The process and perspective of the therapist in the treatment of self-mutilation

Megan M. Parketon
University of Northern Iowa

Recommended Citation
https://scholarworks.uni.edu/grp/1323

Copyright ©2003 Megan M. Parketon
Follow this and additional works at: https://scholarworks.uni.edu/grp
Part of the Counseling Commons, Education Commons, and the Mental Disorders Commons

This Open Access Graduate Research Paper is brought to you for free and open access by the Student Work at UNI ScholarWorks. It has been accepted for inclusion in Graduate Research Papers by an authorized administrator of UNI ScholarWorks. For more information, please contact scholarworks@uni.edu.
The process and perspective of the therapist in the treatment of self-mutilation

Abstract
Research for the past 35 years has involved inpatient mentally ill persons who have been institutionalized. Treatment for self-mutilation has also focused primarily on mentally ill and mentally retarded patients. There has been little research done on the specific topic of adolescent female self-mutilation. Self-mutilation has become increasingly prevalent among female adolescents.

In this paper the therapist’s perspective of treatment and the therapist’s process of treatment were researched. Treatment should be tailored to the specific needs of the adolescent and often involved multiple treatments. Eleven styles of treatment were addressed and the qualities that a therapist needs to possess were also addressed. The main ingredients for success with female adolescent self-mutilators are stability, constancy, reliability, and the formation of a positive therapeutic alliance.
THE PROCESS AND PERSPECTIVE OF THE THERAPIST IN THE TREATMENT OF SELF-MUTILATION

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

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

by
Megan M. Parketon
August 2003
This Research Paper by: Megan M Parketon

Entitled: THE PROCESS AND PERSPECTIVE OF THE THERAPIST IN THE

THREATMENT OF SELF-MUTILATION

has been approved as meeting the research paper requirements for the Degree of Masters

of Art.

June 3, 2003

Date Approved

Duane Halbur

Advisor/Director of Research Paper

June 12, 2003

Date Received

Michael D. Waggoner

Head, Department of Educational Leadership,
Counseling, and Postsecondary Education
Abstract

Research for the past 35 years has involved inpatient mentally ill persons who have been institutionalized. Treatment for self-mutilation has also focused primarily on mentally ill and mentally retarded patients. There has been little research done on the specific topic of adolescent female, self-mutilation. Self-mutilation has become increasingly prevalent among female adolescents. The therapist’s perspective of treatment and the therapist’s process of treatment were researched. Treatment should be tailored to the specific needs of the adolescent and often involved multiple treatments. Eleven styles of treatment were addressed and the qualities that a therapist needs to possess were also addressed. The main ingredients for success with female adolescent self-mutilators are stability, constancy, reliability, and the formation of a positive therapeutic alliance.
Alice Miller (1983) wrote, “An unacknowledged trauma is like a wound that never heals over and may start to bleed again at any time” (p. 81). “Every unhappy family is unhappy in their own way, and each unhappy story told by the body is uniquely unhappy in its own way” (Becky Heeren, personal communication, February 11th, 2003). Self-mutilation is similar to a wound that never heals. The act of cutting creates the physical wound, but it is the reasons behind the cutting that are the true wounds that need to be healed. The self-mutilator uses her body to inflect outward expressions that she feels cannot be dealt with in words.

Walsh and Rosen (1998) defined self-mutilation as deliberate, but non-life-threatening, self-inflicted, bodily harm that is socially unacceptable. The most common form of self-mutilation is cutting and burning on the arms and legs. This definition has been chosen because it supports the views of this author and the type of self-mutilation that will be discussed. Other definitions were broad and included self-mutilation from the delicate type, to eye inoculation which is gouging out ones eye, and self-amputation. Other definitions also were limited in describing the population of self-mutilators. Some only made reference to chronic mental illness and mental retardation. Others assumed that self-mutilation was directly correlated to suicide.
The majority of research in the past 35 years has involved inpatient mentally ill persons who have been institutionalized. There are no known research articles on the specific topic of adolescent female, delicate self-mutilation. Much of the research on adolescents refer to ages 15 through 18 and do not discriminate between male and female. The purpose of this paper is to explore multiple interventions used in the work with female adolescent self-mutilators and the process of therapy through the therapist perspective. The therapist perspective is different from the theoretical foundation of self-mutilation because it is more practical and provides authentic experiences. For this paper the term ‘adolescent’ will refer to females, ages ranging from 12 through 19. The terms self-mutilation and self-cutting will be used interchangeably and will refer to the act of delicate self-mutilation. This term is not used empirically but is widely used in self-help literature and websites. It describes the type of mutilation most female adolescents inflict. Delicate self-mutilation is the act of cutting on specific parts of the body resulting in superficial scratches and moderate to minimal blood loss. In rare occasions medical attention beyond a compression wrap is needed.

It is hoped that this paper may spark interest in others to further the research on such a potentially harmful disorder; that self-mutilation will someday be recognized as a disorder rather than a symptom of a greater problems and be better diagnosed and treated.
The Self-Mutilator

Profile of the Delicate Self-mutilator

The profile of a typical delicate self-mutilator is: onset in early to middle adolescents; multiple episodes of self-cutting, low lethality, despair, anxiety, anger, and aggression symptoms; lack of social support; drug and alcohol abuse; and depression (Pattison & Kahan, 1983). Delicate self-mutilators are more likely to come from families of neglect, divorce, or they have been deprived of parental figures. Self-mutilators also experience loss through emotional distancing and inconsistent parental warmth (Suyemoto, 1998). They also have a history of physical or sexual abuse. The incidence of self-mutilation in adolescents and young adults has been estimated at 1,800 per 100,000 (Favazza & Conterio, 1988).

Causation

Usually at 12 to 14 years of age, the delicate self-mutilator begins to experiment. At first self-cutting is done lightly and unnoticeably, but before long, adolescents begin to cut more often, with more pressure, and with longer strokes. For many, harming their own bodies represents being in control of their own body. It is a way of controlling the way others controlled them in the past (Farber, 2002). Walsh and Rosen’s (1998) research suggested many conditions that may predispose an adolescent to self-mutilate including, impulse control disorders, peer conflict, loss of a parent, witnessing family violence, sexual or physical
abuse and alcoholism in the family. Delicate self-mutilation is closely related to eating disorders, in that they both center on the issue of control. Simpson (1980) identified similar origins of both behaviors. Disturbance of body image, self-directed aggression, and self-destructive behavior were the most common.

The absence of appropriate attachment and nurturing also greatly influence the onset of self-mutilation. Favazza and Conterio (1988) found that more than half of the participants they studied described their childhood as "miserable" and 62% reported abuse. Lack of social support, and isolation were reported in half of Pattison and Kahan's (1983) study. Alderman (as cited in Zila-MacAniff & Kiselica, 2001) saw self-mutilation as a means of physically and emotionally keeping others at a distance. It seems appropriate to deduce that female delicate cutters, self-mutilate due to shame and secrecy because of trauma and then feel shame and secrecy about their cutting behaviors to the point that they have come full circle and now it controls their inner world (Briere & Gil, 1998).

Farber (2002) eloquently described self-mutilation as follows:

To walk through life deadened by depression or numbed by dissociation is to feel dead inside. Bodily pain can jolt one momentarily out of a depression or dissociated state and make one come alive again. To feel pain in the body is to experience it as alive and vital, a welcome relief that mitigates the severity of the physical pain (p. 285).
Experience of the Self-cutter

In the absence of better coping strategies, self-mutilation becomes a way to calm down. It is a way of escaping from an overwhelming state of emotion. After self-cutting, the adolescent feels more normal, less confused, and relieved (Zila-MacAniff & Kiselica, 2001). A female adolescent often reports feeling anxious, tense, angry, or fearful just before cutting. Sometimes she reacts to her overwhelming emotions by dissociating. Her cutting is usually controlled and she is at little risk for suicide. Razor blades are the tool of choice by adolescents; they are easy to purchase and easily hidden in a backpack. The majority of cutters experience little pain during the act. Most inflict cutting on their forearms, hips, and ankles. Few, but some, cut on their stomachs and thighs. Occasionally, adolescents will feel guilt or disgust after they have self-cut but the more common response is relief and calm.

This author has received consent to share the typical experience of one of her clients in order to create a profile of what this paper will attempt to treat and of what a female adolescent self-mutilator experiences. This 19 year old, Hispanic and Native American girl received some distressing news and was flooded with fear, anger, hostility, and intense sadness. She began to feel "good for nothing", and she felt lightheaded. She was alone in her room and could see that she had a razor blade in her hand. During this time she felt like she was outside of herself watching what she was doing. She tried to stop the person she
saw cutting but it was as if she was screaming but no words would come out. All of the sudden she was jolted back to reality and discovered that she had cut and the blood was dripping on the carpet. Her mother called from the kitchen to come and eat and she began to feel intense guilt for not being able to stop herself because she has been able to in the past. The client was in a dissociated state but she could see herself cutting. She was oblivious to her surroundings and unaware of the pain.

Treatment

Goals of Treatment

Talking about one’s experiences makes them real. To know what is inside themselves, their feelings and sensations, they must be able to talk about experiences and their inner world. Because some adolescents might not be able to do this, they replace verbal communication with gestures of body language (Farber, 2002).

The overall task of treatment is to help the adolescent move from living in the immediacy of bodily experience to living within a reflective self in a representational world, and second to take the attachment relationship in treatment and use it to bridge new and different relationships in the real world (Farber, 2002). Another critical goal is to help the adolescent explore the meaning of her cutting and what is creating the conflict within her. This could be difficult due to the fact that younger adolescents are still trying to identify and form their true self.
Before the adolescent can care for herself, she must feel cared for and protected and know that her well-being is foremost in her therapist's mind. A working relationship must be formed in which the adolescent feels safe and secure, that over time can change the traumatic attachments in her mind.

Treatment should aim at helping the adolescent develop the ability to tame her aggression and impulsivity, alter a negative body image, and develop a greater capacity for self-care, affect, tolerance, and an ability to use words symbolically instead of gestures (Farber, 2002). Given that anger, low self-esteem, abandonment, and the lack of ability to self-soothe are the most common reasons for adolescents to self-mutilate, treatment should focus on these issues as well as the meaning behind the self-cutting.

Farber (2002) stated, "Treatment must address three issues: the pathological split between mind and body, the perceptual and conceptual disturbances, and the severe ego regression suffered" (p. 361). Treatment should be tailored to the specific needs of the adolescent. Some may be better treated by an exploratory approach, while others might need a more supportive treatment.

**Biological Treatment**

Bandaging, ointments, or a placebo pill will only indirectly act on the underlying psychiatric problem, but they may be beneficial in symbolizing the concern and care that adolescents are craving. Biological means of treatment may
also open the door to supportive psychotherapy and be used as a motivator (VanMoffaert, 1990).

Few adolescents who self-mutilate actually need to be hospitalized. Hospitalization can actually be more damaging than good. Involuntary hospitalization can affect the therapeutic relationship in a negative way, breaking apart trust, communication, and rapport.

**Pharmaceutical Treatment**

There is no concrete evidence that any current medication can consistently control self-mutilating behavior. Even though there is no specific medication, most adolescents who self-mutilate are treated pharmaceutically at one time or another. Medication can control the basic diseases, mania, depression, and schizophrenia in hopes that it may reduce self-mutilation (Favazza, 1987). Some medications prescribed are antidepressants, lithium, tranquilizers, and anxiolytics (VanMoffaert, 1990; Favazza, 1998). Even these medications will only be a temporary solution if nothing is done to look at the underlying problem that led the adolescent to self-mutilate.

In addition, all of these medications have side effects, some of which are very unpleasant. Medication can exacerbate adolescents' difficulty to recognize and understand how they feel. They can also interfere with their ability to communicate their emotions.
Electroconvulsive Therapy (ECT)

Professionals who consider self-harm to be a symptom of severe depression may consider ECT. Although exactly what happens in the brain during ECT is not known, it is still regarded as an effective and useful treatment to many in the psychiatric profession. A course of treatment typically consists of two convulsions a week for six weeks. There is no evidence that this is effective in reducing self-mutilating behavior and any improvement seems to be short term. It also has side effects including memory loss and confusion (Smith, Cox, & Saradjian, 1999).

Trauma Focused Therapy

Some therapists believe that if an adolescent’s trauma is worked through and integrated into their experience, then they will not feel the need to self-mutilate. This type of approach provides a supportive, respectful, positive, and validating relationship. The adolescent is not seen as ill but as a person who has been shaped by her experiences and an unbearable event. The goal is to help the adolescent surface thoughts and feelings associated with the trauma that she has avoided and hidden. In doing this it is hoped that the adolescent can resolve past trauma and regain her sense of control over her emotions without resorting to self-mutilation (Smith, Cox, & Saradjian, 1999).
Behavioral Therapy

The literature on behavioral therapy is cumbersome and complicated. Most articles refer to mentally handicapped patients and see self-mutilation as a learned behavior maintained by positive reinforcement. Behavioral therapy is based on the idea that only behavior that leads to reward is repeated: Change occurs by either altering the way those rewards are obtained or by preventing those rewards from being obtained by the behavior. Behavioral therapy for self-cutting focuses on the removal of positive reinforcement by withholding attention following an act, or isolating the adolescent to exclude her from any form of reinforcement (Favazza, 1987). Unfortunately there are some therapists who use very simplistic approaches to this complex problem. One example is “thought stopping”, which involves the adolescent telling herself to stop and imagine a STOP sign each time the desire to self-mutilate arises. These techniques aim to stop the behavior without dealing with the real cause (Smith, Cox, & Saradjian, 1999). Van Moffaert (1990) stated that behavioral techniques are necessary to “cure the self-mutilating habits” which often remain after conflicts in psychotherapy have been resolved (p.379). Relief is often temporary or self-mutilation is replaced by an eating disorder or a drug problem (Zila-MacAniff & Kiselica, 2001).
**Behavioral Diagnostic Intervention.**

Bailey and Pyles (1992) described a behavioral approach to analyzing and treating self-mutilation. Behavioral Diagnostics involves collecting all possible information about a client and the events surrounding the self-mutilation and then employing active and passive behavior management. The active behavioral intervention of choice is compliance training and another is aversion intervention. The most common passive behavioral interventions are improving communication by the client, teaching the staff more adaptive responses, allowing clients more choices and input into their own treatment, and finally, “Do not treat; Be more tolerant” (Bailey and Pyles, 1992, p. 175).

**Dialectical Behavior Therapy**

Dialectical Behavioral Therapy has been found effective at reducing the incidence and frequency of all forms of self-mutilation in women and adolescent girls (Suyemoto, 1998; Ivanoff, Linehan, & Brown, 2001). This approach combines behavioral, cognitive, and supportive interventions. It focuses on problem-oriented techniques including exposure to emotional cues, skill training, and cognitive modification, which are balanced with empathy, and acceptance (Suyemoto, 1998). Adolescents treated with this approach also receive group therapy to develop tolerance to stress and develop interpersonal skills.

There are four stages in Dialectical Behavioral Therapy. The pretreatment stage consists of orienting the adolescent to the structure and philosophy of the
program. A contract to refrain from self-cutting is drawn up at this time. Stage one targets the behavior with the goals of decreasing the self-mutilation, and increasing tolerance, and regulation skills. Stage two targets post traumatic stress. The adolescent must possess a strong commitment to living and succeeding before this stage can be entered. Stage three addresses self-respect and achievement of individual goals (Ivanoff, Linehan, & Brown, 2001).

**Cognitive Therapy**

Cognitive therapy makes a connection between an adolescent’s thoughts and her self-mutilation. It addresses the difficulty these young women have with verbal communication of emotions. Walsh and Rosen (1998) discovered four categories for thinking that lead to self-mutilation and can best be addressed with cognitive therapy. These include: self-mutilation is acceptable, one’s body and self are disgusting and deserve to be punished, action is needed to feel better, and action is needed to communicate feelings to others. Talking in therapy and actively addressing these four ideas have proven successful according to Walsh and Rosen (1998) and Farber (2002).

**Family Therapy**

Given that relationship issues are most often reported as the trigger of self-mutilation, it seems reasonable that family therapy would be beneficial. Family therapy can help the members of an adolescent’s family become more sensitive to
her situation and possibly intervene in more helpful ways instead of yelling, grounding, or punishing the behavior.

**Psychotherapy**

For some adolescents self-mutilation is easier than self-reflection. Adolescents can find it easier to describe the events that lead up to the act, and through this they can begin to gain insight into the reasons for cutting (Gardner, 2001). Some adolescents find it easier to talk about their dreams rather than feelings. They feel less exposed or more detached. Dreams brought to therapy can be very revealing about inner conflict. Getting adolescents to write about their feelings can also help them and their therapist to see the adolescent's inner life (Farber, 2002). The more difficult part is to understand what lies beneath the behavior and what it may symbolize to the adolescent. A survey by the Mental Health Foundation (1992) indicated that adolescents should be seen as the expert on their own thoughts, feelings and what works and does not work. The Mental Health Foundation also found that compared to physical treatments, 88% of their sample thought talking treatment was more helpful (Smith, Cox, & Saradjian, 1999). The job of the psychotherapist is to understand while exploring the destructive attempts of the adolescent to take control of her life (Gardner, 2001).

**Multimodal Therapy**

Most therapists have a specific theory they prefer to follow. Many treatment techniques have been offered and no single technique is better or more
helpful on its own. What is suggested is that many approaches are used in combination to achieve a successful outcome. Walsh and Rosen (1998) have consistently found it necessary to use a Multimodal approach. Multimodal therapy is a comprehensive, systematic, holistic approach to behavior therapy developed by Arnold Lazarus (Corey, 1996). Together, the adolescent and therapist determine what relationship and what treatment strategies will work best.

Therapist’s Perspective

Unlike a theory that has concrete beliefs and modalities, the therapist’s perspective of self-mutilation has beliefs based on current experiences and observations. The purpose of the therapist’s perspective is to allow for a more realistic view of treatment by illustrating what happens in the therapist’s office instead of trying to make self-mutilation fit a theory. Often therapists in training are surprised and caught off guard by self-mutilating girls because the girls do not fit the mold of what the therapist was taught in his or her classes.

From the therapist’s perspective, dealing with a client who self-mutilates can be challenging, difficult, and sometimes frightening. Therapists are concerned that they will be held responsible for the behavior of their clients (Conterio & Lader, 1998). Not all therapist are suited for working with this population. Some may find the behavior too upsetting or frightening to deal with, and a therapist who is disgusted by a client’s behavior can only do more harm by continuing therapy.
Attachment

The success of therapy for self-mutilation is correlated with two factors related to attachment rather than specific techniques or orientations (Kroll, 1993). First, is the fit between the client and therapist, which is a positive therapeutic alliance. The second factor is supervision of some sort for the therapist. This provides the therapist with the supportive attachment from colleagues or supervisors that they need to maintain safety and security during a potentially difficult treatment (Farber, 2002). At the heart of psychotherapy is a safe and secure attachment that has the potential to alter and repair the attachments to pain and suffering in the self-mutilators mind (Pao, 1969). The main ingredients for success with self-mutilators are stability, consistency, reliability, and the formation of a positive therapeutic alliance. No therapist can provide consistency and reliability if they are caught up in their own anxiety brought on by the client’s self-destructive threats and actions.

The therapeutic alliance is the means by which the therapist and the client work together towards the same goal (Farber, 2002). It is the significant interactions between the client and the therapist that lead to change. Some clients may need to take time getting used to being a client whereas others have been through treatment in the past and have been in the client role before. Ultimately, therapists need to begin where the client is, and many self-mutilators are at a level that makes the capacity for a therapeutic alliance very difficult. Often times the
therapeutic alliance represents the end of successful therapy, and not a mechanism by which therapy works (Kroll, 1993). This is because the most pronounced features of the client’s difficulties are those that block the development of the therapeutic alliance in the first place.

Problems in Treatment

If there is anything that makes a client even more anxious and dissolves any sense of hope, it is an anxious therapist with whom a meaningful attachment is problematic. Self-mutilating adolescents arouse feelings in their therapists from confusion, contempt and anger, to a genuine desire to help. When a therapist’s attempts to get their client to stop self-mutilating fails, the client can feel misunderstood, and the therapist perceives themself as being ineffective and overwhelmed (Himber, 1994). Only after admitting that the therapist does not fully understand the self-mutilating adolescents world, and suspends clinical judgment, can the adolescent be able to explain her behavior.

Trauma is contagious in that all therapists run the risk of developing symptoms of traumatization from their client. Listening to and accepting the client’s stories of victimization and despair can be overwhelming. Therapists often feel incompetent to respond and may feel angry with the client for provoking such feelings (Farber, 2002). Consultation with supervisors and colleagues experienced in self-mutilation is more likely to keep the therapist from becoming traumatized by the work.
Adolescent female clients want what everyone wants, to speak, to be listened to, to be heard, and to feel real. The therapist’s interest in the meaning of self-mutilation gives the client the idea that there is a method and reason to her madness, which is a new and welcomed way of thinking about herself, one that is healthy (Conterio & Lader, 1998). To tell the client that she is being understood and help her verbalize what she is unable to say herself, takes the behavior out of the realm of craziness and into the realm of communication. The therapist’s curiosity and willingness to serve as a guide provides hope, helps engage the client’s own curiosity about herself, and provides motivation (Farber, 2002).

Expecting the client to make big changes in her self-mutilating behavior is not realistic and can set her up to fail and feel even worse about herself. It is crucial that the therapist not force his or her own agenda on the client. This is done by not having an agenda and being forthright and transparent about his or her motivations and values (Walsh & Rosen, 1998).

A common experience for therapists working with female adolescent cutters is that it is often difficult to go below the surface statements. It may be hard to get to the meaning behind the gesture. It may be very difficult for the client to think about her difficulties and talk about them with her therapist. Part of the necessary shift from surface talk to below the skin involves a move from acting out to acting in, in the sense of bringing the conflict into therapy. Gardner
(2001) made the comment that therapists need to make themselves ‘acted-out on’ more often. The benefit for the therapist is that they gain a sense of the client’s internal world and a glimpse at how past trauma is experienced in the present. It is also a means of communication. There is often a problem with silence when working with young girls. Silence can either mean that she is inhibited in general, or that she is embarrassed by her lack of vocabulary and has little to no exposure with thinking about feelings.

Projection by an adolescent female can be seen as a defense based on regression of an intolerable experience. This is what is projected onto the therapist. The cumulative effects of projection can leave the therapist’s resources drained. If the process of introjection and projection breaks down between the therapist and client, a stalemate is reached and no movement is possible in treatment (Farber, 2002).

A therapist preparing to work with female adolescent self-mutilators should plan for a period of crisis intervention. There may be times when symptoms get worse in therapy. If there is a loss or even a threat of loss of a significant relationship in her life, she may respond with increased self-cutting. Any worsening of the client’s self-mutilation during the course of treatment should be treated as a bodily communication to the therapist that something disturbing is going on in her life which she is unable to talk about (Pao, 1969).
Qualities of the Therapist

The therapist who chooses to work with female adolescent self-cutters needs to enjoy taking on a challenge and know that his or her efforts might fail, so the therapist must also be unafraid of failing. This type of therapist needs to be lively, vital, and interested in the client. They must also be willing to enter a long-term commitment. When an adolescent girl is devitalized and terrified of her own affective experiences, knowing her therapist’s vitality, strength, and humor can stimulate her hope for recovery and becoming alive again. A therapist who is not afraid to express humor, and sadness, laughter, and tears, is a therapist who can rekindle a spark in the client (Farber, 2002).

Many mental health therapists have strong rescue fantasies that may have lead them to this field. Self-mutilating clients have an uncanny ability to pick up on this and use it to evoke guilt in the therapist. The therapist, therefore needs a clear sense of professional and personal boundaries and must be in touch with their rescue fantasies. Frankel (2001) said the therapist is not a bystander, nor a rescuer who tries to undo the trauma. Rather, he or she is a witness: someone who knows by seeing and who affirms what they have seen.

Conclusion

Many of our young people today live life without the love and care that they need. They are told that their feelings do not count or they are never taught what feelings are. Many have been traumatized as young children and have never
been given the opportunity to deal with and heal the wounds inflicted in a healthy way. Before the adolescent can care for herself, she must feel cared for and protected and know that her well-being is foremost in her therapist's mind. The client becomes real and alive with the therapist. A shift in the defining role of young women to that of capable, strong, independent thinking women might eliminate the need for destructive coping mechanisms.

Self-mutilation is a perplexing phenomenon, but its increasing prevalence, especially among female adolescents, needs to be addressed. An increased awareness of self-mutilation by the general public and mental health professionals is a start. The inclusion of self-mutilation in the American Psychiatric Association's Diagnostic and Statistical Manual would be another significant step. This would not only validate the existence of self-mutilation but also allow for identification by counseling professionals. Regardless of whether this happens or not, more research into the causes and treatments of self-mutilation in adolescent females is necessary.
References


