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Why people self-injure and what school counselors can do to help

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Why people self-injure and what school counselors can do to help

Abstract
Today school counselors are working more with students who choose self-injury. In order to do so effectively, it is important that counselors understand the nature of self-injury and effective ways to treat it. This paper looks at reasons behind self-injuring and explores the difference between self-injury and suicide attempts as well as the different classifications of self-injury. Knowing the risk factors such as loss, childhood illness, physical and sexual abuse, familial violence, familial self-injury, peer conflict, and impulse control problems will aid counselors in targeting at-risk students. Once risk factors were targeted, it was found that behavioral treatments that address the distorted thinking of self-injurers were often successful. Overall, counselors hold a powerful role in intervening and preventing self-injury.
WHY PEOPLE SELF-INJURE AND WHAT SCHOOL COUNSELORS CAN DO TO HELP

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Today school counselors are working more with students who choose self-injury. In order to do so effectively, it is important that counselors understand the nature of self-injury and effective ways to treat it. This paper looks at reasons behind self-injuring and explores the difference between self-injury and suicide attempts as well as the different classifications of self-injury. Knowing the risk factors such as loss, childhood illness, physical and sexual abuse, familial violence, familial self-injury, peer conflict, and impulse control problems will aid counselors in targeting at-risk students. Once risk factors were targeted, it was found that behavioral treatments that address the distorted thinking of self-injurers were often successful. Overall, counselors hold a powerful role in intervening and preventing self-injury.
“How will you know I’m hurting if you cannot see my pain? To wear it on my body tells what words cannot explain.’ By C. Blount” (Conterio et al., 1998, n.p.)

Self-injury is a growing epidemic in this country. More and more adolescents are injuring their bodies to help themselves cope with their stressors. According to Kress et al. (2004), an estimated 13 percent of adolescents are engaging in self-injurious behaviors. Austin (2004) reported the number to be approximately three million Americans and one in every 200 teenagers. By all accounts, this number is low. Many self-injurers are not accounted for – they do not draw the attention that suicidal persons do. Even though it seems as if this country is just becoming aware of self-injury, it is not a new phenomenon.

According to Conterio et al. (1998), self-injury is documented as early as biblical times. Bible verses report “demon-possessed” men who cut themselves with stones; the Middle Ages had flagellants who wandered around Europe lashing themselves in the name of society’s sins; and rites of passage or rituals to pacify angry gods have existed in practically every culture and every era.

However, when speaking of self-injury it is important to differentiate between it and suicide. Self-injury is not the same as attempting suicide (Ross, 2002). According to Ross, (p. 2) “distinction between these...is critical given the bulk of research findings which indicate that SM (self-mutilation) and suicidal attempts are distinct and have different etiologies.” Ross also found that defining and worse, treating self-injury and suicide attempts, as the same is dangerous to the client and therefore must be differentiated. According to Zila and Kiselica
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(2001, p. 47), “self-mutilation is considered an act of low lethality as opposed to the high lethality of a suicide attempt.” Further, they noted that self-injury leaves the person with a sense of relief whereas failed suicide attempts do not. In addition, the persons most likely to engage in the behaviors are opposite. Suicide is most prevalent in middle-aged men and self-injury in adolescent females.

Conterio et al. (1998) wrote that one of the main differences between the two was that self-injury is a life-sustaining act while suicide is a life-ending act. Those who self-injure are trying to ease their suffering but not by ending their lives. They further compared the danger of self-injury to that of bulimia, anorexia, or drug/alcohol abuse. All these can be carried to the extreme and at that point cause death – but death is not the primary focus (Conterio et al.).

Self-injury itself, however, can take many forms and there are many different degrees of injury. Kress (2003) has classified all self-injury into four categories: stereotypic, major, compulsive, and impulsive. Stereotypic is organically based, with such actions such as head banging, self-hitting, self-biting, and hair pulling. Kress also noted that major includes self-castration, eye enucleation, and limb amputation. People, who suffer from this classification, have severe psychosis and/or severe character disorder. Compulsive self-injury occurs automatically without any conscious urge. The injury can include repetitive hair-pulling, skin picking, and nail biting. Impulsive injury is repetitive and addictive in nature and includes injuries such as skin cutting, burning, self-hitting, and more. Conterio, et al. (1998) gave a list of the most commonly used methods. They include cutting skin (most common), hitting oneself, extracting
hair to excess, head banging, scratching to excess, biting oneself, burning oneself, interfering with healing wounds, breaking bones, chewing the lips, tongue, or fingers, eye enucleating, amputation of limbs, breasts, digits or genitals, facial skinning, and ingesting sharp or toxic objects. Conterio et al. noted that approximately 75 percent of those who self-injure use more than one method. Many times those who begin with cutting move onto burning, finding that they need a more severe wound to get the same relief (Conterio et al.) In many ways, it is as if the injurer is building a tolerance and needs to injure more and more and use harsher methods to get the high – much like a drug or alcohol abuser may. In fact, Conterio et al. further noted research that suggested the act of self-injury might indeed release chemicals into the brain, which are similar to addictive opiates. This may also contribute to the hard work and dedication it takes to stop the act.

Just as there are many varying degrees of self-injury, there are also many definitions. Suyemoto (1998, p. 532) defined self-injury as, “when...the individual is in a psychologically disturbed state but is not attempting suicide or responding to a need for self-stimulation or a stereotypic behavior characteristic of mental retardation or autism.” Yarura-Tobias (1995, p. 33) defined it as “a volitional act to harm one’s own body without intention to cause death.” Conterio, et al. (1998, p. 39-40) gave the definition that will be referred to for this paper’s purpose in their book, Bodily Harm (1998), “self-injury is the willful alteration of body tissue, in disregard for considerations of health and safety, which serves the purpose of restoring or preserving a person’s emotional equilibrium.” It is also
hypothesized that those who self-injure do so for the control that it gives one over their own body (Austin, 2004.) No matter the definition or hypothesis given, the common theme seems to be that these people have difficulty expressing their core feelings and emotions and find no other way to release the pressure other than by self-injuring.

There are many hypotheses about why people choose to self-injure. The persons who usually first discover that an adolescent is self-injuring are not the parents – but school personnel. Adolescents are more likely to turn to their teachers and counselors for help than to their parents (White, 2004). For that reason alone, it is important that all professionals working with adolescents are familiar with this epidemic. A school counselor is one person that the adolescent should feel like they can confide in without judgment or harsh reaction. However, without education on this topic, many would jump to incorrect assumptions or worse over-react and turn the student away from seeking further assistance. Conterio et al. (1998) noted that many self-injurers are isolated, lonely, scared, and depressed – they need someone who will listen with an unbiased ear and who better to be this person than the school counselor.

Research

Causes and Predictors

There are many theories of why people begin to self-injure. Princess Diana, who was a self-injurer, is quoted as saying, “You have so much pain inside yourself, you try to hurt yourself on the outside because you need help.” (Austin, 2004). Others have hypothesized that self-injury stems from cultural issues,
emotional deprivation, negative reinforcement, biology (endorphin rush), negative coping skills, and a need for a physical wound (Conterio et al. 1998). However, the most widely accepted reason for self-injury is an escape from emotional pain (Austin). Austin further noted that most teenagers are unable to handle the mounting pain associated with adolescents so they turn to self-injury as a way to get the feelings and emotions out. However, the self-injurer, most likely, does not want her injuries seen by others — that would interfere with her ability to do it (Austin). Because of this, the injurer may wear long sleeves year round, bands and bracelets, or other pieces of clothing and jewelry to hide the cuts and scars.

White, females in middle to late adolescence make up the majority of self-injurers (Suyemoto, 1998). Nichols (2000) reported that 9 out of 10 self-injurers are females. Ross and Heath (2002) noted that in one study, 64% were female and 36% were male. Conterio et al. (1998) believed the reasons men are less likely to choose self-injury include the following: they are more likely to externalize their anger; deny emotional or psychological problems — less likely to seek mental health treatment; and are more likely to turn towards alcohol and drugs rather than self-injury. Further, they find that one usually begins to self-injure around the same time she begins going through puberty (Conterio et al.). The researchers go on to correlate this to the fact that girls are entering into puberty earlier with every generation. These girls are forced to deal with their rapidly changing bodies before they have developed the cognitive and emotional capacities to do so. Furthermore, if they have not developed the coping skills to
deal with this mounting pressure, many will then choose the immediate relief of self-injury.

There are other predictors other than puberty that factor into someone choosing self-injury for coping. Conterio et al. (1998) noted many predictors or correlates of self-injury, which include issues concerning parents, whether it is a loss of a parent or extreme parenting styles. Conterio et al. reported that whether it is a male or female in their program, they are likely to state the same reason for choosing to begin self-injury, their parents. Conterio et al. further reported that both overly intrusive parents as well as underparenting could be predictors of self-injury. Those who have parents who smother or hover have difficulty thinking for themselves may cause the child to turn inward becoming secretive and withdrawn. On the other side, with emotionally absent parents, a child tends to lack in the development of a healthy sense of self. Conterio et al. wrote that any extreme of parenting is damaging to a healthy self-development. They found that a common theme throughout nearly all of the families was an atmosphere of severe anxiety and the inability for the parents to respond appropriately to the emotional needs of their child. These children were often given the message to “be strong” and to not show emotion.

However, nearly all of the research noted that the best predictors of self-injury are a history of sexual abuse and family violence. Nichols (2000) stated that 79% of self-injurers reported significant childhood trauma of sexual or physical abuses and that the earlier the abuse occurred, the earlier the self-injury would start. Conterio et al. (1998, p.144) wrote that there are common situations
among the families of self-injurers. They include “the presence of traumatic losses, illnesses, or instability in the family life (such as frequent moves)”; neglect or any form of abuse; strong religious views which are applied in inconsistent manners, and children taking on parental responsibilities prematurely or inappropriately. Sometimes, however, it is not the actual occurrence or actuality of abuse or neglect but the perception of such abuse or neglect, which may trigger self-injury. In their practice, Conterio et al. have worked with clients whose parents are awestruck at the types of accusations given by their child. The therapists noted that even though the accusations may be fabricated, they are still the client’s reality and therefore must be addressed as factual.

**Diagnosis**

There are two reasons why it is important to be able to diagnose and assess self-injury accurately. First, through proper assessment it will be possible to select proper diagnoses and to determine the severity and potential degree of danger. Second, the appropriate diagnosis will help lead to an effective intervention (Kress, 2003). According to Kress (p. 490), the *DSM-IV-TR* diagnoses that are most related to self-injury are “stereotypic movement disorder with self-injurious behavior, trichotillomania, impulse-control disorder not otherwise specifies, and bipolar disorder.” Conterio et al. (1998) break it down even further into Axis I (clinical disorder) and Axis II (personality disorder). Conterio et al. further noted they do not believe that self-injury should be classified as a distinct disorder, however, they stated that it may help the self-injurer and their family better understand the rationale that lie behind treatment.
For Axis I, Conterio et al. stated that mood disorder, anxiety disorder, thought disorder, post-traumatic stress disorder, and dissocialize disorders might fit. The later two may be assigned to those who have a history of severe traumatic abuse. As for Axis II, Conterio et al. noted that the following disorders could be assigned to self-injurers: borderline personality disorder and other personality disorders (such as dependent personality, passive-aggressive, paranoid, narcissist, and histrionic personality). Conterio et al. noted that bipolar personality disorder is the diagnosis that is most likely to be assigned to a person who engages in self-injury. Further, “one of the salient indicators of borderline personality disorder is a history of suicidal gestures or self-mutilating behaviors.” (Conterio et al., p. 177).

Also worth note is the connection between self-injury and eating disorders. In their book, Conterio et al. (1998) reserved an entire chapter to this connection. According to Conterio et al. (p. 7), the two most common words etched into the skin were “fat and ugly.” Nichols (2000, p. 151) calls this connection, “bad body fever.” Conterio et al. reported that of those who self-injure, 40.5% are bulimic, and 35% are anorexic. Conterio et al. hypothesis behind this connection was the association between the act of food/feeding and the symbolism of loving, nurturing, giving, soothing, need gratification, and sensuous pleasure. Therefore, someone who had a life where nurturing was somehow disrupted, food and eating become a part of the repertoire of self-injury. “Food, calorie counting, purging rituals, razor blades, and shards of glass are props that set the scene.” (Conterio et al., p. 119). Being aware of everything the
client is dealing with and their interconnectedness is important to proper
diagnosis, assessment, and creating of interventions.

Working with Self-Injurers

The earlier self-injury is caught, the less difficult it is to recover (Conterio et al., 1998). That is why school-counselors are in such a unique role when working with self-injurers. According to Kress (2003), school counselor will become aware of self-injurious behaviors before those outside of the school setting. This awareness may come from observations of injuries, reports by classmates, concerns from parents and/or teachers, and self-reports by the self-injurer.

School counselors have the responsibility to their students to facilitate student success be it academic development, career development, or personal/social development. Therefore, school counselors play an important role in ensuring that all students are safe and that they have the resources necessary to develop in all the above areas.

Treatments and Interventions

Before a therapist begins to work with the client to develop a plan, it is important to realize the psychological aspect of the self-injury. For example, most of those who self-injure do not feel the physical pain until later – sometimes days later (Conterio et al., 1998). Conterio et al. also report that those who self-injure have learned to dissociate themselves from their physical body in order to disconnect from the pain. Conterio et al. further noted that this dissociation was more than likely a skill developed early in life due to trauma. Many self-injurers
have noted that they view their body as an object and may continue to feel disconnected from it, even when they do not wish to do so (Conterio et al.).

Once a therapist has become aware of a person’s self-injury, it is important to act quickly since the earlier the detection the better the outcome (Conterio et al., 1998). First, assess what is actually happening. Like all other human behaviors, a continuum ranges from harmless to destructive. For example, piercing an ear, then a nose, and then a belly button can be harmless and innocent if the teenager does not come to crave the piercing and becomes depressed when she is no longer able to get them (Conterio et al.).

Once decided that the adolescent is in fact self-injuring, the therapist must then work with the client to develop a plan of action. According to Mace (2001), behavioral treatment yields better results, long-term, than does medication, specifically haloperidol. Mace reported that with behavioral treatments, 80% of those treated were responders compared to just 25% with haloperidol. Since behavioral treatment is proven effective, the question is then what exactly can a therapist do? According to Kehrberg (1997) it is important to recognize the negative cognitions or distorted thinking that the client has come to believe. These cognitions include “self-mutilation is acceptable”, “one’s body and self are disgusting and deserving of punishment”, “action is needed to reduce unpleasant feelings and bring relief”, and “overt action is necessary to communicate feelings to others.” (Kehrberg, p. 38). When a client has these beliefs, the first step is to stress that they can have these feelings and communicate them effectively without resorting to self-injury (Kehrberg). Therefore, Kehrberg’s choice of treatment
focuses on helping self-injurers alter their negative thoughts preceding the act. This type of therapy is also effective in preventing the self-injury, discussed later.

Along with recognition of distorted thinking, it is important to acknowledge the environment that may be enabling the self-injurer. Conterio et al., 1998, emphasize repeatedly that self-injury is a choice. They stated that those who chose to self-injure could just the same choose not to. Bottom line, the client must want change. With that said, there are changes that can make this choice easier. Pawlicki and Gaumer (1993) stated that the environment needs to contain structure, consistency, and predictability. These qualities should be implemented in all areas of the client's life, including the therapist-client relationship. This may be done by making detailed safety plans, which provide structure and support while stabilizing the client (Pawlicki and Gaumer). This plan should include identifying self-injury triggers, physical cues, and reducers related to self-injury; explore safe people and safe places to go when wanting to self-injure; and the deliberate avoidance of objects that could be used to self-injure (Kress, Gibson, and Reynolds, 2004).

Once the environment has been secured to the best degree possible, it is important to assess a student's vulnerability to suicide (Kress et al., 2004). Kress emphasizes that self-injury is not a premonition of suicide unless the student indicates a wish to die. To do this, Kress et al. noted the following considerations: an assessment of depression, helplessness, and hopelessness; suicidal ideation, plan and intent, preparation and access to a means of suicide, and past attempts; social support network; family history of suicide; and recent
stressors. Still, Simeon and Favazza (2001) stressed that one can have suicidal ideation and self-injure and still not be considered suicidal. Furthermore, an over-reactive stance could alienate the client and break an important alliance in the treatment of self-injury (Simeon and Favazza). This journey is a difficult one for everyone involved and at times intuition is just as important as the science.

Cessation is the ultimate goal for the injurer and those helping them make that choice. Dallam (1997) has indicated two important factors that help contribute to the ending of self-injury. First, it is important for the injurer to develop the ability to identify and verbally express their feelings. The self-injurer has the false belief that they are incapable of verbalizing their inner-thoughts and feelings. Conterio et al. (1998) stated this as a way of “displacing the feelings in your head onto your body.” (p. 276). They further noted that the ability to just be with your feelings is a strong sign of recovery - to allow them to wash over you. Because of this, a large portion of treatment then becomes realizing and facing the true issues that are leading to the behavior. Dealing with the issues rather than ridding the body of them is essential to recovery. Dallam’s (1997) second factor is learning to use behavioral alternatives instead of self-injury, allowing the client to connect to this purging of feelings. Through journaling, art, music, exercise, relaxation, etc. the client can begin to work through the core issues.

Prevention

Working through all the associated feelings and core issues will expectantly lead to the choice of cessation (Kress et al., 2004). Prevention, however, is the real goal when working with adolescent students. Knowing the
problems related to self-injury such as loss, childhood illness, physical and sexual abuse, familial violence, familial self-injury, peer conflict and intimacy problems, and impulse control problems will aid in targeting at-risk students (Kress et al.). Once these students are targeted, the techniques are nearly the same as in interventions. Kress et al. noted that the counselor can work with the students to help them effectively express, identify their feelings, and at the same time develop healthy behavioral coping skills. Group counseling and outreach activities can also be helpful (Kress et al.). However, according to Conterio et al. (1998), it is important that you do not allow those in groups to speak of their methods of self-injury. Like with eating disorders, their methods may give others in the group ideas and new ways of inflicting self-injury. The idea with prevention is to catch those who are at high-risk of choosing self-injury early and help them choose a different outlet (Kress et al.). In addition, it is important to find them other help as well (Conterio et al.). This additional help may come in the form of outpatient treatment or family service agencies (in the case of abuse/neglect.)

Unsuccessful Forms of Treatment

Along with the proven ways to help treat self-injury there are many that are unsuccessful. Being aware of these allows counselors to serve their clients better and faster. The following are cited in Favazza (1996) as ineffective forms of treatments: physical restraints, hypnosis, chemotherapy, no-cutting contracts (no long-term success), faith healing, group psychotherapy, relaxation therapy, electroconvulsive therapy, family therapy, educational therapy, and chiropractic care.
Ethical Considerations

Student's rights

When working with any student, school counselors need to be constantly aware of the ethical considerations surrounding each student. This is especially true when working with students who are harming themselves. According to the American Counseling Association, the primary responsibility of counselors “is to respect the dignity and to promote the welfare of clients” (as quoted in White, 2003, p. 47). However, school counselors also have the duty to warn (Froeschle and Moyer, 2004). The question is then when, even if, do school counselors break confidentiality. According to Froeschle and Moyer, breaking confidentiality can break an already rocky relationship and alienated student. Froeschle and Moyer also reported on a study conducted in Illinois by West & Kayser in 1991, which revealed that the number two reason why students did not confide in their school counselor was a fear of inappropriate disclosure. Vernon (1993) stated that the decision of whether to disclose or not is based on the student’s age and capability, the possible consequences on the therapeutic process, and the legal and ethical policies regarding confidentiality already in position.

Parental rights

In addition to the student’s rights are the parent’s rights. There are conflicting views on parent’s rights to access student information disclosed to school counselors. Fischer and Sorenson (1996) believe that school counselors have a right to secure the content of a counseling session while Ritchie & Norris Huss (2000) believe that even though the child is the client ethically, the parent is
legally. The research has no conclusive answers on this topic. Therefore, it seems it is up to the counselor to make an educated judgment call.

Conclusion

The good news about self-injury is that it is not something that defines a person—it is not a disease or addiction, it is a choice. Moreover, just like with every choice, once someone chooses to begin self-injuring himself or herself, he or she can choose to cease. However, this journey of stopping is not an easy or painless one—it takes motivation, strength, faith, and hard work. Once those involved choose to begin the healing process the first step is to delve into the core issues behind the injuring. School counselors are a great resource for the millions of teens who are struggling with self-injury. If made accessible, school counselors hold a unique role in the recovery process. In order to be this person, however, the school counselor needs to be educated, informed, prepared, and able to handle the specifics behind the issue. The school counselor should have a repertoire of community services and mental health counselors in the community to refer the student to for additional help while remaining the student’s number one ally and advocate. Self-injury hurts more than the injurer herself, so being ready with resources for all those involved is also an important part of the job.

The other good news about self-injury is that if caught early enough and treated effectively, many will recover (Conterio et al., 1998). Overall, counselors hold a powerful role in intervening and preventing self-injury. By educating parents, teacher, and students and by referring to specialists who can help, counselors are providing a voice for the student who has lost theirs.
References


