Article 66

Self-Injurious Behavior: An Emerging Phenomenon

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Introduction

Self-injurious behavior recently has been termed the *new anorexia*, affecting an increasing number of individuals in America (Favazza, 1996; Levenkron, 1998). Because of the secretive nature of this phenomenon, determining exactly how many people are engaging in self-injurious behavior is difficult. Klonsky, Oltmanns, and Turkheimer (2003) estimated that "approximately 4% of the general population and 14% of college students have reported a history of self-injurious behaviors" (p. 1501). In spite of this emerging phenomenon, self-injurious behavior remains a taboo subject and continues to be highly stigmatized by the counseling profession (Favazza & Rosenthal, 1993). Consequently, many counselors lack a clear understanding of how to effectively intervene with this population.

Defining Self-Injurious Behavior

Over the past 60 years there has been a long-standing debate about naming this phenomenon. According to McAllister (2003), Karl Menninger first described a behavior known as wrist cutting syndrome in the late 1930s. Other terms include *deliberate self injury, self-mutilation, self-harm,* and *self-inflicted violence* (p. 178). In addition to these multiple terminologies, no universal definition of self-injurious behavior currently exists. Favazza and Rosenthal (1993) described self-harm as the deliberate alteration or destruction of body tissue without conscious suicidal intent. Additionally, Simeon, Stanley, Frances, Mann, Winchel, and Stanley (1992) defined self-injurious behavior as "the deliberate harm to one's body resulting in tissue damage, without a conscious intent to die" (p. 221). A common example of self-injury is cutting, which is probably the most frequently occurring form of self-injury and which has also been popularized in contemporary motion pictures (e.g., *Girl, Interrupted; Thirteen*) and literature. Although cutting is the most popular form of self-injurious behavior, burning, self-hitting, interference with wound healing, hair pulling, and bone breaking are also types of self-injurious behavior.

Recognizing that these two definitions distinguish between self-injury and suicide is critical for appropriate intervention and treatment. In fact, many researchers have argued that the majority of self-injurers are harming themselves in order to keep themselves alive. Levenkron (1998) maintained that the desired outcomes of self-injury and suicide are widely divergent. One one hand, those who injure themselves seek to escape from intense affect or achieve some level of focus. Following the act of cutting, these individuals feel better. On the other hand, depression and despair dominate, and death is the intent for those who seek to commit suicide. In spite of this differentiation, data indicate that 55% to 85% of self-injurers have made at least one suicide attempt (Stanley, Gameroff, Venezia, & Mann, 2001), and a person who self-injures is 18 times more likely than non-self-injurers to eventually commit suicide (Ryan, Clemmett, & Snelson, 1997). With this being said, all counselors need to be aware that the lines are often blurred between a suicidal ideation and self-injurious behavior. Thus, best practices for counselors necessitate conducting a suicide assessment to determine the intent behind the self-injurers' behaviors.

Self-injury can be divided into two dimensions; dissociative and nondissociative (Favazza, 1996). Many individuals are not aware that they have harmed themselves until the act is complete, in many cases not until they notice the blood running from the wound; they experience a dissociation in the act of self-harm. As counselors determine that the client experiences this type of dissociation, asking whether he or she is feeling numbness in other areas of his or her life facilitates an accurate assessment. An affirmative answer suggests that dissociation is a more widespread psychological mechanism, thus calling for an extensive framework for treatment.

For nondissociative clients, the feeling of numbness is not the goal; rather, the feeling of pain is. These individuals are acutely aware of themselves

before, during, and after the act of self-injury. Literature has suggested that these individuals comprise the largest segment of this client population, and most treatment models are developed for this particular presentation.

Contemporary Cultural Considerations

Society views many forms of self-injury as normal or acceptable. Some examples of culturally approved behaviors include ear piercing, personal tattoos, and eyebrow plucking. For the majority of people, these behaviors are viewed as artistic or as a form of self-expression; many tolerate the pain for the finished product. Although many researchers are quick to distinguish between these two behaviors, it is important to do so with caution; individuals with excessive tattoos or piercings may be satisfying the same intent as one who frequently cuts him- or herself. Thus, it is imperative to determine the intent behind any behavior that has the potential of causing harm or pain.

Characteristics of Individuals Who Self-Harm

Current research and literature on self-harm has focused on White middle to upper class adolescent women (Simpson, 2001), ignoring other racial and ethnic groups. Thus little is known about this activity in marginalized or nondominant groups, and further research is needed. Differing contextual elements and life experiences may contribute to the phenomenon of self-harm among individuals who cope with oppression and cultural invisibility, and new models of assessment and intervention may be needed.

Although many researchers have argued that self-injury is more common in males than females, Favazza (1996) has noticed a different trend: he contends that self-harm is becoming increasingly more common in males. The implications of gender and sex role socialization appear salient to this behavior, and research is needed to address these questions. Favazza and Conterio (1989) wrote that the age at the first episode of self-injury is usually in middle to late adolescence. In fact, counselors note that the majority of self-harmers are in their teen years.

The reasons why an individual may chose to self-injure are likely to be numerous and complex. Further, each time it is done, it does not have to be for the same reason. Reported instigators for self-harm (Levenkron, 1998) include those that are seen to

- release anger, pain, or anxiety: Many who self-injure explain that the act of self-injury immediately allows them to feel a sense of relief. Following the behavior, their feelings of anger, anxiety, or fear have subsided for a temporary amount of time.
- gain a sense of control: In many ways, this behavior is regulated by the self-injurer. For individuals who feel out of control, self-harm is one type of behavior they feel as if they can manage on their own terms.
- feel physical pain to distract from one's emotional pain: Clients may express that "feeling something is better than feeling nothing at all." Those who self-injure often feel numb and void of any emotions. They report that they harm themselves in order to feel something, in order to know that they are still alive.
- inflict pain on someone who is not available: Some who engage in self-injury may have intense negative feelings for someone who is not available to them in their lives. Transferring that pain onto themselves expresses their anger toward the absent person.
- ground oneself: Some who self-injure explain that harming themselves provides a grounding in reality and brings them back to the here and now. These types of individuals are generally demonstrating a dissociative state.
- communicate a need for support: Some clients lack the ability to express their emotions verbally. Self-injury allows the person to consciously or unconsciously communicate a need for help.
- prevent suicide: For many individuals, self-harm is a coping mechanism that may prevent individuals from attempting or committing suicide.

Treatment Approaches for the Individual Who Self-Injures

Despite growing interest in this phenomenon, no consensus has emerged for intervention (Hawton et al., 1998). Treatment for self-injury currently takes a number of different approaches and strategies. Individual counseling tends to dominate the treatment modalities, including cognitive behavioral therapies, problem-solving approaches, dialectical behavior therapy, and intensive in-patient treatment. Outcome research remains limited. Most studies reported in the literature employed small samples that were extremely heterogeneous; many of the studies were conducted upon patients treated in emergency rooms or within in-patient setting. Given that the target population for self-injury is adolescents, the reported research may not be

generalized for application to outpatient intervention and counseling.

Specific recommendations useful in community and private practice settings have been identified, however. Drawn from the current literature, the following list addresses the Do's and Don't's of working with this population (Alderman, 1997; Favazza, 1996, 1996; Levenkron, 1998;):

Do:

- conduct a suicide risk assessment: Although the literature argues that the two behaviors are distinct, it is imperative to know what the intent is behind every self-injuring act.
- know school /clinic policies on reporting self-harm with minors. Some schools and clinics have a mandatory reporting policy for parents while others adhere to a different philosophy. Fully understanding the stance that local institutions take will aid in risk identification, intervention, and treatment.
- attempt to understand why the individual is engaging in self-harm: A wide and complex variety of reasons motivate an individual to self-harm. Take the time to understand why your client is engaging in these behaviors.
- ask your client to show the actual wound or scar: In many instances, observing the wound may not be appropriate because of its location. However, if the location can be easily shown, and a strong therapeutic relationship has been established, ask your client to verbalize feelings before, during, and after each self-harming act, for every instance. Levenkron (1998) argued that routine discussions of injuries and discussing what to do about them increases trust, begins to integrate the person's sense of relationship to another person, and can successfully begin to replace self-harm with positive attachment.
- create a feelings vocabulary: For many who self-injure, verbal expression is a difficult task. Thus, help your client find words to express his or her pain. This can be done by prompting your clients: "If your wounds could speak what would they say?" Also, creating a feeling vocabulary list or playing games that promote expression of feelings can be extremely successful with this population.
- create a support system for your client: Many clients who self-harm have a real or perceived lack of support. Thus, in your counseling sessions, it is important to create a list of supports that the client can rely on during difficult times.
- make it clear that you care about the person behind the self-injury: Many times counselors make the mistake of failing to see their client beyond their self-harming behaviors. In fact, many counselors focus the majority of their sessions on self-harm and do little to get at the true feelings beyond the wounds.
- make statements that demonstrate empathy and an understanding of the self-harmers' feelings: "I see you are having a bad time again," "You must be in a lot of pain right now," "I can tell you are hurting," versus "Your behavior is really getting out of control," "I can't believe you did this again," "I just don't understand you."
- find alternative coping behaviors: For many, self-harm is a coping mechanism. Your task as a counselor is to create additional and healthier coping behaviors. Creating a list with your client during sessions can be extremely successful.
- create an atmosphere of openness and trust: Make it clear to your client that it is alright to talk about self-harm and that you are not offended by his or her behavior.
- seek supervision and consultation: When in doubt, seek supervision or consultation when working with difficult cases.

Don't:

- scold or reprimand your clients for harming themselves.
- force your clients to stop their actions; their self-harming behaviors are coping strategies.
- let your own discomfort or uneasiness with this behavior get in the way. Your clients are likely to be good at reading your expressions and body language and can easily sense our disgust, or fear.
- miss/cancel/show up late for appointments.

Using a Family Systems Perspective for Treatment

At the present time, the literature is limited concerning a systems perspective for working with self-injury. Nonetheless, Stone and Sias (2003) have argued for the potential benefits of family therapy for treating self-injurious behavior. In their work with a client who self-injured, they reported the successes of a

psychoeducational approach with the family that entailed educating the entire family about this behavior and instructing the family members on ways to appropriately respond to a family member's self-harming behaviors. Building upon their work, the following recommendations represent additional systemic themes to include in family therapy related to self-injurious behavior. The family counselor can

- promote appropriate, meaningful, and more engaged relationships among all family members;
- assist all family members to express and name their feelings;
- identify each person's reaction to the individual's self-harming behaviors;
- create a safety plan with the self-injurer and the family to prevent future occurrences or to assist in emergencies;
- develop a support network among family, school, and community resources. (This works particularly well for an adolescent self-injurer. for example, the counselor may ask the client, "what is it that you need from your parent?" and Then asking the parent, —"are you willing to do this?"); and
- encourage and model appropriate and open communication patterns among family members.

Information for Counselor Educators

Because of the increase of this phenomenon, counselor training programs have a responsibility to provide future counselors with information and strategies for working with self-injurious behavior. Education regarding self-injurious behavior is appropriate and relevant for community and agency counselors, family counselors, and school counselors. At a minimum, counselor education programs have a duty to do

- educate future counselors about the prevalence and significance of this behavior;
- encourage dialogues about the ethical and legal implications of reporting self-harm;
- encourage supervision and consultation with colleagues when working with individuals who self-harm;
- be aware of current research and resources on this topic; and
- initiate discussions with students regarding personal opinions and reactions students may have when working with this population.

Summary

Self-injury is prevalent and on the increase within the United States, especially among adolescents. This article has summarized current knowledge on the topic and noted that counselors in a variety of settings are likely to encounter individuals who self-harm, or are already treating such clients. Diverse treatment options, including both individual and family systems frameworks, were discussed with a listing of recommended counseling interventions and techniques. Clearly, all mental health professionals will benefit from a greater understanding and acceptance of this phenomenon to insure that those who practice the behavior continue to receive effective care. More research on self-injury and its related dimensions, including gender, developmental stage, life cycle tasks, race, socioeconomic status, and cultural influences, is urgently needed to provide direction toward prevention, intervention, and treatment congruent with best practices.

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