Self-mutilation: a growing concern

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Self-mutilation: a growing concern

Abstract
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SELF-MUTILATION: A GROWING CONCERN

A Research Paper

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by

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Abstract

According to an article by Nock and Prinstein, “Self-mutilative behavior is a pervasive public health problem occurring at a rate of 40% in the general adult population and 21% in adult clinical populations. Adolescence is a period of significantly increased risk for self-mutilative behavior, as evidenced by rates of 14%-39% in adolescent community samples” (Nock & Prinstein, 2005, p.140). Raising awareness about the behaviors and emotions involved with individuals who self-mutilate may help counselors and school administrators understand better methods of treatment for adolescents. The following is a review of current research and literature regarding the nature of adolescents suffering from self-mutilative behavior.
Self-Mutilation: A Growing Concern

Self-mutilation is the deliberate act of harming one's body without the intent of committing suicide (Knock & Prinstein, 2005). This paper will address the prevalence rates, characteristics, and symptoms of adolescence who self-mutilate. There will also be a description of three interventions counselors can use to help clients who display self-injurious behaviors.

Prevalence Rates

Research estimates that approximately 700 out of every 100,000 individuals use self-mutilation as a coping mechanism (Froeschle & Moye, 2004). "Researchers indicate that 53% of a social worker’s teen case load includes some form of self-destructive behavior, with 14 to 16 year olds comprising the largest group" (Froeschle & Moye, 2004, p. 2). Malikow (2006) believes an estimated two million people in the United States use cutting (a form of self-mutilation) as a way to cope with emotional pain. Nock & Prinstein (2005) reported that self-mutilation is occurring at a rate of 4% in the general adult population and 21% in the adult clinical population. This risk increases for the adolescent population with rates as high as 14%-39% in adolescent community samples and 40%-61% in adolescent psychiatric samples. These statistics show the devastating amount of individuals who use self-mutilation as a coping mechanism. It is apparent that counselor education and awareness is necessary to provide the correct support for these individuals.

Characteristics

Repetitive Self-Mutilation Syndrome (RSM) is classified as an impulse disorder. Impulsive disorders follow two general guidelines. "First, they occur episodically [...]"
usually following some precipitating event. Second, there is some gratification achieved by the behavior; which is why it becomes addictive and repetitive” (Lieberman, 2004, p. 1). When an adolescent is cutting, piercing, or burning themselves endorphins are released from the brain. Endorphins act as a natural anti-depressant and create a sense of relief from overwhelming anxiety and anguish. Self-mutilators, “have never learned to cope with strong emotions and have a very negative self-image and poor emotional resiliency” (Lieberman, 2004, p. 2). Adolescents who display RSM typically come from families of divorce; have experienced neglect, or a deprivation of parental care. Research also shows a strong correlation between childhood sexual abuse and RSM behavior (Lieberman, 2004).

Malikow (2006) believes that adolescents cut for three purposes. The first purpose is distraction. The adolescent is most likely terrified by emotional feelings and the act of hurting themselves interrupts the development of rage and anguish. The second purpose is dissociation. Malikow (2006) states, “…if the only emotion experienced is a continuously deepening sadness, the emotional life eventually shuts down” (p. 47). Self-mutilation allows these individuals to feel connected with their bodies. Feeling the pain from an injury proves they are human and still alive. The third purpose is symbolism. “For some cutters, blood flowing out is an outward expression of an inner release of undesirable emotion” (Malikow, 2006, p.48). One 16-year-old girl described her experience as being able to feel the pain and fear flow out of her body at the site of blood flowing from her cut (Malikow, 2006).

Lieberman (2004) believes individuals self-injure because they never learned to cope properly with their overwhelming emotions. According to Lieberman, these
adolescents "... feel chronic anxiety and tremendous rage (usually against themselves), are dissociated from reality (emotional numbness), and have a sense of depersonalization and powerlessness". Self-mutilation has become a way for these adolescents to transfer those terrible emotions into something physical to relieve the emotional stress.

When an individual harms themselves through self-mutilation, the brain releases endorphins that can act as a natural antidepressant. Usually when an adolescent is in the act of harming themselves they feel no pain. Instead they feel an extreme sense of relief, release, calm, or satisfaction (Lieberman, 2004).

Another reason can be found in the strong connection with previous child abuse among adolescents who self-mutilate. Author Diana Milia (1996) believes that some victims of child abuse "... compulsively seek painful or abusive experiences in an attempt to master the trauma". Victims of child abuse may use their body as a "theatre" that allows them to reenact their painful abusive memories, and in turn creates a way for them to identify with their abuser and with themselves as the victim. When child abuse victims look at the scars they have created from their self-injurious behaviors, the scars may act as reminders of their past traumas, but some also view those scars as a record of healing and survival (Milia, 1996).

Adolescents may also perform self-injurious behaviors because the act of hurting oneself is associated with amnesia and denial. Researcher Pao (1969) "... relates self-cutting to the "cutting off" of thoughts from feelings, adding that most such patients have no memory of their early developmental histories" (as sited in Milia, 1996, p.101). After an individual "cuts" they experience a dissociated state that distracts them from their
emotional problems. The actual cutting functions as a way to transform a painful memory into a physical one, so the painful memory can remain repressed (Milia, 1996).

Self-mutilation is not a suicidal act. Adolescents who choose to self-harm do not intend to end their life. They injure themselves because the act of cutting allows them to feel better and the wounds are typically not life threatening. In some ways self-mutilation is a way to prevent committing suicide because it acts as an outlet for pain (Lieberman, 2004). Although the characteristics of individuals who self-mutilate can be described as very bleak and destructive, the injurious behavior has a calming affect on their anxiety and depression. That self-healing may be preventing them from more destructive behaviors.

Symptoms

Individuals who intentionally harm themselves can use various forms of mutilation such as burning, picking, cutting, scratching, pulling hair, and head banging (Lieberman, 2004). Malikow (2006) reported that some individuals with RSM have gone so far as to apply acid to their skin and sandpaper their face as a method of self-mutilation. An extreme form of self-mutilation could even result in amputation. This would normally be characterized by individuals suffering from a psychotic disorder (Froeschle & Moye, 2004).

Because individuals who self-mutilate go to great lengths to avoid being noticed, it may be difficult for outsiders to recognize symptoms. It is important for care givers, school officials, and parents to pay attention to adolescents wearing long sleeves during warm weather in an effort to cover scars. These individuals may present themes of aggression, pain, or emotional numbness during work, activities, or communications in a
daily setting. It is important to pay close attention to adolescents who have frequent and unexplained scars, engage in secretive behaviors (spending unusual amounts of time in secluded places), and who carry around sharp objects like razor blades or thumb tacks (Lieberman, 2004). MacAniff Zila & Kiselica (2001) also believe self-mutilators have difficulty verbalizing feelings and are operating from a false sense of self. The first step in helping adolescence with RSM is recognizing when an individual may be displaying the above mentioned symptoms and approaching them in a non-threatening manner.

**Interventions**

Cognitive therapy has been one method used to successfully eliminate self-destructive behaviors elicited by individuals with RSM. There are four categories of thought that are common with self-mutilators. These thoughts include: “self-mutilation is acceptable, one’s body and self are disgusting and deserving of punishment, action is needed to reduce unpleasant feelings, and overt action is necessary to communicate feelings to others” (MacAnif Zila & Kiselica, 2001, p. 7). When these four areas are addressed in counseling, the client has a much better chance of recovering from self-mutilating behavior. If the client can understand how his or her thoughts are connected to the decision to self-mutilate, they can learn to separate one from the other.

Behavior modification has also been used with clients who self-mutilate. If the client is able to find a different method to release tension that does not involve physical harm, they will have a better chance of eliminating the destructive behavior. One suggestion would be to stick an arm or leg into a bucket of ice cold water. This alternative behavior is less damaging and achieves a similar affect by creating a sense of release, much like self-mutilation (MacAniff Zila & Kiselica, 2001).
Perhaps one of the most important interventions is creating a non-judgmental and supportive relationship with the client. When a counselor builds trust with a client and genuinely seeks information about their experience, the client learns to safely display emotions in other ways besides physical harm. The client may be filled with shame and guilt, so the opportunity to form a bond with another person who will not scold or lecture them is a very valuable tool for the client’s recovery. The counselor acts as an outlet and allows the client to substitute verbalization for the self-harming behavior that had been previously used to express internal anguish (Froeschle, 2004).

Adolescents who self-mutilate are experiencing extreme isolation and confusion when it comes to expressing emotions. Self-injurious behavior may be the only way for these individuals to cope with past experiences or traumas. It is vitally important that counselors learn the importance of creating a way for these individuals to verbalize emotions, which will in turn help them find their true self. Individuals who self-mutilate are simply searching for a release from the overwhelming emotions they cannot define. By addressing the characteristics and symptoms of adolescents who self-mutilate, loved ones will be able to identify when a child needs treatment. Counselors who are educated in the different interventions that have been successful in treating RSM will be able to create a supportive environment that allows the client to recover from the destructive behavior.
References


