Self-mutilation: a misunderstood behavior

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Abstract
Self-mutilation is most accurately described as the intentional harm of one's own body. Individuals engage in this behavior as a means of coping with intense emotions. The act of harming one's own body provides a release of endorphins, which provides the self-mutilator with a sense of relief. This behavior is becoming problematic within the adolescent population and a growing concern for those in the field of school counseling. School counselors need to have a strong grasp of the characteristics, functions, and intervention strategies involved with self-mutilation to be effective advocates for this population of students.

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SELF-MUTILATION: A MISUNDERSTOOD BEHAVIOR

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Abstract

Self-mutilation is most accurately described as the intentional harm of one's own body. Individuals engage in this behavior as a means of coping with intense emotions. The act of harming one's own body provides a release of endorphins, which provides the self-mutilator with a sense of relief. This behavior is becoming problematic within the adolescent population and a growing concern for those in the field of school counseling. School counselors need to have a strong grasp of the characteristics, functions, and intervention strategies involved with self-mutilation to be effective advocates for this population of students.
Self-Mutilation: A Misunderstood Behavior

Self-mutilation is described as “the direct and deliberate destruction of one’s own body tissue without suicidal intent,” (Nock & Prinstein, 2005, p.140). According to Pipher (1994) self-mutilation can be cathartic, as a way to calm down and relieve the intense feelings experienced. The origin and purpose of this behavior is debatable within the field of counseling and psychology. Even today, it continues to baffle the most educated professionals. It is difficult to conceptualize how a person could cause harm to his or her own body as a way to relieve emotional pain. However, despite the lack of research, self-mutilation is real and is becoming increasingly popular among adolescents. According to Ross and Heath (2002), an estimated 13.9% of high school students report engaging in self-harming behavior at least once during their lifetime.

Since the research on self-mutilation is limited and counselors are not adequately trained in this area, those who engage in this behavior often have difficulties finding help (MacAniff-Zila & Kiselica, 2001). These individuals are left feeling helpless and alone with this secret behavior and their pain. They often feel shameful and guilty, which continues to add to the complexity of self-mutilative behaviors. It is crucial that counselors become more adept at working with these cases, as self-mutilation becomes more prevalent within the adolescent culture.
School counselors in particular need to have a strong grasp in regard to identifying characteristics, prevention, and intervention techniques concerning self-mutilative behavior. Furthermore, they need to have a basic understanding surrounding the reasons an individual self-mutilates, especially since this behavior generally begins during early adolescence and continues through young adulthood (Nock & Prinstein, 2004; Froeschle & Moyer, 2004; Ross & Heath, 2002).

School counselors have the unique opportunity to not only intervene during the early stages of this behavior, but also to educate and counsel individuals struggling with this problem, as well as educate the adults involved in these students' lives. They also play a vital role in referring students and their families to community agencies that counsel individuals struggling with this behavior.

The purpose of this paper is to examine the current research and trends associated with self-mutilative behavior. The bottom line is that self-mutilation works. It creates a temporary sense of relief in those persons who hurt themselves, while causing turmoil and emotional pain following the physical act.

To understand how to best counsel, support, and guide the self-mutilator, school counselors must first understand how this behavior works within the brain itself, and what characteristics lead a person to engage in this means of coping. This paper will explore the function of self-mutilative behavior, the individual characteristics associated with those who self-mutilate, and effective counseling methods for treating this population.
Self-Mutilation: A Misunderstood Behavior

Self-Mutilation

The Behavior

Self-mutilative behavior is often misunderstood as a suicidal gesture; however, it is not. When an individual engages in this type of behavior, he or she causes intentional harm to his or her body as a means of coping with intense feelings. It is uncertain how an individual discovers self-mutilation. Yet, according to Kluger (2005) “Self-mutilators say they began cutting for one of two reasons: to feel less or feel more,” (p. 48). Self-mutilation becomes a life sustaining behavior, a way to cope with powerful emotions the individual sees as unmanageable within his or her life (Conterio & Lader, 1998).

Self-mutilative behavior is performed in various ways. The most common methods used among adolescents are self-cutting and self-hitting (Ross & Heath, 2002). Other types of self-mutilative behavior include carving, scraping, biting, picking, burning, and erasing the skin. Inserting objects under the skin, self-tattooing, and pulling out one’s own hair are also included (Nock & Prinstein, 2004). The most common target for self-mutilative behavior are the arms and legs, or a place where the cuts and scars are not readily visible (Conterio & Lader, 1998). This behavior is usually performed until the individual sees blood and/or begins to feel an emotional release. The self-mutilator is generally ashamed of this behavior; for that reason, self-mutilative behavior is most likely to occur when the individual is alone.
According to Nock and Prinstein (2005) the majority of self-mutilators think about engaging in self-harming behavior for less than three minutes before they act. This finding suggests that the amount of time spent deciding whether to engage in this sort of behavior or not is limited. The self-mutilator has little time to react to the intense emotions and desire to hurt his or her body. Furthermore, self-mutilators experience little to no pain while mutilating their body. Instead, they report experiencing a sense of calm and relief from the emotional state they experienced prior to self-mutilating. These factors create a dilemma in working with those who self-mutilate for counselors, especially since the time spent contemplating the act and the likelihood of the individual experiencing an unpleasant or painful natural consequence because of the act are minimal (Nock & Prinstein, 2005).

*The Physiology of Self-Mutilative Behavior*

"When the body is injured, hormones called endorphins are released to fight anxiety, agitation, and depression," (Levenkron, 1998, p.41). Self-mutilating prompts the brain to release endorphins, which creates a temporary high (similar to one would experience using a mind-altering substance). The endorphins block the pain that cutting or the harming of bodily tissue would normally cause, providing the individual with a sense of relief instead of pain (Nock & Prinstein, 2005). The self-mutilator is in a state of dissociation where he
or she is psychologically detached from reality (Galley, 2003) while he or she cuts.

The self-mutilator does not feel physical pain in the same manner one would expect. Harming the body creates the opposite reaction, causing the individual to feel a sense of calmness to the overwhelming emotional pain he or she is experiencing (Miller, 1994). Essentially, the self-mutilator not only experiences physical pain differently, but emotional pain has become confused within his or her mind as well. Attacking the body then becomes a means of regulating and maintaining a balanced emotional state without the presence of better coping strategies (Pipher, 1994).

Self-mutilation can become addictive (Mehta, 2004), similar to an addiction to drugs or alcohol. The self-mutilator becomes addicted to the release of endorphins the self-harming behavior provides. Self-mutilators behave in a way that could be classified as “chasing the high” in some circumstances. For instance, “cutters in particular find they have to make deeper cuts more often to get the same effect.” (Mehta, 2004, p.12). This behavior is similar to the addict who increases his or her use of mind-altering substances (to experience the release of dopamine and serotonin in brain) in hopes of reaching that initial high. Eventually, like the addict, the individual begins to use self-mutilation as his or her sole means of coping with intense emotions, and searching for the neurochemical high becomes normal (Kluger, 2005).
The Function of Self-Mutilative Behavior

Adolescence is a time for teenagers to begin exploring how to manage their moods and relationships. Hormones are also changing during this time, which may cause adolescents to feel as if they have even less control over their moods. All these issues are normal during adolescence. However, when you couple the normal changes with some type of trauma or abusive situation, this normal developmental rite of passage becomes more complicated as the adolescent searches for a way to relieve emotional pain. Adolescents who self-harm experience overwhelming feelings of hopelessness (Whotton, 2002).

Nock and Prinstein (2005) determined four primary functions of self-mutilative behavior for adolescents: automatic negative reinforcement (to stop bad feelings), automatic positive reinforcement (to feeling something, even if it is pain), social negative reinforcement (to avoid doing something), and social positive reinforcement (to get attention). The purpose behind self-mutilative behavior among adolescents is generally categorized as automatic negative reinforcement (Nock & Prinstein, 2005).

The self-mutilator simply wants the emotional pain to stop and has discovered that physical pain can heal emotional pain. Self-mutilation becomes a way to regulate intense or complex emotions that may otherwise seem hopeless (Tyler, Whitbeck, Hoyt, & Johnson, 2003). Furthermore, Haines and Williams
(2003) found that tension and anxiety are greatly reduced through self-mutilation, so although it is not a healthy means of coping, it is effective.

Levenkron (as cited in Ellis, Gormley, Ellis, & Sowers, 2002) described the process an individual goes through during an act of self-mutilation. “First, the individual experiences feelings of tension or intense emotion, which is followed by a deliberate act of self-harm. This act produces a sense of emotional relief. Afterwards, the individual feels ashamed of the act and fears someone finding out what they have done, so they quickly hide the evidence,” (p.77). The act of self-harming occurs rather quickly; however, the shame and guilt that accompanies the act stays with the individual. It becomes a vicious cycle and the individual feels alone in how he or she feels and copes.

Profile of a Self-Mutilator

Characteristics

The self-mutilator is most likely to be a female adolescent (Nock & Prinstein, 2004; Ross & Heath, 2002) and of above average intelligence (Froeschle & Moyer, 2004). Simmons (2002) noted that girls tend to internalize negative feelings because the outward expression of anger is not as socially acceptable for girls as it is for boys (Ross & Heath, 2002). Therefore, young females are more likely to turn negative emotions inward, and self-mutilation becomes a way to manage these emotions. Males also engage in self-harming behaviors, but research on this population is limited (MacAniff-Zila & Kiselica,
2001) and it is difficult to determine what behaviors fall into this category since it is common for males to have bruises, scrapes, and scars.

An individual who self-mutilates has difficulties expressing negative emotions (Mehta, 2004), specifically finding the words to describe feelings (Levenkron, 1998). In fact, sharing and experiencing emotions seems unrealistic. He or she believes that no one could understand the emotional pain, or the behavior used to cope with that pain. Consequently, the self-mutilator is ashamed of the emotional pain and the behavior used to cope with it. Therefore, since this individual chooses not to discuss these feelings and behaviors with others, he or she often feels isolated (MacAniff-Zila & Kiselica, 2001).

The self-mutilator usually has a combination of depressive and/or generalized anxiety disorder (Levenkron, 1998). Ross and Heath (2002) found higher levels of anxiety in adolescents who self-mutilate. The anxiety grows until the individual cannot manage it any longer. Self-mutilation becomes the coping mechanism, as sharing and experiencing real emotions seems unrealistic self-mutilators.

There is also a strong connection between self-mutilation and other addictive behaviors, according to Conterio & Lader (1998). These authors stated that many individuals who self-mutilate also abuse alcohol and/or drugs or suffer from an eating disorder, and that approximately 61% of self-mutilators are also diagnosed with either bulimia or anorexia. In addition, 56% of individuals who
self-mutilate identified having a problem with alcohol and 30% had experimented with other drugs (Conterio & Lader). Self-mutilation then becomes a symptom of a classifiable disorder.

**Childhood Trauma and Sexual Abuse**

In addition to being female, the typical self-mutilator is most likely a survivor of childhood sexual abuse and/or another type of childhood trauma. Childhood trauma and sexual abuse often leave an individual with many questions, overwhelming pain, and fear. When a child is left alone to cope with an abusive and/or traumatic incident, he or she is often unable to express his or her emotions and has no one to share or validate the experience (Frankel, 2001). The emotional pain is often so overpowering that the individual learns to be numb to it, and begins to feel nothing (Kluger, 2005). Research findings reveal that sexually abused children display more symptoms and disturbances in functioning such as suicidal ideation, sexual aggression, and self-mutilation (Kisiel & Lyons, 2001). Furthermore, “self-mutilation is often associated with the inability to deal with one’s sexuality due to earlier or ongoing sexual abuse, or rape,” (MacAniff-Zila & Kiselica, 2001, p. 48).

Levenkron (as cited in Froeschle & Moyer, 2004) stated, “Cutting becomes a re-enactment of childhood trauma, a method of communicating the unspoken, and a way to manage the psyche,” (p.234). The self-mutilator is searching for emotional balance that has been threatened by a traumatic
Self-Mutilation: A Misunderstood Behavior

experience. Miller (1994) suggested that adolescents who hurt themselves are searching for an escape from emotional pain experienced during childhood and become preoccupied with the need to regain control (Froeschle & Moyer, 2004) within his or her life. Once the individual begins to self-mutilate, he or she forms a connection between the self-mutilative behavior and the emotional release experienced, which gives he or she a sense of control over his or her emotions.

Treatment Recommendations

Counselors who have little to no training about how to work with these individuals often feel at a loss of what to do. However, according to MacAniff-Zila and Kiselica (2004) as long as the counselor acknowledges that he or she does not understand this behavior and lets go of the need for answers, the individual client is able to explain how self-mutilation works in his or her life. By letting go, the counselor is able to gain insight into the client and create more effective interventions, while the client becomes an active participant within recovery (MacAniff-Zila & Kiselica, 2004).

The relationship between counselor and client is of the utmost importance when working with individuals who self-mutilate, because it is when the client feels misunderstood that treatments fail (Himber, 1994, as cited in MacAniff-Zila and Kiselica, 2004). Levenkron (1998) stated, “As the connection between patient and therapist becomes stronger, the benefits of self-wounding become weaker,” (p.112).
The counselor needs to be prepared to bear witness to the client's pain (Frankel, 2001). Because self-mutilative behavior is commonly a symptom of past childhood abuse and trauma, the counselor must be ready to explore these events and how they affect the clients present and future (MacAniff-Zila & Kiselica, 2001). Since the self-mutilator feels very alone and vulnerable with his or her pain, the counselor needs to be sensitive to these emotions and create a safe and open environment. The counselor must keep in mind that although a situation may not be classified as abusive, it is the perception of the client that is most important (Frankel, 2001). Therefore, if the client senses the counselor passing judgment, the therapeutic process will be in jeopardy.

*The Role of the School Counselor*

Although, the school counselor most likely would not provide intense therapy with a student who self-mutilates, he or she plays a crucial role in identifying this type of student. School counselors are in a position to intervene early on, while providing support and education to others within the school. The school counselor needs to be prepared to consult with outside agencies for support and guidance in these cases, especially since most school counselors are not sufficiently trained to provide intense individual and/or family therapy within the school setting. Therefore, it is appropriate for the school counselor to refer the student and his or her family to an outside agency for individual and family counseling (Froeschle & Moyer, 2004).
While working within the school setting, it is important to follow school procedure and notify school personnel and parents where appropriate. If the school counselor decides to refer or involve parents, it is important to be open and honest with the student. The student will need the counselor’s support and guidance as other people become more aware of the current situation, especially since the student is most likely experiencing intense feelings of shame about this behavior.

School counselors also have a responsibility to educate others within the school. This instruction can take the form of presentations that emphasize the importance of the educators’ role of listening and supporting the student (Froschle & Moyer, 2004). Teachers can also be supportive by allowing and encouraging students to visit with the school counselor when intense emotions are evident (MacAniff-Zila & Kiselica, 2001).

In addition, school counselors can work with classroom teachers to educate students in the classroom. These presentations could include information about drug and alcohol abuse, violence, self-esteem, assertiveness training, and healthy ways to express troublesome emotions (MacAniff-Zila & Kiselica, 2001). These topics are appropriate for all students, in addition to those who self-mutilate. It is important for both the school counselor and teachers to model appropriate expression of feelings and assertiveness to give students a guide to managing their own emotions.
Although school counselors do not provide it, family counseling is instrumental in the change process when dealing with a child or adolescent who self-mutilates (Miller, 1994). Levenkron (1998) described the two goals of family counseling as providing a consistent source of information regarding self-mutilative behavior and a source of strong emotional support for the family. The family must process and gain an understanding of the events that brought their child to mutilate his or her body as a means of coping (Levenkron, 1998). Family counseling is one therapeutic method where families can begin to explore their feelings about this behavior, each other, and recovery.

Parents are in a position to provide strong emotional support for a child or adolescent who self-mutilates (Mehta, 2004). They often know their child best, and are key players in the recovery process. However, parents are often at a loss of what to do. As part of the counseling process, parents need to be educated on how to support, guide, and communicate with their child (MacAniff-Zila & Kiselica, 2001). Additionally, parents must have a strong grasp of what behaviors constitute as self-mutilation, as it will be their responsibility to make accurate assessments regarding the nature of behaviors exhibited within the home (MacAniff-Zila & Kisleica, 2001). It is most important to support and guide parents in keeping their child safe, even if it is from him or herself. Parents not
only have a strong influence when it comes to changing these behaviors; they also have a responsibility to their child to be part of the healing process.

**In-Patient Treatment**

SAFE (Self Abuse Finally Ends) Alternatives in Chicago is the only in-patient treatment program for individuals who self-mutilate in the United States. According to the program founders, Conterio and Lader (1998), most self-abuse cases can be managed on an outpatient basis. However, there are cases that can benefit from a controlled setting, according to these founders. The SAFE program has three basic guidelines. To begin, the individual must want to get better. Without making a commitment to working the program, he or she will not be admitted. Secondly, whether the individual receives services on an in-patient or outpatient basis, he or she must have a therapist who plays a critical role in supporting an individual recovering from self-mutilative behaviors through the therapy process. Finally, the SAFE Alternative program focuses on each person as an individual. This program understands that the recovery process for each person varies, recovery from self-mutilation is not time limited, and one treatment does not necessarily work for everyone (Conterio & Lader, 1998)

**Intervention Strategies and Recovery**

**Cognitive Behavior Therapy Techniques**

Cognitive behavior therapy (CBT) techniques are most effective when dealing with self-mutilation because individuals struggling with self-mutilation
must learn to identify the connection between their thoughts and behavior, and
cognitive therapy focuses on making these connections (MacAniff-Zila &
Kiselica, 2001). Walsh and Rosen (as cited in MacAniff-Zila & Kiselica, 2001)
determined four categories of thoughts that lead to self-harming behaviors: that
self mutilation is acceptable, that the body is disgusting and deserves to be hurt,
that there is a need to relieve unpleasant emotions, and that this is the only way to
share feelings with others. The counselor works with the individual to identify
the underlying thoughts with regard to his or her emotions and/or the self-
mutilative behavior. Then, the counselor disputes these thoughts with the
individual while helping him or her make a connection between the thoughts and
behavior. Once these connections become evident, the counselor and individual
develop new thoughts and behaviors to replace the maladaptive patterns. This
process takes time and patience.

Behaviorally, these individuals must learn to change their thought
processes in a way they can stop hurting themselves (Pipher, 1994). In addition to
changing thought processes, the self-mutilator must learn healthy ways to relieve
stress, express intense emotions, and build relationships (Ross & Heath, 2002).
The counselor can support and teach these skills during individual and group
counseling sessions. The individual needs to become more aware of his or her
own mood cycles to be able to identify high-risk emotions and urges to self-harm.
The counselor and individual should work together to develop a safety plan to
keep from reverting to past self-harming behavior (Ellis et. al, 2002). It is also important to remember that there will be setbacks, and the counselor and individual should prepare for the possible relapse. Furthermore, as previously mentioned, those who self-mutilate may also be diagnosed with depression and/or generalized anxiety disorder, so medication may also be appropriate as part of a treatment plan.

**Skill Development**

Above all, the self-mutilator must improve his or her communication skills by learning to express feelings in words instead of manifesting them through self-harming behaviors (Levenkron, 1998). Since self-mutilators have become passive within their relationships, often compromising personal needs, they need to learn how to be assertive and state their needs, wants, and emotions to others in order to become a self-advocate. These skills are crucial to recovery and help them gain self-confidence.

The counselor can teach these skills during individual, group, and family therapy. In addition, the individual will need practice utilizing these skills. Role-playing during counseling sessions can be a useful way to practice assertive communication skills in a safe environment (Levenkron, 1998). In addition, the counselor may eventually invite others to participate in the role-plays or may be present with the individual as he or she confronts another individual. By
providing a safe environment, the counselor is able to set up more opportunities for success, thereby supporting the individual as he or she learns these new skills.

Unlike other emotional disorders, self-mutilation leaves physical scars that are a constant reminder of past behaviors and feelings (Levenkron, 1998). As part of recovery, it is necessary to discuss the scars and the feelings surrounding their permanency. The individual will need to decide how he or she wants to deal with any questions that may arise in the future regarding the scars, as well as feelings associated with them. The counselor needs to be sure to address how the scars could possibly trigger a relapse and help the client develop a safety plan. Family and friends should be made aware of the individual’s safety plan since the individual needs to have a strong support network as part of the recovery process.

Recovery

Developing healthy coping skills is of the utmost importance in terms of recovering from self-mutilative behavior. The individual must learn how to verbalize and express feelings in a proactive manner. If the individual is unable to acquire and utilize healthier coping skills, he or she is will struggle to let go of his or her maladaptive ways.

Overall findings suggest that the child’s age and severity of past abuse are strong predictors in recovery (Levenkron, 1998). In addition, the current support system and healthy trusting relationships the individual has within his or her life has a strong influence on the likelihood he or she will heal (Levenkron, 1998).
Self-mutilators feel very alone and misunderstood. The emotions they experience are intense and they often are at a loss of how to cope. Recovery depends on the individual's ability to find supportive and trusting relationships in which to share their deepest most painful emotions (Levenkron, 1998). If the individual is unable to find such a relationship, the prognosis for recovery is diminished.

Conclusion

Self-harming behaviors continue to be a challenge and baffle those working in the field of counseling. It can be frustrating working with individuals who hurt themselves. However, these individuals need support and help. Counselors, particularly school counselors who will encounter this issue, need to be prepared to intervene, listen, and counsel. These individuals need a supportive non-judgmental hand to guide them to a healthy recovery. There are treatment options available and school counselors have the unique opportunity to intervene early on. It takes kindness, patience, and a bit of humility to break through the strong walls of the self-mutilator. They are hurting in ways only they can describe, and the counselor is trained to listen in ways others cannot. This relationship is a partnership that can save someone from his or her worst enemy, him or herself.


