Self-mutilating behaviors

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Abstract
Treating self-mutilating behaviors (SMB) is complex. Since people are continuing to engage in the behaviors, counselors need to be informed of the various techniques that are used with SMB as well as to be informed about common myths around self-mutilating behaviors. This paper will explore the methods of SMB, the common myths surrounding SMB, and the theories that explain and inform treatment of.
Self-Mutilating Behaviors

A Research Project

Presented to
The Department of Educational Leadership, Counseling
And Postsecondary Education
University of Northern Iowa

In Partial Fulfillment
Of the Requirements for the Degree
Master of Arts

By
Patience Niemoth-Coleman

December 2008
This Research Project by: Patience Niemoth-Coleman

Entitled: Self-Mutilating Behavior

has been approved as meeting the research paper requirements for the Degree of Master of Arts.

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Abstract

Treating self-mutilating behaviors (SMB) is complex. Since people are continuing to engage in the behaviors, counselors need to be informed of the various techniques that are used with SMB as well as to be informed about common myths around self-mutilating behaviors. This paper will explore the methods of SMB, the common myths surrounding SMB, and the theories that explain and inform treatment of.
Self-Mutilating Behaviors

Self-mutilating behavior (SMB) is a serious symptom of several mental disorders, such as borderline personality disorder and Stereotypic Movement Disorder. However, it has been observed that many individuals involved in SMB do not appear to have another diagnosis.

When a counselor is working with a person who self-mutilates, it is important to learn everything that is possible about the SMB and the reasons the individual gives for the SMB. By exploring the past and assisting a client with coping skills, the reasons for mutilation will become clear and successful treatment not only for the behavior but also their thoughts and feelings will be possible. It is important to understand that there are many ways to self-mutilate as well as many reasons the client feels they need to do so.

Addressing Self-Mutilating Behaviors

Functional Approach

Nock and Prinstein (2004) address a functional way to approach SMB. If clinicians are able to understand how people self-mutilate, as well as understand why they do it, the treatment can be better tailored to the clients' needs. Clients were asked to describe how they participate in SMB and also what the function of SMB was for them (Nock and Prinstein, 2004). After the inventory the data was analyzed to figure out why and how people participate in SMB.

The data was set into four categories. These four categories included automatic-negative reinforcement (ex. to take away negative feelings), automatic-positive reinforcement (ex. to help me feel something, even if its pain), social-negative reinforcement (ex. to not have to go to school today), and social-positive reinforcement
(ex. to get my mother’s attention) (Nock and Prinstein, 2004). These categories are important to understand the reasons that many people participate in SMB.

Nock and Prinstein (2004) also asked the clients how they self-mutilated and how often the self-mutilator uses each of the given methods. Of the sampled population, many individuals cut or carved into their skin more than eleven times in addition to picking at a present wound (Nock and Prinstein, 2004). It is important to understand the severity of the mutilation and the number of times that the individual has participated in SMB. By continuing research in this area it can help researchers and practitioners understand how SMB are formed as well as diverse ways for treating SMB (Nock and Prinstein, 2004).

Theories to Explain Behaviors

When dealing with SMB it is important to understand who self-mutilates and why they do it. One important study on the functions of self-mutilation was done by Suyemoto (1998). Suyemoto found that it is difficult to know how many people actually are self-mutilating now or have done it in the past. The reason for this is that many people do not want to discuss SMB and will not bring it up unless asked about the specific behaviors (Suyemoto, 1998). Due to this there are many different ranges of occurrence for SMB. Although it is difficult to assess the normal group of people who participate in SMB, those who participate in SMB seem to be easily described. They tend to be young female adults who start to self-mutilate during adolescents (Suyemoto, 1998). This does not appear to be universal throughout time and different research studies (Ross and Heath, 2002).
The act of self-mutilating also appears to be correlated with other behaviors such as Anti-social behavior, sexual dysfunction, and increased physical illnesses (Suyemoto, 1998). This is important because when treating someone for self-mutilation it is important to also treat them for the other things that may be going on that are not quite as obvious. It also has been said that people who self-mutilate also express more anger and have less self-control than those who do not self-mutilate (Suyemoto, 1998).

Trauma Component. Children who were sexually abused are up to four times more likely to self-mutilate than their non-abused counterparts (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003) These statistics are unique to children that are survivors of sexual abuse rather than other kinds of abuse. Noll et al (2003) followed a group of children that were sexually abused and not sexually abused throughout adolescence and young adulthood to determine whether or not the abuse plays a part in the re-victimization and self-mutilation of the individual. Noll et al (2003) determine what kind of childhood maltreatment had a stronger positive correlation with SMB. They found that sexual abuse was the highest predictor of self-mutilation later in life (Noll et al, 2003). This is vital to understand since many of the survivors of sexual abuse need to go to counseling to learn healthy coping skills so they do not “turn” on themselves later in life. Self-mutilation may appear years after the abuse has stopped and the survivor seems to be living a normal life. When a client has a history of sexual abuse, it is also important to evaluate them for SMB along with teaching them healthy coping skills. It is also important to understand that when a client comes to counseling and shows signs of self-mutilation, there is a good chance that there is a deeper issue that is causing them to
cope by self-mutilation. Therapy ideally should focus on exploration for SMB along with education about healthy coping skills.

*Environmental Model*. SMB is an act that is reinforced by the release of tension and also the resolution of threatening conflicts (Suyemoto, 1998). When a person decides to self-mutilate it makes his/her body feel better, as if they will be okay again. Since SMB are reinforced the individual will continue to mutilate when he/she feels the need to resolve internal issues.

*Drives Model*. The drives model explains that self-mutilation as a suicide replacement and that it is a compromise between the life and death drives (Suyemoto, 1998). If an individual has suicidal ideations as well as SMB then there may be a time when the death drive wins and he/she will no longer be satisfied with the self-mutilation.

*Sexual Model*. Many people self-mutilate due to conflicts over sexuality and the process of puberty (Suyemoto, 1998). This is a model that gets some support when the person does not self-mutilate prior to puberty, but starts to self-mutilate post puberty. Self-mutilation can serve dual purposes in sexuality including achievement of sexual gratification as well as destruction of the genitals to inhibit gratification (Suyemoto, 1998).

*Affect Regulation Model*. SMB occurs because the individual is angry, anxious, or in pain and needs to express that but cannot through other means (Suyemoto, 1998). This seems to be the model that many people have looked into as well as used as justification to why an individual self-mutilates.

*Dissociation Model*. The dissociation model explains self-mutilation as a way to cope with the dissociation caused by the intense feelings or affect (Suyemoto, 1998).
This goes well with the affect regulation model because it explains what can happen when a person does not deal with their feelings appropriately or learn healthy coping skills. This emphasizes the importance of treating someone with self-mutilating tendencies with coping skills that can help in the healing process.

*Boundaries Model.* SMB is a way to distinguish one individual from another, rather than to be just another face in the crowd. Other research indicated some people who self-mutilate have peers that do the same thing (Nock and Prinstein, 2005). In this case the act of self-mutilating they may be trying to “fit in”.

*Implications for Counselors*

*Community Involvement.* SMB is not just a concern for people who work with adolescents in a treatment facility but also for people who interact with children and adolescents in the community. Ross and Heath (2002) found that, when they compared two separate high schools, around 13.9% of students had self-mutilated at least once. It was also found that the numbers did not change when looking at an urban school versus a suburban school (Ross and Heath, 2002). SMB appears to occur universally. Since many people who are involved in SMB also have a peer group that is involved, it is not a surprise that this could become more prevalent.

Even if a student did not admit to participating in the act of SMB, there were other things that a student may do that were not categorized as SMB but caused self harm (Ross and Heath, 2002) such as hurting oneself mentally or participating in risk taking behavior. SMB is not just physically hurting oneself; it can also be the participation in other actions that may cause self harm.
Common Myths

Ross and Heath (2002) found that more females self mutilate than males. This is one of the few studies that have sighted gender differences in a community sample (Ross and Heath, 2002). They also found that most of the individuals who reported participating in SMB only admitted to using one type of self-mutilation. This is different than findings by Nock and Prinstein (2004) who found that a majority of the people who participate in SMB used various ways to harm themselves. This difference could be explained by the fact that Nock and Prinstein (2004) looked at a clinical sample, while Ross and Heath (2002) researched a community sample of people.

Self-mutilating behaviors do not just affect adolescents. Research suggests that an increase of hospitalizations due to SMB in children five to nine years of age has been occurring (Olfson, Gameroff, Marcus, Greenberg, & Shaffer, 2005). In a study evaluating national trends in hospitalization due to intentional self-mutilating behavior Olfson et al (2005) found that from 1990 to 2000 the rates for hospitalization seemed to be steady except for the age group of five to nine years.

Methods of SMB

When evaluating the different methods of self-injuries it seems that cutting and hanging are on the rise (Olfson et al, 2005). In addition the ingestion of antidepressants, opiates, and Tylenol were also on the rise for SMB (Olfson et al, 2005). When dealing with SMB it is vital to understand that it is not just cutting that can cause damage but also risk taking behaviors and ingestion of toxic chemicals. It is important to evaluate all types of self-mutilation, not just the obvious such as being a “cutter”.
Conclusion

Anyone working in the mental health profession should be aware of the SMB that they may come in contact with. SMB occurs across various cultures and settings. Client's who are seeking mental health services may be engaging in SMB, regardless of their age, gender, socio-economic status, and apparent reason for seeking services. Professionals should continue to educate themselves about the history and current trends of SMB, rather than assuming they know what is going on. There are many myths that explain SMB, but do little to actually treat the behaviors. By continuing to educate themselves, professionals can work to find ways to assist their clients in stopping the behaviors.
References


