). Talking openly about cuts and burns and looking at jagged, reddened scars must not be too overwhelming for the counselor (Alderman, 1997). The ability to be empathetic toward the client and be patient, even when the client doesn’t make sense, is essential (Alderman, 1997; Levenkron, 1998). It is important for the counselor to distinguish between empathy and sympathy (Conterio & Lader, 1998). In working with the self-
mutilator, the therapist may find that the capacity for empathy is continually and relentlessly challenged (Conterio & Lader, 1998).

Another important characteristic of an effective counselor is the ability to appear knowledgeable about the client’s behaviors, including the cutting, depression, and low self-esteem (Levenkron, 1998). According to Alderman (1997) most therapists lack adequate knowledge about self-mutilating behaviors due to a lack of training on the subject in addition to the secrecy surrounding the disorder. Most clients come to therapy with a different presenting problem and only after a relationship of trust with the counselor has been established may the client reveal the self-injurious behaviors (Alderman, 1997). An understanding of the client’s needs and of her deep emotional wounds should be a goal of the therapist (Alderman, 1997). No attempt on the part of the therapist should ever be made to control or shape the client (Clery, 1998; Sutton, 1998).

Counselors who were able to understand their clients and suspend judgment, while allowing the adolescent clients to explain their behaviors, gained better insights into the disorder (Zila & Kiselica, 2001). The self-mutilating client then felt empowered by becoming a part of her own recovery (Zila & Kiselica, 2001). The failure of counseling strategies that were aimed at getting the client to stop self-mutilating resulted in the client feeling misunderstood (Zila & Kiselica, 2001). This led to the counselor feeling overwhelmed and ineffective (Himber, 1994; Zila & Kiselica, 2001).
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Counselor-Client Relationship

It is also beneficial for the counselor to convey a nurturing posture toward the self-mutilating client whether it is requested or not (Levenkron, 1998). Most cutters come from homes in which nurturing played very little part, and the client will repeatedly test the therapist (Levenkron, 1998). For many self-mutilators, previous harsh and unsympathetic treatment by parents or other caregivers induced them to falsely admit to suicide attempts in order to be treated more humanely (Zila & Kiselica, 2001).

The initial goal of counseling should be to develop and build a relationship with the client that is able to contain the overwhelming emotions (Alderman, 1997; Zila & Kiselica, 2001). Building a rapport with the client involves the development of trust and respect (Alderman, 1997). One of the necessary components to building rapport is being patient and attentive in a nonjudgmental manner (Alderman, 1997). The adolescent client needs to know the counselor is listening (Alderman, 1997). Even though descriptions of the client’s trauma may at times be difficult to listen to, staying connected will influence the outcome of the therapeutic progress (Alderman, 1997). By listening and staying connected, the therapist can become the client’s anchor to reality and sanity (Alderman, 1997).

Also necessary to a healthy counselor-client relationship is the establishment of appropriate boundaries (Conterio & Lader, 1998). The establishment of
boundaries is necessary in any therapeutic relationship but is particularly important when working with clients who self-mutilate (Alderman, 1997; Conterio & Lader, 1998). In many cases, the counselor may be the only person the self-mutilator has confided in concerning these behaviors (Alderman, 1997). “It’s a delicate balancing act to keep professional boundaries, avoid the rescue trap, and simultaneously offer comfort and solace” (Conterio & Lader, 1998, p. 181).

In addition to the effective and beneficial treatments and techniques, there are many examples cited of treatments that have been found to be ineffective in dealing with cutting and other self-mutilating behaviors (Zila & Kiselica, 2001). Examples of ineffective treatments include: physical restraint, hypnosis, chemotherapy, no-cutting contracts, faith healing, group psychotherapy, educational therapy, the display of scars and wounds, prescribing substitute behaviors, and cathartic methods such as throwing a soft object or punching a pillow (Conterio & Lader, 1998; Favazza, 1996; Himber, 1994; Zila & Kiselica, 2001).

Conclusion

Cutting and self-mutilating behaviors are still considered by most people as frightening, disturbing, and repulsive. Self-mutilation has been defined as the act of harming oneself, usually by cutting the skin with sharp objects, scraping the
skin, burning, or causing bruises by hitting or gouging the skin. The main goal in all cases is to cause physical pain in order to escape from the adolescent’s deep emotional pain and anger. Although self-mutilating behaviors may appear to have a suicidal intent, they are instead a coping mechanism used in order to sustain life during an emotionally difficult time.

Most self-mutilators do not enter therapy for their self-injurious behaviors, but rather to treat associated conditions such as depression, emotional trauma, abuse, or stress. The initial goal of the counselor is to build a trusting relationship with the adolescent self-mutilator. Of extreme importance for the counselor is the ability to listen openly in a non-judgmental manner and establish appropriate boundaries with the client. The primary counselor goal is to seek to resolve the underlying symptoms caused by abuse and neglect and help the client to achieve independence, gain self-esteem, and incorporate better coping skills.
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