

## What School Counselors Need to Know About Students Who Self-Injure

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### Abstract

The following paper is a summary of the literature on self-injury focusing on knowledge useful to school counselors. The paper includes basic knowledge needed to assist the school counselor in making informed decisions and suggestions for helping the student through creating a supportive environment.

“For many in the younger generation... the body is a critical message board, a way to convey information about the self” (2006, p. B8)

“I hurt myself today...to see if I still feel...I focus on the pain...the only thing that's real” (Reznor, 1994,Stanza 1)

### What Is Self-Injury?

The definitions of self-injury are as numerous and vary among the authorities. The definition most commonly found throughout professional articles describes self-injury as a “direct, deliberate destruction or alteration of one’s own body tissue without conscious suicidal intent” (Favazza, 1996, p. 226). Put simplistically self-injury is purposely hurting oneself, without suicidal intent. Self-injury behavior has been listed in the literature as

“autoaggression, intentional injury, symbolic wounding, malingering, Munchausen syndrome, deliberate self-harm, self-abuse, local self-destruction, delicate self-cutting, self-injurious behavior, aggression against the self, parasuicide, attempted suicide, and focal suicide” (p. 233).

Self-injury can include any one or more of the following means of harming oneself: cutting, scratching, picking at scabs or hindering healthy wound healing, skin carving, burning, abrasions, biting, self-punching, injecting/sticking objects beneath the skin or into the body, infecting oneself, branding, bruising, and breaking bones (S.A.F.E.. 2007"Self-injury facts,"). This list could possibly be extended as adolescents explore more methods of physical self-injuring to achieve the same emotional results.

Adolescents who self-injure typically cut into and on their skin. Froeschle and Moyer (2004) reported that the type of self-injury most commonly seen in adolescents is superficial damage to the skin, like carving marks, scratching or scraping, piercings done with needles, and slight burn mark. Austin and Kortum (2004) stated the most common method of adolescent self-injury is cutting with razor blades, knives, or burning with matches.

Favazza (2006) separated self-injury into two broad categories. The first of these is culturally sanctioned, which includes customs and ceremonial practices. The second is deviant-pathological, which is further split into three areas based on the amount of physical damage and the behavior’s frequency and patterns.

Culturally sanctioned body modification includes culturally common rites of passage into adulthood such as circumcision, tattooing, lip piercing, ear piercing, and foot binding, which are parts of various cultures' healing, spirituality, and social order (Favazza, 2006). These body modification rituals are practiced in the belief that they will correct or prevent threats to the stability of the society: disease or angry gods. These culturally sanctioned practices are not considered to be self-mutilation.

Deviant-pathological self-mutilation is divided into three major areas: major, stereotypic, and moderate/superficial. According to Favazza (2006), major self-mutilation involves infrequent acts of self-destruction that result in great physical damage and are most commonly associated with psychosis and/or drug and alcohol use. Castration and limb amputation are included in this category. Stereotypic self-injury refers to repeated acts that seem to follow a pattern, such as head banging. Stereotypic self-injury is most commonly seen in "institutionalized mentally retarded persons" and individuals with Autism and Tourette's Syndrome. Moderate/superficial acts of self-injury are the most common and usually result in little permanent physical damage and low risk of death. These acts include "hair pulling and skin scratching, picking, cutting, burning, and carving ... (as) the most commonly encountered forms of self-mutilation" (p. 241). Moderate/superficial self-mutilation lacks a pattern and usually "requires the use of implements such as (matches, pins, or razors) in a complex sequence of events" (p. 233).

Favazza (2006) stated that the most common type of self-mutilation is the moderate/superficial category of injury. Strong (1998) agreed with Favazza that the most common type of self-mutilation falls under moderate/superficial, and she adds that the behavior usually exists of "controlled and relatively shallow cuts" (p. 27) in one's skin.

Favazza further breaks down moderate/superficial self-mutilation into three types: compulsive, episodic, and repetitive. "Compulsive self-mutilation occur(s) many times daily and (is) repetitive and ritualistic" (p. 242). Episodic self-mutilation is usually present alongside a mental disorder, like anxiety or depression. This type of self-mutilation follows a theme: to release tension, to snap back to reality, to gain a sense of control, to promote feelings of security and to feel special, to influence others' reactions or emotions, to deal with negative perceptions of oneself, to release pressure from multiple personalities, to enhance or repress sexual urges, to increase positive feelings and emotions, to vent anger, and/or to provide relief from alienating feelings (Favazza, 2006; Strong, 1998)

In the school settings, counselors will encounter youth who engage in episodic self-injury, which is often a learned reaction or coping mechanism in response to one of the above themes. Strong explains "the difference (between episodic and repetitive) is in the frequency and the importance these acts come to assume in a person's life" (p.27). As a coping skill for teenagers, episodic self-injury is used in place of healthier communication and emotional release.

Self-injury is observed more often in females than in males. Researchers suspect that just as many males self-injure as females. Males may be able to hide self-injury because of the ease of their ability to explain cuts or marks on their skin as a result of scuffling, fighting, or physical work but that is most likely a misconception (Alderman, 1997; Favazza, 1996; Strong, 1998).

The ages at which students begin and end self-injury vary. White-Kress, Gibson, and Reynolds (2004) stated self-injury begins in middle adolescence, with the first occurrence in most often occurring about the ninth grade. White-Kress, Drouhard, and Costin (2004) indicated that age eighteen is the average age self-injurious behavior ceases. Therefore, high school counselors are most likely to have daily contact with high risk adolescents within this self injurious behavior age range. High school counselors are in a position to intervene and to make referrals for students at the onset of self-injurious behavior and throughout high school.

### What Is Not Self-Injury

Self-injury is very often misunderstood. Favazza (1996) said “all living creatures share in the struggle for survival and the avoidance of pain” (p. 226). Although self-injury appears to go against basic human survival and self-protection, the behavior is not suicidal. Accidental suicide should always be a concern; however, as a result of cuts that go too deep or wounds that are dangerous (Levenkron, 2006). Allen (1995) explained “self-harm is a problem with an unparalleled ability to evoke rage, terror, punitive feelings, and disagreement... perhaps because it is seen as both dangerous and willful” (p. 248). Self-injury can induce strong reactions in others, but Allen reminds us that “self-harm is not primarily intended to ‘manipulate’ or upset others. The self injury can be viewed as part of a struggle to cope with conflicts within the self. Austin and Kortum’s (2004) research supported the idea that self-injury is not intentionally manipulative because the behavior itself is so shameful and hidden to those doing it. Self-injury is usually kept hidden from others, not displayed or shown off. The authors expressed that self-injury is not intended to attract attention from others, although self-injury may feel circuitous to those who observe it.

### Reasons Students May Self-Injure

Strong (1998) explained that people who do not cut or self-injure may see the behavior as self-destructive, masochistic, or irrational. However, self-injury has meaning for the person who self-injures. Self-injury fills something in an individual that other actions or behaviors cannot, and to an emotionally fragile adolescent self-injury can be very consequential. Research consistently indicates that self-injury is a maladaptive means of coping performed by an individual with poor problem solving skills; it is a temporary way of managing overwhelming emotions and an attempt to heal oneself (Favazza, 2006; Levenkron, 2006; Strong, 1998).

Alderman (1997) suggested that by self-inflicting pain and injury, an individual may be trying to nurture and heal. An external, visible wound is easier to attend than a non-specific, intangible hurt, and even though hurting oneself seems contradictory, she states “by nurturing and taking care of ... physical wounds, [the student] is actually caring for internal scars. As odd as it may sound, [self-injury] may actually be a way for [one] to physically and psychologically take care of [oneself]” (p. 45).

Deiter, Nicholls, & Pearlman (2000) examined the relationship between self-injury, childhood abuse, and self-capacities in adults, and found that self-injuring individuals had greater than average weaknesses in their self-capacities, which include the abilities to deal with strong emotions, have a sense of self-worth, and connect with other people. Individuals who do not have adequate self-capacities most likely have poor relationships with others and low communication and coping skills, and may turn to self-injury as a strategy to maintain emotional equilibrium.

Other researchers put more weight on relationships, or lack thereof, with parental figures, and the communication within these relationships. Coy and Simpson (2002) explained “...the common quality (in individuals who self-injure) is the literal or symbolic loss or disruption of a significant relationship” (p. 18). This loss or disruption leads an individual to believe the only option to communicate emotional distress is self-injury.

Strong (1998) wrote that in most incidents of self-injury behaviors are generated by fear of being abandoned, whether or not the abandonment is real or just perceived by the individual. These feelings of “tension, anger, rage, fear, anxiety, panic” (Strong, 1998, p. 55) build up until they are overwhelming and the individual feels he cannot maintain control. Because self-injuring individuals do not know how to regulate these strong emotions by communicating in a healthy way, they must be dealt with by an equally strong action.

In a study of children and teenagers hospitalized for self-mutilation, Strong (1998) described what self-injury can mean to those who do it:

...the researchers viewed self-injury as serving a variety of purposes for these abused kids: a cry for help, an outlet for pent-up rage, a means of self-punishment, a controllable method for reducing emotional trauma, a form of ‘body stimulation’ for children who had

become inured to pain as a result of physical and sexual trauma, and a way of feeling something other than despair (p. 52).

Alderman (1997) explained that self-injury is “actually a method of sustaining life and coping during an emotionally difficult time... helps some people feel better by giving them a way to physically express and release their tension and emotional pain” (p.7). She suggested that self-inflicted violence is one way of exerting power over one’s body and asserting a sense of independence, which is an important factor for adolescents and school-aged individuals.

Alderman says the following about adolescents and their need for independence:

“One of the new things adolescents must learn to deal with is increased need for autonomy and control that accompanies adolescence. Adolescence is the time in life when you start to achieve a real sense of yourself as an independent and autonomous person, capable of making your own choices and decisions... When you injure yourself, you are demonstrating (if only to yourself) that you are in complete control of your own body, and in that respect you have autonomy” (p. 17).

Adolescence is a time of “finding oneself,” and often teenagers feel like they do not fit in anywhere or with anyone. Strong (1998) reiterated this by saying that adolescence is a difficult time for individuals who have poor coping or communication skills. She explains that adolescence is marked by coming to terms with the person’s sexuality and all the anxieties and responsibilities of becoming an adult.

Alderman (1997) explained that one widely recognized factor in the study of self-injury is the individual’s need for an immediate endorphin rush. These hormones, released by the body in times of stress, pain, or anxiety, result in a pleasurable sensation and often block out the physical pain caused by self-injury. The behavior becomes a way of self-medicating that can become habit-forming or even addictive. Eells (2006) supported the theory of endorphins by explaining that endorphins provide a numbing or high feeling which may temporarily relieve the emotional pain. Self-injury then becomes part of a cycle in which the individual does not learn how to appropriately recover from emotional states without the act of self-harm.

Self-injury can be a form of self-punishment, typically as a result of abuse suffered in the past. Abuse in one’s past can cause individuals to reenact the abuse or physical pain in order to gain a sense of control that was taken from them in the original case of abuse, or even as a flashback of post-traumatic stress (Alderman, 1997). When an individual feels out of control, self-injury might give a sense of structure, or a sense of being in control. In much the same way, negative thoughts can also be controlled through self-injury. “By changing [one’s] behaviors, emotions, or physical sensations, [one] can also affect [one’s] thoughts.... Therefore, [one] may hurt [one’s self] in order to control intrusive, obsessive, or otherwise unwanted thoughts” (p. 51).

Strong (1998) wrote:

Whatever the source, the child is left feeling emotionally abandoned, [the child’s] unmet needs and unsoothed fears create an overwhelming level of anxiety. Later in life, cutting or burning becomes [the child’s] primary strategy for regulating ... emotions and avoiding further mental deterioration. It is a means of self-soothing and in that sense can be viewed as a flawed attempt at self-mothering (p. 48).

### **Development and Possible Causes**

Conterio, Lader and Bloom (1998) explained self-injurers can have a varied background and history. While some may grow up in homes with healthy families, others may suffer abuse or neglect. Some may be children of alcoholics, addicts, or parents with mental illness. Some might have been on the receiving end of constant criticism, or maybe they were punished and ridiculed for displays of emotions. Other self-injurers might have struggled with families that offered no guidance for appropriate communication. The authors explain that the first time an individual self-injures the injuries are most likely accidental. Somehow the resulting wound or

bleeding turned out to be cathartic and the individual realized that this behavior made him feel immediately better. Allen (1995) cited three reasons people learn that self-injury is beneficial: 1) they learn they can manage their moods or feelings, 2) they learn to punish themselves in response to negative beliefs about themselves or perceived wrongdoings, and 3) they learn they can manage interactions with other people: their self-injury causes reactions in others and then their emotional needs are indirectly met.

To further explain how self-injury can manage moods or feelings, research by Austin and Kortum (2004) said “most students self-injure themselves because they are unable to handle intense feelings, and so they turn to self-injury as a way to express their feelings and emotions” (p. 518). Favazza (2006) and Levenkron (2006) further explained why self-injury might be in response to negative beliefs about oneself. An individual who has been abused might use physical pain to diminish emotional pain, which is harder to typify. Thoughts and emotions, which are intangible, are harder to understand than something that is physical, which can be seen and felt. Physical expression of emotional pain allows the individual to have concrete evidence of that which seems intangible, amorphous, or indefinable (Alderman, 1997). Self-injury may also be a learned act of anger turned towards oneself because to direct it at another person might be physically impossible (towards a past abuser), or emotionally risky (towards a parent) (Levenkron, 2006).

Managing interactions with other people is often a result of families frequently avoiding or sometimes punishing direct communication (Eells, 2006). An individual’s attempts at healthy communication of needs and feelings were not supported and self-injury is the only way one feels one can express individual gains self-expression. The self-injury becomes a learned behavior because other attempts at communication or expression fail (Allen, 1995; Eells, 2006).

### **Best Practices for School Counselors**

School counselors must balance providing guidance for students with a teenager’s need for autonomy. As we all know, teenagers can be an enigma without adding the issues of self injury. If self-harm is connected with low self-esteem, lack of self-confidence and high levels of anxiety, schools need to ask themselves what they can do to promote a healthy self-concept and equip young people with the confidence and skills necessary to handle problematic situations without experiencing overwhelming levels of anxiety (Best, 2006).

The American School Counselor Association (ASCA) Ethical Standards for School Counselors (2008) specifies the school counselor’s primary obligation is to the student, and the counselor should be “concerned with the educational, academic, career, personal and social needs and (should) encourage the maximum development of every student”. Working with a student who self-injures, the school counselor can help by listening; encouraging support and, if necessary, intervention; encouraging the student to advocate for himself; and making referrals to appropriate community resources.

Austin and Kortum (2004) wrote

...it seems that through ...body language, self-injuring children and teenagers can communicate much more directly and forcefully than they can speak in words. Because of this same inability to communicate, many of them cannot or do not like to go to professionals with their problems.... The professional must initiate the first step of communication (with students suspected of self-injury) and yet at the same time give the teenager power to communicate back” (p. 521).

Alderman (1997) supported this by reminding us that self-injury can be a means of communicating that an individual is deeply hurting or suffering psychologically. If a student tells a trusted teacher or counselor about his injuries, he may be trying to talk or start a conversation about his struggles.

Best’s (2005) research with school staff showed that a few students had occasionally engaged in self-injury, including cutting, while at school. He reported that while many teachers did not seem to

know what self-injury was, or understand it, teachers are in the best position to see and report self-injury in their students. The school counselor's role is that of providing training and educational opportunities for the entire school on student self-injury.

In support of what school counselors can do for students who self-injure, Coy and Simpson (2002) maintained that the intervention limitations placed on school counselors through local policies and state guidance plans prevents school counselors from providing more than crisis intervention with these students. They suggest working with local "experts" in the field and using these professionals to train counselors and school staff for the extended support that these students may need. A counselor who is educated and understands self-injury is better able to connect with and provide services for students who self-injure. The student is likely to need continued support during times when school is not in session. Therefore, a school counselor should see themselves as a support person for the primary care mental health worker, who can provide on-going care.

Crawford, Geraghty, Street, and Simonoff (2003) advocated training for all staff within the school and community who will be working with youth that self-injure, including counselors, teachers, coaches, administration, and health care providers. They suggest that if education can identify "evidence-based, effective treatments" then staff will feel more comfortable working with self-injury. The school counselor's role is to locate the appropriate training and to schedule the training through the school's route of in-service provision.

White-Kress et al. (2004) suggested that the school counselor's main goal to be to maintain a safe and trusting environment at school for self-injuring students to talk if necessary, with an emphasis on "structure, consistency, and predictability" (p. 17), until community counseling can begin. The counselor working with other school personnel and behavioral committees, would initiate the school personnel to identify a safety plan that details what the student feels his or her triggers are so the student can try to avoid them, what has been previously effective in reducing the behavior, who are safe people and where are safe places the student can trust and contact in times of need, and avoidance of tools used previously for self-injury. The safety plan would stress the importance of not having tools on campus, both for personal safety and adherence to school policy.

McAllister (2003) encouraged the school counselor to listen attentively to the student and the student's reasons for self-harm rather than making cause and effect assumptions about the behavior. By remaining open to the student's interpretation of the events, the school counselor can reframe the self-injury as a coping skill rather than a harmful act upon oneself. Seeing the behavior as purposeful and necessary for the student's personal concept of well being, and not just as a symptom of a bigger problem, can help school counselors clarify the behavior to the faculty and help to create a less stressful environment for both the school and the student. Societal attitudes towards mental health and well-being definitely impact the reactions of faculty, staff, and students to students, who are purposefully harming themselves. The school counselor can better serve this population of students by providing education and awareness of the behavior through in-service and guidance activities. Through gaining a better insight into the behavior, the self-harming students can better be served, as well as the community at large in creating an enlightened environment for understanding and removing the alarm that many people feel with the discovery of the behavior (Best, 2006). Although there are no clear guidelines or ethical standards for dealing with students who self-injure, Alderman (1997) suggested that counselors follow this principle regarding reporting the behavior or not: "...do the risks of our actions surpass the benefits that may derive from these actions?" (p. 202). Alderman also suggested that school counselors remain aware of the shameful feelings self-injury brings for the individual, and maintain appropriate boundaries when working with these students.

Malikow (2006) cautioned against focusing too much attention on the self-injury behaviors. He says that a relationship between student and school staff that is built on the self-injury reinforce and encourage the behavior. The school counselor's role is to help school faculty and staff to realize that asking about the behavior or talking about it to the student is not appropriate, as this attention may exacerbate the behavior. The

faculty and staff can be encouraged to provide the student with attention in areas that are not related to the self-injury, i.e., perfect attendance, prepared lessons, participation in sports and school functions.

When working with a self-injuring student, Conterio et al. (1998) encouraged counselors to believe self-injury is not an attempt at gaining attention. They feel that statements made to that effect will only “belittle” the distress an individual feels. The authors offer three guidelines for school counselors NOT to try with clients who self-injure. They suggest discouraging individuals who want to show or describe their wounds or incidents of self-injury. Focusing on the marks instead of the underlying issues is not what is best for the student. They also discourage encouraging alternate behaviors, like snapping a rubber band on the wrist or drawing “cut” marks. Destructive acts should not be encouraged in any way. Lastly, they discourage any physical anger or release, saying ... “these methods tend to reinforce the erroneous belief that feelings of anger must inevitably bring about an expression of violence...” (p. 189). The authors firmly believe that the “fully functioning, healthy adult” (p. 189) expresses emotions and anger verbally and appropriately, and encouraging or supporting other methods will not cease self-injurious behavior. School counselors participating in the building wide treatment plans will want to be cognizant of these guidelines in the development of the individual plan for the student who self injures.

Allen (1995) supported this belief by saying that “... it is vital that healthy and appropriately assertive expression of negative feelings is encouraged and rewarded” (p. 248). If self-harm is a way of expressing and communicating distress or anger, then these individuals may have to learn appropriate releases. The school counselor will need to work with the primary mental health worker to help develop a strategy that will reinforce the learning in appropriate emotional expression. This step in the intervention requires that the school counselor and the building based intervention committee work closely with all the mental health providers to create a consistent and supportive environment for the student.

Notifying parents of the self-injury may pose some special problems and considerations for the school counselor. School counselors must keep in mind the best interest of the student before contacting the parents. Strong (1998) said “...when the scars are uncovered and ... their children’s pain is revealed, some parents respond with anger and annoyance rather than sympathy and understanding. They overreact ..., only driving their symptoms further underground. Other parents under react, dismissing the cuts, bruises, and broken bones as melodrama” (preface, p. 19). The school counselor who is prepared with educational information, referrals, and an understanding of the student’s family life will be more likely to approach the parents in a way that they can understand and be helpful to the student. The parent needs to be informed of the school’s role in any interventions and how the school counselor intends to help provide a supportive environment for the student. Parents do have the right to deny services for minor children; therefore, the school counselor may have to call upon his or her skills of persuasion to illicit the cooperation of the parent in helping the student.

Froeschle and Moyer (2004) cautioned school counselors working with students who do not want to share information with their parents. Consulting with other counselors, being familiar with state law, and keeping appropriate records are just a few of the guidelines to follow, but knowing your school and district policy regarding disclosing information to parents is the first place to start (Froeschle & Moyer, 2004). White-Kress et al. (2004) encouraged school (I am guessing that the author means 2006 because that is what is in the reference section) counselors to always contact parents in cases of self-injury, even without threat of suicide or serious harm. If there is concern over disclosing to parents, they suggest consulting school administration and the school district attorney. Because self-injury involves the possibility of accidental death, school counselors must carefully consider referring the student to mental health for an evaluation if the student is clearly a danger to himself or herself. One should always consult and refer to school protocol when available (ASCA, 2008) and include the parents when possible.

Roberts-Dobie and Donatelle (2007) encouraged school counselors to take on a dual role, of coordinator and liaison, to help students who self-injure. School counselors can coordinate education of faculty and staff in position to recognize and report self-injury. In addition to school personnel, school counselors should educate students and families. Students can be taught the signs of self-injury within an existing health curriculum and

how to refer a friend to a trusted adult. Educating families informs parents of school policies regarding student self-injury, plus it teaches parents to recognize warning signs in their own children. Some ways to provide assistance to families is to have links on a counseling website to many concerns of adolescent and child mental health problems, including self-injury. The school counselor needs to maintain a local file of referrals that are knowledgeable in the various areas of mental health concerns of youth. Being a liaison links the school counselor between school and community systems, including possible free and low cost resources for families within the community to select among for services. School counselors want to remember that referrals to sources outside of the school can result in the school district being required to contract and pay for student services received. Referrals of this nature are best posed and discussed through the committees that are part of the normal referral system within each school district, and used only when the school district cannot provide adequate services.

According to Roberts-Dobie (2004), the school counselor can help maintain students' well-being and ensure a successful academic environment for them by providing a safe outlet in case students needs to talk or need to be alone, or by addressing concerns to the student's teachers or parents. In addition, the student may need a Section 504 Plan, or a health care plan to further his safety while in school.

All schools should develop and implement plans for working with students who self-injure. Eells (2006) urged that the plans should line out specific protocol and roles of everyone involved, from administrators to staff members. Ideally the plans would include education about self-injury and training for all staff members.

White-Kress et al. (2004) encouraged school counselors to become part of a policy making system within their schools. The author stresses school policies that address the following questions: when and to whom teachers and other staff report student self-injury; what is the role of administration, the school counselor, and the school nurse; and what is the policy on parental notification and other involvement. Having an established policy helps protect students, counselors, and the school itself. Onacki (2005) suggested school policy be developed using the nurse, counselor, and administration as facilitators of the plan. She encourages a policy that involves educating students and encouraging healthy communication, educating staff members on how and when to report, and working collaboratively with parents and the community.

### Summary

In conclusion, school counselors have obligations to their students, their school and district, and themselves. Self-injury is a serious and dangerous phenomenon, and to provide the best services possible to our students we need to become educated about self-injury, aware of our own reactions to it and the limitations we have in working with self-injuring clients, and we must become active in developing a response to students in need. Our roles as school counselors are multi-faceted, and providing appropriate services for students in their educational setting remains our main goal.

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