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Students who self-injure : how can counselors help

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STUDENTS WHO SELF-INJURE: HOW CAN
COUNSELORS HELP

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Students Who Self-Injure: How Can Counselors Help

Self-injury is called many things, such as self-harm, self-inflicted violence, parasuicide, self-abuse, delicate cutting, autoaggression, and self mutilation (Martinson, 2001). Strong (1998) states that self-injury is "...the deliberate, direct, nonsuicidal destruction or alteration of one's body tissue," (p.5). Based on this definition, there are many ways one could alter his or her body tissue and the level of injury can also range from minor cuts and the pulling out of eyelashes to first degree burns and limb removal.

There are three types of self-injury. Major self-mutilation is the most extreme form and also the least common. It is called 'major' because "a great deal of tissue is removed or destroyed," (Nadelson, 2000, p. 12). Examples of major self-mutilation are self-castration, eye gouging, or amputation of a limb or extremity. Nadelson (2000) states it is most often associated with psychotic states or acute drug intoxication. This means that generally those who indulge in major self-mutilation are possibly consumed with drugs and possibly hallucinating or having an out of body experience.

The second type of self-injury is stereotypic self-injury. This usually involves banging the head repeatedly on a hard surface, eye ball pressing, and finger and arm biting. This behavior typically occurs frequently in people "...suffering from disorders such as autism, schizophrenia, and Tourette's Syndrome," (Ng, 1998, p. 15). It is also commonly seen in mentally challenged patients in institutions. The behavior is usually fixed, rhythmic, and repetitive (Nadelson, 2000). It would not be rare to walk through the psychiatric ward and see many patients with such disorders standing near a wall in one spot and continually banging their heads against the concrete wall and not stopping until a staff member assists the patients in need.

Superficial, or moderate, self-injury is the third and most common form of self injury. 'Moderate' injures are inflicted on the body through cutting, burning, skin picking, bone breaking, and hair pulling (from the head and body) according to Nadelson (2000). Ironically, the previous examples are only deemed 'moderate' although blood is lost, tissue is damaged, and the person's body is altered in ways where it may never return to its normal state again, even after the self injury stops and much time has passed. Superficial or moderate self-injury is found through out the world in all social classes (Strong, 1998).

Branding, piercing, and tattooing are not considered self-injury unless the person is indulging in these behaviors for the same reasons one decides to cut or burn himself or herself. Body art is generally a conscious decision that is completed to make a statement. The people with tattoos and piercings are usually proud and want to show off their newly acquired body art, rather than being ashamed and wearing long sleeved shirts in the middle of summer.

This manuscript will address several components of self-injury, its victims, as well as assistance for those who do self-injure. The following sections will address the prevalence, myths, precipitants, discomforts, personal problems, assessments, risks, and treatments surrounding self-injury. This paper will conclude with some practical techniques and strategies that school counselors can incorporate in their counseling sessions with students who commit self-injurious acts.

Prevalence

Self-injury has been practiced for hundreds of years in many different countries and cultures. "...Australian Aborigines sliced open their penises along the urethra as

part of rites of passage. This act represented physical courage and served to bond together members of the same group” (Nadelson, 2000, p. 12). Foot binding was also practiced by many Chinese women. Small feet were considered to be a symbol of beauty and a sign of belonging to the upper class. Bones in the foot were literally broken and forced the women’s toes to bend into the sole (Nadelson, 2000).

It is estimated now that about two million people in the United States self injure. Ng (1998) states in the teenage years it is very common to see self-injury occurring in about the same number of boys and girls. However, by the time the teens that self injure reach adulthood, females far out number the males. Research states the average self-injurer starts at age 14 years, and most proceed through the 20’s up to the early 30’s (Strong, 1998).

The typical person who self injures is a young, intelligent, Caucasian woman from a middle or upper class background (Nadelson, 2000). Be aware that just because one may not fit the ‘typical’ profile of one who self injures, anyone can be at risk. The estimated number of two million includes people from all walks of life, from actors, celebrities and runaway teens. Actor Johnny Depp and Princess Diana both had histories of self-injury (Ng, 1998). Many self-injurers come from a background of abuse (sexual, physical, and/or emotional), alcoholism, drug use and abuse, and divorce. Many self-injurers suffer from drugs and alcohol, eating disorders or a mental disorder (Strong, 1998).

Myths

Knowing what self-injury is not, is extremely important when deciding the factors of what self-injury is. Martinson (2001) states that it is not considered self-injury if the

person's primary purpose is sexual pleasure, body decoration, or fitting in to a specific group. For example, if one drips wax on his or her sexual partner's body for arousal, this would not be considered self-injury. In addition, if a fraternity pledge needs to brand his arm in the pledging process, Martinson would not believe this is self-injury.

Many people may think those who self injure are trying to kill themselves.

However, some researchers (Crowe & Bunclark, 2000; Martinson, 2001) believe those who self injure have no intention of committing suicide. When suicide occurs with a self-injurer, it is done by accident, as when a razor hits an artery and the person bleeds to death. Martinson (2001) also states that some people who self injure may later commit suicide but almost always the person uses a method different from their preferred method of self-harm. For example, if a person is known as a 'cutter' and usually slices his or her thighs as self-injury, committing suicide by a self-inflicted gunshot to the head is completely different. This person did not kill himself or herself by a self-injury method.

Additionally, many may believe that most people who self-injury are psychotic in some way and need to be medicated. It is believed that one who self injures is no more psychotic than a person who drowns his or her sorrows in liquor. Self-injury is a coping mechanism but is just not as understood as other coping mechanisms like alcohol abuse, cigarette smoking, or anorexia (Martinson 2001). There are people who have mental disorders that also self injure; however, simply self-injuring does not mean one must possess a mental disorder.

Another myth is that people who self harm are just trying to get attention.

Although this is possible in some cases, the majority of people who self injure go to great lengths to hide their wounds or scars (American Self-Harm Information Clearinghouse,

2002). Many feel ashamed and dread the consequences if their secret were to be discovered.

Lastly, a myth regarding self-injury is that if the wounds are not bad enough then self-injury is not that serious. The American Self-Harm Information Clearinghouse (2002) states that the severity of the self-inflicted wounds has very little to do with the level of emotional distress the person is feeling. Just as people have different pain tolerances, so do self-injurers. One may think cutting is too drastic and unnecessary, and that hair pulling provides him or her with the release of tension or the feeling he or she needs to get through certain feelings.

Precipitants

In general, deliberate self-injury is triggered by a specific precipitant.

Adolescents quite often cite arguments with parents as the precipitating factor (Hurry, 2000). These adolescents usually have other troubles at home as well as at school. For young people, ages 15-24 years, "... fights with a girlfriend or boyfriend become an important precipitant, especially for young women" (Hurry, 2000, p. 33).

During the preteen and teen years, adolescents face many situations that may cause stress and frustration. Peer pressure is powerful and the adolescent may feel pressured to talk, dress and act a certain way. In addition, parents may be pressuring for better grades, extra curricular activities, and college plans. There are also numerous hormonal and bodily changes for preteens and teens in the normal developmental process of growing up.

It is important for parents, teachers, counselors and other adult professionals to know what is considered 'normal' in most teens in order to see better what may be

considered an 'abnormal' behavior. The American Academy of Child and Adolescent Psychiatry (1997) believes from the years between middle school and early high school, students struggle with many 'normal' developmental issues. These preteens and teens worry about being normal, are concerned about their physical and sexual attractiveness to others, and display shyness, modesty and blushing. At this age, adolescents also test the limits, experiment with drugs and sex and select their role models. The combination of some normal developmental issues with outside forces, such as divorce, death of a close friend, or sexual abuse, could be just the triggers to bring an adolescent to self injure.

Emotional discomfort

Common feelings among teens are anger, fear, confusion, depression, loneliness, anxiousness and being ashamed. To combat these feelings, many teens resort to self-injury in one form or another. Ng (1998) states that 72 percent use cutting, 35% burn themselves, 30% use self hitting, 22% percent interfere with the body's healing process, 10% resort to hair pulling, and 8% break bones. Seventy-eight percent of self injurers use a combination of the previously mentioned methods. "People who hurt themselves often hide their emotions rather than face them. They bury them deep inside as a way to code with the stress their emotions cause" (Ng, 1998, p. 29). Most often teens are substituting intense physical pain (i.e., burning their arms or slicing their chest) for emotional pain (i.e., feelings of rejection from peers or feelings of anger toward parents). The teens that self injure are reducing the level of their mental distress by experiencing physical distress. For them, "physical pain is easier to handle than overwhelming emotions (Ng, 1998, p. 31).

The American Academy of Child and Adolescent Psychiatry (2003) state that adolescents who have "...difficulty talking about their feelings may show their emotional tension, physical discomfort, pain and low self-esteem with self-injurious behaviors," (p. 1). The inability to talk about feelings because of an unsupportive environment or because the feelings are overwhelming and buried may cause teens to feel they are about to explode and cut to release this tension.

Invalidating environment

Another important factor that contributes to self-injury centers around the teen being in an environment that is invalidating (Nadelson, 2000). An invalidating home is one in which the child is not seen as having valid feelings or opinions. "In other words, the parental response does not accept those feelings or experiences as truthful" (Nadelson, 2000, p. 23). Not being validated leads many of these children to believe their own, original feelings and thoughts about a situation are wrong. If a child says he or she did not break the window and the parent response is "You really did it. Stop lying." Or after a fright from the sight of a big dog, a parent says "Stop crying. Do you want me to give you something to cry about?" then, the child begins to think that maybe in fact he or she is responsible for the broken window or that crying about a big dog is uncalled for according to the parent. Thinking one does not matter or that one does not deserve to cry, can lead to self-hate and a need to punish oneself for having 'invalidated' feelings or opinions. Many self-injurers cut or burn to feel the pain that they think they rightfully deserve.

Power issues

Many experts also believe power and control play important roles in why a person chooses to harm himself or herself (Ng, 1998). When a person is abused, he or she has no control over his or her body. So, to get back the control, the victim decides to hurt his or her own body. Many teens that self injure state they felt alive when they saw their own blood and they found a way to cope (Egan, 1997). Being abused is such a violating act and the teen might feel that no one has a right to hurt him or her but the teen himself or herself which leads to the self injurious behaviors.

Ng (1998) states there are four basic thoughts that a person will have before he or she begins to harm himself or herself. The thoughts are recited below:

- Self injury is acceptable or okay
- The human body is disgusting and should be punished
- Bad feelings can be reduced through certain actions
- Only drastic measures will let others know about my feelings

“People who begin to hurt themselves may not even be aware of these ideas.

However, subconsciously they have accepted and believe in these thoughts “(Ng, 1998, p. 25). These beliefs seem to justify the self-injurious behavior according to the self injurer.

Assessment and Referral

Accident and emergency clinics do not offer extended psychosocial therapy; however, these clinics are usually the first stop for adolescents who have self injured themselves (Hurry, 2000). Since accident and emergency clinics first see the adolescents, they are the “...gateway to any further intervention,” and need to assess and refer

effectively, not only with regard "...to physical but also to psychosocial aspects" (Hurry, 2000, p. 34).

The patient assessment is not a simple process and needs to focus on three areas, which are risk of suicide, risk of repeated self-harm episodes and the presence of chronic psychosocial problems (Hurry, 2000). Emergency staff focused on the first two aspects more heavily than the third. Since many self-injurers do not intend to kill themselves, emergency staff may be upset with the self-injurer and overlook any psychosocial issues or not believe the injuries are as serious as they really are. "Although nearly two thirds of children are assessed by a specialist, on average, only 41% of deliberate self harm patients aged 16 years and over are seen by a specialist, even for assessment, following presentation at an accident and emergency clinic" (Hurry, 2000, p. 35). This leads one to believe that adult professionals are assisting with the perpetuation of the self-injurious acts.

Because teens who self injure may not be deemed 'at risk' for suicide, many are released without seeing a specialist for social and emotional needs, which are the underlying reasons youth self injure in the first place. If the issue is presented to qualified medical professionals and is misdiagnosed or dismissed, those medical specialists have done an absolute disservice to their client and released the client back to the world of self-injury with no support.

Risks

Although researchers state those who self injure do not intend to kill themselves, they definitely are at a greater risk than their peers (American Self-Harm Information Clearinghouse, 1999). Many youth who self injure may accidentally kill themselves by

cutting their arm too deep and striking an artery, which causes the youth to bleed to death. Or possibly the youth bangs his or her head against the wall too much, becomes unconscious and then dies. However, if committing suicide was the primary motive for those who self injure, the person would have used more drastic and definite means, such as a gunshot to the brain or slitting one's throat. "The best single predictor of death by suicide is probably a previous suicide attempt" (Hurry, 2000, p. 35).

Repeated suicide attempts

Thatcher, Reininger, and Drane (2002) report that suicide currently ranks as the second-leading cause of death for youth aged 15 to 19 years. Additionally, "for each youth suicide, an estimated 200 youth attempt suicide," (Thatcher et al, 2002, p. 72). Hurry (2000) states that approximately 25% of youth who self-injure have made at least one previous attempt. This figure may be high to some and low to others. In either case, parents, counselors, teachers, clinicians, and other caring adults need to be educated about the myths and truths behind self injury and help the youth in their lives that are self harming.

It is also important to know that repeated self-harm does not increase the intent of suicide or the lethality, according to Haw, Hawton, Houston, & Townsend (2003). Their findings showed no straightforward link to suicide if one self-harms. In addition, counselors, parents, and friends need to take any suicide attempt or talk of suicide seriously, but also know that just because one self-injures, does not mean that the person is trying to commit suicide.

Psychiatric problems associated with self-injurious behaviors

Research in 2000 and prior indicates that "...self mutilation is not classified as a psychological disorder by the American Psychiatric Association (APA)," (Nadelson, 2000, p. 29). Parts of some disorders include self-harm acts and those who self-injure may suffer from some other disorder.

Usually, the act of self-injury is impulsive and precipitated by interpersonal crisis; however, it is also associated with depression (Ross & Heath, 2002). Determining an accurate number of self-injurers who suffer from depression varies by the method used. Hurry (2000) states that higher rates of depression are generally found when a structured interview is completed. When clinical diagnosis is the sole determinant of depression in self-injurers, less cases are found. This corresponds to previous information in this report regarding the emergency personnel who are treating and diagnosing patients who have committed self-injurious behaviors. It is crucial to assess the present mindset of the client. Most often, about 67% of adolescents ages 11 to 16 years, who self-injured, were diagnosed with major depressive disorder according to Hurry (2000).

Diagnosing a person who self injures with borderline personality disorder is also very common (Nadelson, 2000) since two of the many criteria for borderline personality disorder, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is that of recurrent suicidal behavior and impulsivity in at least two areas that are potentially self-damaging. Many of the traits and statistics common to self-harmers can be seen in people with borderline personality disorder. Crowe and Bunclark (2000) caution that borderline personality disorder is often over diagnosed or misdiagnosed so it

is not unusual for those who self injure to be considered having borderline personality disorder and treated as such even though this may not be true.

Obsessive-compulsive disorder is characterized by recurrent obsessions or compulsions that are severe and cause the person distress or impairment (Nadelson, 2000). “A person with obsessions attempts to ignore or suppress his or her thoughts or to neutralize them with another action or thought” (Nadelson, 2000, p. 31). Compulsions are behaviors (i.e., repeated hand washing) or mental acts (i.e., counting cars in a parking lot) that are intended to reduce anxiety or stress. As previously discussed, those who self injure are usually bottling up their emotions and thoughts and feel the release of tension by cutting their own flesh or pulling out their own hair. Generally those who self injure and are also diagnosed with obsessive-compulsive disorder, compulsively pick or scratch their skin or pull out their hair on their own body or head (Ng, 1998).

The self-injurers who feel a need to control some aspect of their life because possibly they were abused as children, may also suffer from an eating disorder. As with self-injury, the main causes of anorexia or bulimia includes stress, childhood trauma or abuse. Anorexics control their food intake and exercise routine where as those who cut, for example, attempt to control their mental suffering through physical pain (Nadelson, 2000).

Post-traumatic stress disorder (PTSD) is another common diagnosis of those who self injure because the commonality is that the client has been through some major shocking experience that has left the person anxious, irritable, and angry (Ng, 1998). Those with PTSD also have little desire to be around people or activities that remind them of the traumatic event and fail to feel emotions involving intimacy. When one has

been raped, mugged, taken hostage, or even confined to a behavior center for outbursts in school, he or she may suffer from PTSD and turn to isolation or even self harm to have an outlet of his or her feelings and built up tension. For the victim, self-injury is a safe way to feel alive and is a very personal, deliberate act. The self-injurer may not realize the complications of the induced harm until long after the periods of self injury are over.

Hurry (2000) believes “drugs and alcohol often play a role either as part of the act of self-harm or in the period preceding the act” (p. 34). Many reports show that many self-injurers and those who attempt suicide have high rate of both serious alcohol and drug abuse (Hurry 2000). When very serious injury occurs or even death of self-injurers, the lack of judgment is taken into account and many of them were high or intoxicated. The feelings of drunkenness or euphoria by using alcohol or drugs is one coping mechanism of the self injurer and the actual act of self injury is yet, another, coping mechanism.

Family Problems

It is not unusual for people to have difficulties within their family. However, people cope with past, present and future family challenges in different ways. Youth, ages 12-18 years old, are at a much higher rate of self-injury if they come from a home with divorce, separation and/or death. (Hurry, 2000). Even adults have problems many times dealing with the strains of their marriage and family. When one adds divorce or death to the equation, many adults are unable to cope effectively. Now imagine an adolescent within the same situation but lacking the knowledge of proper coping skills and life experience. Children role model their parents, quite often, and if the child sees the anger, the fists hitting the wall, the sadness and the masking of feelings through liquor

consumption, the child is likely to follow suit in his or her own way, which could be through self injury. In addition, there is somewhat of a trickling down effect on the children when adults cannot handle their problems productively.

When parents argue and one moves out, the parent who leaves may cut off ties with the spouse, as well as the children. The parent in the home may be overstressed or lonely and isolate himself or herself from the children in the home. These children feel neglected, lonely, angry and sad and without proper communicating with their parents, these children resort to dealing with their feelings and thoughts privately. Self-injury is one way a child is able to solve this overwhelming emotional problem. Martinson (2001) states with self-injury the adolescent may feel a strong uncomfortable emotion, not know how to handle it, and know that hurting himself or herself will reduce the emotional discomfort quickly. "They still may feel bad (or not), but they do not have that panicky, jittery, trapped feeling; it's a calm bad feeling" (Martinson, 2001, p. 4).

Divorce, death and separation are just some family issues. The daily struggles parents have with their children and vice versa may be enough to have a child turn to self-harm. When parents and teens argue over chores, curfews, and grades, the teens may feel they have little say as to what the rules and consequences are in their life. This lack of control may lead the teen to many other risky behaviors either out of spite of their parents or because the teens are trying to take back some control. The teens may engage in drinking and driving, piercings, skipping of classes or cutting. The teens feel they are gaining back a sense of control in their life.

Treatment and interventions

The kind and amount of treatment provided to one who self-injures depends primarily on the individual. What will work with one person who self-harms may not work with another person. Many basic principles should be used for anyone who is going through therapy and other treatment measures; however, the specific interventions and strategies used need to be decided upon in regard to the specific individual.

The overall goal is for self-injurers to stop the self-injurious behaviors. To accomplish this, the self-injurer need to identify the underlying causes of self-injury. Many times, the self-injurer needs help of professionals to know why he or she does this to himself or herself and what behaviors and thoughts can replace the self-injurious acts.

Parents and friends of those who self injure are encouraged to approach the person with an accepting, open attitude (Ng, 1998). Try to be non-judgmental as the self-injurer may already feel ashamed, embarrassed or have low self worth. Parents and friends should also understand the self injurer may not know how to stop and simply asking him or her to do so seems incomprehensible. It is important parents do not get into a power struggle with their child who is self-harming because then the child may secretly self injure and mistrust the parents (Nadelson, 2000).

Types of treatment modalities

Treatment may consist of inpatient or outpatient. Those who self injure are likely to be treated with individual and small group counseling. However, those who self injure are also likely to be treated with individuals with eating disorders, compulsions, attempted suicide and substance abuse issues (McCormick, 2000). Often times the treatment of these issues is handled in the same manner because the underlying cause of

one feels, and hence, how one reacts. Those using RET with clients that self injure attempt to have the client share their thoughts about situations and see how rational those thoughts are. Changing irrational thoughts to rational can lead to irrational feelings being changed to rational ones. Once the feelings are valid for the situation, the behavior should follow suit and be valid also. A teen male who cuts because he feels unworthy after his girlfriend breaks off the relationship would need assistance with changing those thoughts and beliefs to more rational ones and then coping accordingly. This teen is likely to feel lonely, because that would be a natural response to a breakup; however, feeling no one will ever love him again or that he is unworthy of love and needs to be punished by cutting himself is irrational.

School counseling approach

As a school counselor, it is important to follow suit with those interpersonal skills and strategies implemented by the mental health professionals that the self-injurer sees in a residential treatment center, outpatient mental health center, or hospital. School counselors have the advantage to interacting with the student who self injures in a much different kind of environment. Many different interventions can be employed with a student who cuts, burns, self-hits, or the like.

Once the root of the self-injury is reached through individual and/or small group counseling in the school setting, then specific strategies can be determined. If the feelings for self-injury are due to anger, restless and/or frustration, some of the following strategies were suggested by Martinson (2001):

- Hit a punching bag
- Play handball or tennis

- Slash an empty plastic soda bottle or a piece of heavy cardboard
- Rip up an old newspaper or phone book
- Throw ice into the bathtub or against a brick wall hard enough to shatter it
- Use a pillow to hit a wall, pillow-fight style
- Crank up some music and dance

These behaviors require the release of that build up anger or frustration. Ripping, tearing, and using large motions like dancing or throwing can relieve the restlessness and have one reach a calm state. Unfortunately, in a school setting, not all of these strategies would be feasible. Blasting a stereo would disrupt other students and classrooms and a bathtub is usually not stationed in the counselor's office. However, having old phone books, magazines or newspapers is accommodating for most counselors. Also, having pillows or a stuffed animal in an office is fairly normal so one of these objects could be used if a student needed to release tension. Having the student do jumping jacks or big arm motions is also likely in a school counselor's office.

If the self-injurer is feeling sad, soft, unhappy or depressed, Martinson (2001) states that are other specific interventions that can be used with the client. Some of those ideas are listed below:

- Listen to soothing music
- Visit or call a friend and talk about things you like
- Do something slow and soothing, like taking a hot bath with bubbles or reading a good book on the sofa with some hot cocoa
- Smooth nice body lotion into the parts of your body you want to hurt
- Burn incense or sweet-smelling candles

Many school administrators and districts may not allow the burning of incense or candles in the counselor's office for fear of something catching fire. However, a school counselor could have a soft smelling plug in air freshener at all times. Rubbing lotions or performing any sort of meditation or yoga moves may also be unlikely in a school setting as it may be perceived by many adults as being seductive or unethical. It is important for the self-injurer to cope in other positive ways and not just learn to bury the emotions and stop the self-harming act. Never have a coping mechanism removed and not replaced with something effective and safe.

Many self-injurers state when they saw the blood, then they felt alive (McCormick, 2000). Feeling depersonalized, unreal or dissociated can cause some deep demoralizing thoughts. If a client is self-injuring because of these feelings, the counselor should suggest some of the following strategies (Martinson, 2001):

- Slap a tabletop hard
- Snap your wrist with a rubber band
- Take a cold bath
- Bite into a hot pepper
- Stomp your feet on the ground
- Squeeze ice hard
- Put a finger into a frozen food or put ice, water and salt in a pitcher and put your hand in it for a few seconds

Although some of these behaviors can be painful, they are nothing that would cause permanent damage if used appropriately. You would not want to have the person's hand left in a bowl of ice for hours, for example, but to feel alive for a person who feels

unreal, can simply take a few seconds of squeezing some ice cubes. Even though the client may not cause serious damage to himself or herself by performing some of these activities, the counselor may still believe banging on a desktop or snapping the wrist with a rubberband may be far to extreme for a school setting. Some of these strategies could more likely occur in a home or mental health clinic setting. Stomping of feet or even having ice in a client's hand is more likely to occur in a school counselor's office.

If the client's need is to gain focus, then Martinson (2001) suggests the following activities:

- Do a task that is exacting and requires focus and attention (needlework, computer game like Tetris)
- Eat a raisin mindfully. Pick it up and notice how it feels in your hand. Look at it carefully and roll the raisin in your fingers, and the like. This may take several minutes or more
- Choose a random object, like a paperclip, and try to think of 30 uses for it

Lastly, if the overall desire of the self-injurer is to see blood, Martinson (2001) refers to the following activities:

- Draw on yourself with a red, felt-tip pen
- Paint on yourself with red tempera paint or red lip-liner

These activities will provide the client with the visual he or she may need to get past the urge to cut himself or herself. Journaling and poetry are also great outlets for many different kinds of emotions. This is a positive way for the client to release the tension and 'verbalize' his or her thoughts and emotions without actually having to share them with another person. Talking to himself or herself in a mirror may also be a good

way for the client to share his or her thoughts without having someone else present. This can have the client feeling very much alive and in the moment. This last group of interventions or activities could definitely occur in a school counselor's office as they do not require the use of many items not normally found in a school. Having markers, paper or food in the counselor's office could be a standard and would not be an extra expense to the school district and not too far out of the norm for school administrators.

All of these interventions should first be practiced with the counselor present so there is no miscommunication or misunderstanding of what the client can try if he or she is feeling certain emotions or thoughts while outside of school. Continual individual counseling should be implemented because the client needs to recognize those triggers for certain thoughts and emotions. The client needs to know how to effectively verbalize those feelings and find appropriate coping mechanisms.

It is important that the school counselor is aware of the policies and procedures of the school district and specific school building and be in constant communication with the school administration regarding the theory and practices the counselor uses. Obviously, the counselor would not have to provide specific names or issues; however, letting the administrator aware of the items sometimes used to help students is important so the counselor, school or district does not get sued or deemed as providing a disservice to its students.

Conclusion

Many adolescents who self injure are often misunderstood and/or misdiagnosed. With at least 1% of America's population deliberately harming himself or herself, it is high time something concrete is done to help lower this figure. It is crucial as counselors and other helping adults, that these adolescents are properly treated and assisted with their personal problems and inner emotions.

There are many underlying factors to why one self injures and the same situation for two different adolescents can be perceived in two different ways. The counselor's role is to determine the greatness of the situation or problem for each person and help accordingly. There are also many interventions that can be employed to reach the client at his or her level. A wide variety of strategies were listed in this manuscript that could be used by a number of concerned people. As our homes become more divided, peer pressures are much more alive, and adolescents have access to many more drugs and weapons on the street, the likelihood for adolescents to self injure is great. One should never assume. The bottom line is that parents, friends, teachers, and counselors should investigate the feelings and thoughts behind the self-injury and never feel you already know what is happening with the individual since each person processes certain situations differently.

Counselors need to ensure that parents, teachers, and other adult professionals are well aware of some factors that lead to self-injurious behaviors. Being nonjudgmental and having a caring attitude are the first steps to helping those who self injure. Parents must listen to their child and acknowledge their child's feelings. Mental health

professionals and school counselors need to be able to identify the underlying causes of self-injury and treat accordingly.

Prevention programs also need to begin in elementary and middle school years to help potential self-injurers deal with what is happening or has happened in their lives.

Since many self-injurers are masking what has previously occurred and are unsure how to properly deal with these overwhelming issues, educators need to take the first step to reach out and instill effective skills and strategies for young people. It is vital our children learn the proper coping mechanisms and effective ways to communicate feelings, thoughts, and emotions.

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