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Self-Injurious Behavior: Understanding and Working With Clients Who Self-Injure

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The topic of self-injurious behavior (SIB) has been gaining widespread attention in both the media and professional literature. Self-injury has been defined as "all behaviors involving the deliberate infliction of direct physical harm to one's own body without the intent to die as a consequence of the behavior" (Simeon & Favazza, 2001, p. 1). Thus, SIB encompasses an extensive array of behaviors, ranging from skin picking and hair pulling to bone breaking and self-surgery. The most common types of SIB tend to be cutting and burning. SIB has typically been mistaken by clinicians and medical doctors for a suicide attempt. This mistake may be due to either the high correlation between suicide and SIB, or because the behavior tends to appear to be similar. Although suicide attempts and self-injury can look similar, and have been found to be highly correlated, SIB is not a suicide attempt. Another way to think about the difference between SIB and suicide is that SIB is an escape from an intense affect, or an attempt to achieve a certain level of focus, in order for an individual to sustain and continue life, while suicide is a way to end life with death being the ultimate goal.

Self-injurious behaviors have been documented since biblical times. It is difficult to determine the prevalence of SIB since it tends to be frequently mistaken for suicide and is usually a secretive behavior. Thus, although studies have examined the prevalence of self-injury in the general population, college-age students, and psychiatric populations, the true prevalence remains unclear.

Similar to the problem with determining prevalence rates, it is difficult to truly know the typical characteristics of individuals who engage in self-injury. Recently, some researchers have described the profile for clients who tend to engage in self-injury. These include Caucasian females, in their mid-20s to early 30s, who have been hurting themselves since their teens (e.g., Stone & Sias, 2003). According to research, most individuals who self-injure tend to be middle or upper-class, intelligent, well educated, and from a background of physical or sexual abuse (Levenkron, 1998). However, other research has suggested that males also engage in self-injury, with similar prevalence rates as females. Favazza, De Rosear, and Conterio (1989) found that 18% of male and 12% of female undergraduates reported a history of SIB. Additionally, one of the current authors worked in a correctional facility in which, on average, 1 out of 12 male adolescents engaged in SIB.

Reasons for SIB

Some researchers have attempted to identify the reasons why individuals choose to engage in SIB. The majority of researchers have found that SIB is highly correlated (up to 80%) with childhood physical or sexual abuse (Levenkron, 1998; Simeon & Favazza, 2001). However, not all individuals who self-injure have been abused or neglected as children. Some individuals have an inability to express or cope with overwhelming emotions (Alderman, 1997; Favazza, 1998). Alderman suggested that clients who self-injure may have difficulty regulating emotions because they can not identify, express, or release the emotions. Self-injury becomes a way of expressing and releasing the emotions for an individual. While some people may use self-injury as a way to control emotions, others may use self-injury as a way to end a dissociative state, to keep memories from reoccurring, or to relive or reconnect with an individual, even if that individual has caused them pain (Levenkron, 1998). Overall, it appears that self-injury assists individuals in keeping or gaining control over their lives, whether it is in the form of controlling emotions or pain, feeling "real," or expressing oneself.

Treatment of SIB

In working with clients who engage in SIB, a thorough assessment is critical. In the initial assessment it is imperative to gather information about the behavior. As White-Kress (2003) suggested, the first responsibility of a counselor is to assess for self-injuring behavior by a client and then determine the frequency, duration, and onset of the SIB. It is important that a counselor assess for the severity of SIB in order to

determine if the behavior that the client is engaging in is impulsive and could result in unintended death. It is also important to assess for prior complications of the behavior. For example, has the client previously been hospitalized from self-injury? Have the wounds been infected? Or does the client not allow the wounds to heal once they have been created? Information provided from this initial assessment will assist a counselor in determining how high-risk the SIB is and whether the client is in immediate need of hospitalization or psychiatric evaluation, needs a safety plan and ongoing assessment, or simply needs education on the consequences that can result from SIB.

A counselor also needs to assess the reasons or purpose for self-injury as well as determine the client's stopping point before proceeding to engage in treatment of the behavior. Researchers have suggested that there can be many reasons that clients self-injure, including to manage emotions, to deal with anxiety, or to cope with stressful events (Favazza, 1987). Counselors should not presuppose the reason why a client engages in this behavior. Clients begin, and continue, to self-injure due to a wide variety of reasons. It is important for a counselor to understand the behavior from the client's perspective and reality (White-Kress, 2003). Once the reason and purpose of the behavior is understood by the counselor, it is important to determine the client's stopping point. The stopping point is the moment at which the SIB has served its purpose and the client no longer needs the behavior to gain control, ease tension, stop memories, or regulate emotions (Wester & Trepal, 2004).

Once the counselor has determined the level of severity of the SIB, the reason for it, and the stopping point for a particular client, he or she can begin to assist in the treatment of self-injury, or its underlying cause. White, McCormick, and Kelly (2003) discussed ethical considerations for this stage of counseling, during which a counselor is determining whether he or she should report the SIB, as well as whether it should become an issue in counseling. These authors mentioned that counselors are ethically obligated to manage and understand their personal reactions to the SIB and should avoid actions that seek to meet their personal needs at the expense of the client's needs. They also suggested that a counselor should respect a client's autonomy and the right to choose a particular coping method or behavior, even if it does not make sense to the counselor. However, White and colleagues do mention that when the nonmaleficence (the "do no harm" principle) outweighs the client's autonomy (e.g., multiple emergency room visits and serious infections), the counselor should report the behavior.

Treatment of SIB

Once the initial assessment is completed, the first step in treating a client who is self-injuring is to establish a trusting, reliable, and comfortable counseling relationship. Typically, clients who self-injure do not have close, trusting relationships with anyone, and rarely confide their SIB to other people. Levenkron (1998) discussed the fear of rejection these clients feel when they begin to share their secret with anyone, including friends, family, or a counselor. Thus he suggested that "The easiest way to break through this defense is to indicate that you are comfortable getting close to the person's pain, rage, and despair" (p. 66) and their SIB. Once a relationship is established, counselors can begin to move forward by providing alternatives in counseling in order to begin working toward the underlying reasons for SIB.

Although a goal of most counselors will be to have their clients abstain from SIB, clients and researchers have reported that this might not be achievable (Crowe & Bunclark, 2000). Attempting to extinguish SIB typically does not work, and the most that can be achieved is to reduce either the frequency or the severity. Thus, one of the goals in working with clients who self-injure is to get them to work on delaying the time between the thought of injuring themselves and the actual behavior. Sometimes this delay might be only a few seconds, while at other times it can be an entire day or a week. However, sometimes a client needs something to occupy his or her time, at least in the immediate moment when the self-injuring thoughts can become an obsession.

Wester and Trepal (2004) suggested alternatives that can be effective in minimizing and decreasing self-injuring behavior, as well as in delaying time between the thought or desire to engage in SIB and the actual behavior itself. These are alternatives that counselors can suggest to their clients and should be matched to the client's reason for engaging in SIB and/or the stopping point. Alternatives provide space and time in which the counselor and client can begin to uncover the underlying reasons for the damaging behavior. As an example, an individual may self-injure by cutting on his arm quickly five times in order to terminate or control his feelings when he feels an intolerable or overwhelming feeling. In this example, instead of cutting his arm, the client might choose the alternative of drawing on his arm, or quickly slashing lines on a piece of paper five times. If it is the sensation that he is seeking, and not the act of five lines, he might choose to brush his skin with a toothbrush or hold an ice cube on his skin for a certain period of time, both of which actions will create a sensation but not damage the skin

and tissue as would a razor.

Various types of treatments and methods have been suggested for working with clients who self-injure (e.g., Ross & McKay, 1979) including cognitive counseling; behavior modification, including training alternative behaviors; dialectic behavior therapy; and solution-focused brief family therapy. However, no one treatment has been found to be the most effective.

Although there is no one known treatment that works with all clients who self-injure, some researchers have examined treatments that have been found to be unsuccessful. These include physical restraint, hypnosis, no-cutting contracts, faith healing, group psychotherapy, relaxation therapy, electroconvulsive therapy, family therapy, and educational therapy (e.g., Favazza, 1998; Ross & McKay, 1979).

Conclusion

Working with clients who self-injure is a long, slow process. During this process, it is also important for counselors to pay attention to their own reactions to the client's behavior. Most professionals are at a loss about how to understand the behavior and tend to be frightened, frustrated, repulsed, and angry toward the behavior (e.g., Favazza, 1998). Thus it is important for counselors to assess their own reactions and behaviors toward the client, and seek out supervision if necessary. In sum, each client that comes into counseling is unique, including clients who engage in self-injury. There is no one pathway or etiology regarding how a client begins to self-injure nor are there similar reasons or functions the self-injury serves. Thus, counselors need to explore the meaning and purpose of the behavior with the client.

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