



Self-Injury: Counseling Youth Who Self-Mutilate

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Self-injury has become a topic of intense study and controversy in clinical and school settings. Controversy exists from treatment techniques to descriptive terminology. As Laye-Gindhu and Schonert-Reichl (2005) point out, little consensus exists among practitioners and researchers on how to define and conceptualize the phenomenon thus confusing assistance options for a self-injuring youth. This digest offers a conceptualization of self-injury that may empower counselors to offer support and make appropriate referrals.

The Importance of Understanding Self-Injury

School counselors and fellow school professionals have reported that self-injury in the school environment has grown at an alarming rate. A recent study indicated that 13.9% of 440 adolescents sampled participated in self-injurious behavior (Ross & Heath, 2002). While statistics vary, the prevalence of self-injurious behavior in schools and among the adolescent population raises concerns for those who must work with the behavior.

The phenomenon is easily misunderstood and often difficult to identify. Ineffective techniques of dealing with the self-injuring student can ultimately result in wasting the counselor's time and damaging the relationship with the student. With this said, accurate conceptualization is imperative if healing is to be facilitated (Coy & Simpson, 2002).

Approaches to Intervention

To work with self-injury, a single definition of the phenomenon is important. Conterio and Lader (1998) define it as "the deliberate mutilation of the body or body part, not with the intent to commit suicide but as a way of managing emotions that seem too painful for words to express" (p.16).

Moderate/superficial self-injury is the most common type of self-injury in school settings. Spanning social class, gender, ethnicity, and race, this form of self-injury is one in which the individual cuts to avoid painful or intolerable feelings. A variety of diagnoses may be consistent with this form of self-injury including personality disorder, eating disorders, and posttraumatic stress disorder (Conterio & Lader, 1998). Moderate or superficial self-injury is performed with intent. The person committing the act seeks out the pain associated with self-harm. Additionally, self-injury is a means of managing feelings. The self-injurer specifically intends to avoid inevitable feelings of fear, anger, anxiety, shame, guilt, or any other feeling that might be perceived as negative.

A connection has been identified between self-injury and sexual, emotional, and/or physical abuse in childhood. There does appear to be a strong correlation between the existence of abuse in the individual's background and the use of self-

injury. However, when conceptualizing the self-injurer, it is important to note that other possibilities for the behavior may exist (Conterio & Lader, 1998; Levenkron, 1998). Levenkron (1998) suggests a means of dividing the behavior into two dimensions: nondissociative and dissociative.

The nondissociative self-injurer usually experiences a childhood in which she is required to provide nurturance or support to the parent or caretaker. The child who experiences this reversal of dependence perceives that she/he can only express anger toward herself/himself. In this dimension, the individual does not dissociate when committing the act of cutting or burning. The individual experiences a sense of calm or relief after cutting.

Dissociative self-injury is often precluded by the individual experiencing cruelty by the parent or caretaker during childhood or adolescence. Frequently related with the dissociation that often occurs during an abusive act, dissociation occurs prior to the occurrence of negative feelings. In this instance, cutting or otherwise self-harming serves to center the person or assist her in feeling present or awake. In both dimensions, self-injury serves to reduce feelings of frustration, anger, or anxiety (Levenkron, 1998; Rosen, Walsh, & Rode, 1990; Stanley, Gameroff, Michalson, & Mann, 2001).

Strategies for Implementation

Conterio and Lader (1998) consider the treatment of self-injury as a long-term prospect for practitioners. Although it is unrealistic to expect the school counselor solely to dedicate the required time and effort to treatment of a self-injuring student, the counselor can facilitate the student moving into therapy and remain an instrumental part of the student's support system.

A trusting and sharing relationship with a student who self-injures may be difficult to develop (Levenkron, 1998). Communicating an understanding that the behavior is a means of managing feelings is essential. The counselor may, at least partially, communicate this understanding by reflecting feelings and assisting the student in verbally communicating feelings. For example, if a student revealed a recent cut along the forearm accompanied by the comment, "My teacher just makes my life miserable and this is the only way to feel better," the counselor might reflect to the student, "You were really angry and hurt with your teacher and you believed that this was the only way to express it." If the counselor can empathically communicate a level of understanding and acceptance followed by a mutually decided upon means of alternative expression, a greater chance of facilitating assistance exists (Jeffery & Warm, 2002).

For self-injury to decrease in frequency or cease all together, non-hurtful alternatives must be introduced and practiced (Conterio & Lader, 1998; Zila & Kiselica, 2001). Commonly used techniques for assisting the self-injurer better manage feelings and thoughts include the creation of an “alternatives list” (a list of coping strategies that may be helpful when the student feels the compulsion to self-harm) and journaling (as a means of becoming more comfortable with verbally expressing feelings).

The school counselor will likely experience difficulty providing all of the therapeutic needs of the self-injuring student. Consequently, after a trusting relationship has been established with the student, a primary focus should be on finding a therapist outside of the school environment. Finding a therapist that promotes an environment of healthy expression of emotions and patience is of the utmost importance (Simpson, 2001; Zila & Kiselica, 2001).

Classroom guidance activities may be a useful tool in working with self-injury. Since students who self-injure struggle with experiencing affect perceived as negative, classroom guidance activities that specifically address affect can be beneficial. A variety of appropriate topics would be: feelings in general, divorce, grief, death of a loved one, avoiding abusive situations, identifying abusive situations, alcohol/ drug use, and, of course, self-harm. The constant thread through each of these topics is expression of and alternative measures of managing emotions (Warm, Murray, & Fox, 2002).

Challenges to Treatment

The nature of the self-injuring student is lack of trust. Consequently, breaching confidentiality without weighing the ramifications is full of potential pitfalls. Counselors must clearly outline the limits of confidentiality with students and parents to avoid any misunderstandings or violations of trust (American School Counselor Association, 2004; Froeschle & Moyer, 2004).

To avoid frustration and promote healthy boundaries, the counselor must avoid offering that which cannot be provided (e.g., making promises like, “I will be here whenever you need to talk,” or “I promise I will never talk about this with anyone”). The counselor should schedule specific meeting times to discuss the proposed techniques to encourage the student to learn to appropriately express feelings and thoughts. In addition to preserving the counselor’s ability to provide assistance, setting appropriate boundaries will ultimately promote trust and learning of new coping skills for the student.

Summary and Conclusions

While self-injury is not a new phenomenon, confusion and controversy still surround it. It is imperative to understand that

the act of self-injury is not the focus of treatment, but rather providing alternative and facilitative means of sharing underlying feelings. Only when the student learns to meet her needs through alternative expression of feelings and thoughts will she be able to avoid the compulsion to self-injure. In the school setting new approaches must continue to be developed to not only manage existing cases of student self-injury, but to provide preventative measures for students at risk. Measures to provide students with alternatives to this phenomenon must be researched.

References

- American School Counselor Association. (2004). *Ethical standards for school counselors*. Alexandria, VA: Author.
- Conterio, K., & Lader, W. (1998). *Bodily harm: The breakthrough healing program for self-injurers*. New York: Hyperion.
- Coy, D. R., & Simpson, C. (2002). Kids who cut. *School Counselor*, 40(1), 16-19.
- Froeschle, J., & Moyer, M. (2004). Just cut it out: Legal and ethical challenges in counseling students who self-mutilate. *Professional School Counseling*, 7, 231-235.
- Jeffery, D., & Warm, A. (2002). A study of service providers’ understanding of self-harm. *Journal of Mental Health*, 11, 295-303.
- Laye-Gindhu, A., & Schonert-Reichl, K.A. (2005). Nonsuicidal self-harm among community adolescents: Understanding the “whats” and “whys” of self-harm. *Journal of Youth and Adolescence*, 34, 447-457.
- Levenkron, S. (1998). *Cutting*. New York: W.W. Norton and Company.
- Rosen, P. M., Walsh, B. W., & Rode, S. A. (1990). Interpersonal loss and self-mutilation. *Suicide and Life-Threatening Behavior*, 20, 177-184.
- Ross, S., & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence* 31(1), 67-77.
- Simpson, C. (2001). *Self-mutilation*. Greensboro, NC: ERIC/CASS.
- Stanley, B., Gameroff, M. J., Michalson, V., & Mann, J. J. (2001). Are suicide attempters who self-mutilate a unique population? *American Journal of Psychiatry*, 158, 427-432.
- Warm, A., Murray, C., & Fox, J. (2002). Who helps? Supporting people who self-harm. *Journal of Mental Health*, 11, 121-130.
- Zila, L. M., & Kiselica, M. S. (2001). Understanding and counseling self-mutilation in female adolescents and young adults. *Journal of Counseling and Development*, 79, 46-52.

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