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Understanding Self-Injurious Behaviors:

Treatment and Implications for School Counselors

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Abstract

This review examined the implications of dealing with students who self-harm and how school counselors can effectively cope with this ever prominent issue among adolescents. The current study examined the trend of school counselors who have adopted a school or district-wide policy which dictates whether parent contact was made when a student presents with self-injury. Eighty-five different schools throughout Western New York were surveyed as to the existence of a policy or procedure. The respondents were asked specifically whether parents or guardians were contacted whenever a student presents with self-injurious behavior or if each situation was examined individually. This information was then used to promote discussions regarding the implementation of a policy or procedure at the internship site. A resource manual was also constructed for the education and use of the counseling staff. Implications for further research and limitations of this study were also discussed.

Understanding Self-Injurious Behaviors:

Treatment and Implications for School Counselors

There is a growing concern among school counselors surrounding the increasing prevalence of self-injurious behaviors in adolescents. As recently as 2002, a research survey indicated as many as 13% of adolescents sampled admitted to engaging in some form of self-injurious behavior (Ross & Heath, 2002). Research has suggested the prevalence for self-injury among middle school students is rising, with an average onset at age eleven (Conterio, Lader & Bloom, 1998; Warm, 2002). Suyemoto and MacDonald (1995) found that most individuals, who do not qualify for an additional psychopathological diagnosis, typically cease these behaviors around the age of eighteen. Thus, school counselors are in the unique position to provide prevention, education and intervention for this population.

Introduction

Research has identified several reasons for engaging in self-injurious behaviors including the need for concrete pain when psychological pain is too overwhelming; reduction of emotional numbness by creating physical pain; blocking out of traumatic memories and to keep them from present consciousness through distraction; emotional regulation; to receive support and empathy from others; release of anxiety, anger, despair and disappointment; increased sense of control; self punishment for "being bad"; and the enhancement of self-esteem (Alderman, 1997; Conterio et al, 1998; Favazza, 1996; Himber, 1994; Shearer, 1994; Walsh & Rosen, 1985).

Mental health professionals have theorized that individuals who engage in self-harm lack the ability to regulate their emotions (Suyemoto & MacDonald, 1995). This psychodynamic perspective holds that the inability to regulate emotions caused the individuals to turn his/her

anger inward and self-injury was used as a way to relieve or express that anger, which then facilitated an “emotional catharsis” (Crowe & Bunclark, 2000).

The phenomenon of self-harm is difficult for the average person to understand. Most people would never consider taking a razor to their skin or burning themselves as a way to reduce stress. Many would remark that the very idea sickens them. However, there is an ever-growing number of individuals, adolescents especially, who have resorted to this method of coping. Without understanding why, how, and who is engaging in these behaviors, it is difficult to undertake any intervention or treatment to help these adolescents. Since the average onset of self-injurious behaviors is now seen to be at the middle school level, school counselors, teachers, and administrators need to be poised to deal with the self-harming student, episodes of self-injury and the circumstances surrounding it.

The epidemic of self-injury is becoming more prevalent among middle school students. There is a need to educate teachers and administrators so that they may better provide support and guidance to their students who self-harm. There is the additional need for resource materials and information for school counselors so they may better serve their students who self-harm through individual and group counseling. Currently at this internship site, a middle school in Western New York, there is no procedure in place to handle students who self-injure. Issues of confidentiality are weighed against the risk of harm to the student when determining appropriate action. A proposal was made to investigate current trends in dealing with self-harm in the surrounding school districts while the counseling and administrative staff of the internship site propose and implement policy with regard to treatment, confidentiality and parental involvement in order to help the student who self-injures.

A Review of the Literature

Adolescence is a difficult and trying time of human development. Aside from physical maturation, adolescents must cope with a wide array of social and interpersonal problems. Issues with communication, self worth and identity often plague adolescents as they mature into adults. For some individuals the adjustment is not easy. In certain circumstances an individual may intentionally hurt themselves to gain respite from the pressures, anxieties and stresses of his/her environment. It is a way to cope during a particularly difficult time. It gives the person a way to physically express what he/she is experiencing emotionally (Alderman, 1997; Solomon & Farrand, 1996). Favazza and Conterio (1988) found that self-injurers tended to hurt themselves for a variety of reasons. Commons reasons include: gaining control, venting anger, release of tension and stress, security and relief from alienation, and confirmation of negative perceptions. These motives for self-harm indicated a need to communicate with others which matched the individual's unhappiness with themselves and/or their environment.

Communication between adolescents and parents can be difficult at best. Conterio et al (1998) saw many clients who escalated their self-injurious behaviors as a way to further communicate with their parents. They used self-injury to "up the ante", in order to gain attention from parents who, more often than not, were working more and more hours away from the home. For the average self-injurer, the behavior provided a purpose, garnered immediate attention from parents and care givers, and also served to push people away as if to say "can't you see how painful my life is" (Abrams & Gordon, 2003; Cavanaugh, 2002; Milia, 1996; Walsh & Rosen, 1988). Self-harm, therefore, was often used as an act of communication, to reach out to others. In reality, this was a negative strategy for self-injurers for it often repelled those whom they wished to reach out to. It was a desperate attempt to obtain a reaction from others, to find an emotional

connection that was not there naturally. The behaviors, however, more often served to alienate them from their loved ones (Cavanaugh, 2002; Himber, 1994).

Adolescents today reflect an image of being unhappy with themselves. They tattoo and pierce body parts in order to communicate to the outside world something about their nature (Alderman, 1997; Favazza, 1996). Rather than communicate their feelings verbally, they have taken to demonstrating their feeling through their skin (Jeffreys, 2002). Although tattoos and piercing are a form of communication for adolescents, they are not considered to be self-injurious behaviors (Alderman, 1997). Still, it is important to acknowledge that adolescents today have been inundated with media messages telling them to conform to a certain type or code in order to be successful (Jeffreys, 2002). Few, if any, adolescents fit this mold. The rest, it seems, have been cast aside as unworthy (Conterio, Lader & Bloom, 1998).

In adolescence the child began to develop an adult identity independent of their parents (Mitchell, Disque & Robertson, 2002). Self-harm has been viewed as a rite of passage in a society where many other rites of passage have been eliminated. Self-injury, for some, has been a measure of independence and separation from their parents (Conterio, Lader & Bloom, 1998).

Although there have been as many definitions of self-injurious behaviors as there have been researchers in this field, a commonly held belief regarding self-injury has been that it is a deliberate act against oneself without intent for suicide. Although this may seem to be a straightforward definition there are many aspects of self-injury which impact the severity, prevalence and features that influence self-injury in adolescents.

What Is Self-injury?

Alderman (1997) has developed key components to identify whether a behavior was self-injurious in nature. The behavior must meet these criteria in order to be considered an act of self-

harm. Acts of self-harm must be: a) done to oneself, b) performed by oneself, c) physically violent, d) not suicidal, and e) intentional and purposeful. Common forms of self-injury include; cutting of the skin, hitting, usually the head, thighs or stomach; excessive hair pulling; banging the head against a hard surface; scratching the skin until it bleeds; biting; burning; interfering with the healing of wounds; purposeful breaking of bones; excessive chewing of the tongue, lips, nails and fingers; amputation of limbs, genitals, breasts, fingers or toes; facial skinning; and injection or ingestion of sharp objects or toxic substances (Abrams & Gordon, 2003; Alderman, 1997; Conterio et al,1998; Favazza & Conterio, 1988).

Cutting and burning have been the most common forms of self-injury (Alderman, 1997; Briere & Gil, 1998; Cavanaugh, 2002; Conterio et al, 1998). Most often a self-injurer began cutting an area of the body people were unlikely to see. As the drive to self-injure became stronger and the person began to lose control, he/she began to cut in more obvious places. Very often those who have self-injured wore clothing which covered their mutilations (Briere & Gil, 1998; Conterio et al, 1998; Pipher, 1994). After cutting, burning was the next logical step for a self-injurer. Often a self-injurer escalated his/her forms of injury to gain the same rush from the pain. Seventy-five percent of all self-injurers have used more than one method of injury (Alderman, 1997; Favazza, DeRosear & Conterio, 1989).

The purposeful breaking of bones; excessive chewing of the tongue, lips, nails and fingers; amputation of limbs, genitals, breasts, fingers or toes; facial skinning; injection or ingestion of sharp objects or toxic substances were quite rare and have not been seen frequently in the average self-injurer. Those behaviors have been seen more often in the hospitalized and prison population than in the mainstream (Alderman, 1997; Simeon & Favazza, 2001). Other

more severe forms of self-injury included administering hot enemas and stabbing oneself (Briere & Gil, 1998).

Methods of self-harm vary from minor to life threatening, common to infrequent. Conterio et al (1998) defined self-injury as the deliberate mutilation of a body part without the intention to commit suicide but as a means of managing emotions which were too painful for the person to express. They further stipulated that in order for the behavior to be considered self-injurious, the act must be premeditated.

Simeon and Favazza (2001) developed a four category system for classification of self-injurious behaviors. The first category was referred to as 'stereotypic'. It included behaviors such as slapping; head banging or hitting; lip, mouth and hand chewing; self biting and some forms of hair pulling. These behaviors were most typically seen in populations with organic mental retardation or disorders such as Touretts, Lesch-Nyhan Syndrome, Autism, Cornelia de Lange and temporal lope epilepsy (White Kress, 2003; Stein & Niehaus, 2001). The second category, 'major' self-injurious behaviors, encompassed more potentially life threatening behaviors such as limb amputation, castration and eye enucleation. These behaviors were uncommon in the general population and were generally seen with individuals who suffered from psychosis, personality disorders or intoxication (Simeon & Favazza, 2001). "Compulsive' self-injury, the third category, included repetitive skin picking, hair pulling and nail biting which were viewed as moderate to severe in nature. This category of self-harm was consistent with the diagnosis of trichotillomania and stereotypic movement disorder as seen in the DSM IV-TR (Simeon & Favazza, 2001). The final category was the 'impulsive' set of behaviors. These included skin cutting, burning and mild self hitting. These behaviors were seen as habitual and isolated (White Kress, 2003). Within this category there were two sub-types: episodic and repetitive. Episodic

self-harm would happen only a few times throughout the individual's life. Repetitive self-harm involved re-occurring self-injury which was addictive in nature and difficult to control (Simeon & Favazza, 2001).

This classification system was useful to school counselors in determining if the client requires additional services than were provided at the time by counseling staff or if a referral to an outside community health agency was warranted (White Kress, 2003). The most common form of self-injury in schools fell under the category of impulsive self-harm. The treatment strategies discussed herein focused primarily on this population.

As previously mentioned, some might argue that body modification such as tattooing and body piercing are a form of self mutilation since research has found a strong correlation between body modification and negative feelings towards the body (Carroll & Anderson, 2002). However, Alderman (1997) insisted that since acts such as tattooing and piercing were perpetrated on the individual by others and rarely by the individual themselves, they did not constitute self-injurious acts. Jeffreys (2000) has spoken out about what she calls "self-mutilation by proxy". She described how in the last 30 years there has been a growing industry which specializes in body modification. This included piercing, ritual cutting, scarification, deliberate genital mutilation, transsexual surgery and certain forms of cosmetic surgery. She concluded that much of this industry's client base was the same population of troubled youth who self-injure. By definition, self-mutilation by proxy does not qualify as an act of self-harm (Alderman, 1997), however, Jeffreys (2000) deduced that as a culture, body modification and self-harm has become more and more accepted among adolescent populations, specifically women, homosexuals and abuse survivors.

Prevalence

Strong (1998) reported there were approximately two million self-injurers in the United States today. Research has suggested that between 14-39% of all adolescents in the general population, and 40% of the adolescent inpatient populations, have performed acts of self-harm (Ross & Heath, 2002). In contrast, Briere and Gil (1998) reported that self-harm was rare, occurring in only about 4% of the general population, but found a prevalence of 21% among clinical patients. There was little research which compared the prevalence of self-harm among general and clinical samples of the population (Briere & Gil, 1998). The veil of secrecy surrounding self-harm has been so strong that prevalence was hard to determine (Briere & Gil, 1998) as the behavior was usually carried out in seclusion and was very often not reported voluntarily. Most reported cases were found accidentally (Alderman, 1997; Briere & Gil, 1998). In recent years the prevalence of self-injury in adolescent patients has rivaled that of eating disorders (Conterio et al, 1998). However, true prevalence among adolescents was difficult to calculate since adolescents have been less likely to seek out assistance for their psychological problems than adults (Hurry, 2000). Often self-injurious behavior has been discovered by a parent, teacher or friend before treatment was commenced (Alderman, 1997).

Gender and self-injury. Statistics indicated the majority of self-injurers were white, middle class and female (Abrams & Gordon, 2003; Favazza & Conterio, 1989; Pipher, 1994). Women have been socialized in this culture to deal with pain on an emotional level while men have been taught to act on a physical level (McAllister, 2003). Furthermore, women statistically have experienced more abuse as children and remain more vulnerable to abuse in their adult years (McAllister, 2003). However, this higher prevalence among females may be due to the fact

that women have been more likely to seek counseling than men (Alderman, 1997; Conterio et al, 1998; Hurry, 2000).

In recent years the number of men receiving treatment for self-injury has increased but it was still significantly lower than women seeking treatment. This may be indicative of the growing issue of self-injury (Conterio et al, 1998). Generally, men have been more likely to focus their emotions outward than inward; they have turned to use drugs and alcohol as a coping mechanism rather than self-injury (McAllister, 2003). The most common environment for male self-injury has been found within the prison system, where inmates often turn to self-injury to maintain some sense of control in an environment where they have been denied any control (Alderman, 1997; Conterio et al, 1998; Haines & Williams, 1997).

Clinicians have reported that nearly all self-injurers, male and female, experienced identity and gender confusion (Alderman, 1997; Conterio et al, 1998; Milia, 1996). Clients have reported they received little pleasure from sexual contact but craved physical intimacy such as kissing, hugging or cuddling. Many self-injurers have reported a period of promiscuity (Cavanaugh, 2002; Conterio et al, 1998).This has been attributed to their need for instant gratification and to feel loved (Conterio et al, 1998).

Self-injury and race. Research on demographic differences among self-injurers has been nearly non-existent (Ross & Heath, 2002). The issue of ethnicity as a factor in self-harm has not been widely researched. This may be due in part to the higher number of Caucasian clients, who have sought treatment for self-injurious behavior, which has been highly disproportionate to other ethnicities (Goddard, Subotsky & Fombonne, 1996). Since minority cultures have been less represented in treatment, they have been equally underrepresented in research. Currently, less attention has been focused on the role of ethnicity and culture in relation to self-harm (Abrams &

Gordon, 2003), however Goddard et al (1996) believed ethnicity was an important factor in self-harm. They reported that black adolescents who self-injured appeared to have higher levels of social anxiety and stress than Caucasian self-injurers. They proposed that self-harm served a different purpose for different ethnic groups. They further stated there was a strong need for further research in the area of ethnicity and its influence on self-injury.

Self-injury in special populations. Abrams and Gordon (2003) examined both urban and suburban populations who self-harm. In this study the urban population consisted primarily of ethnic minorities who were working class, while the suburban population consisted primarily of affluent Caucasian participants. Some obvious differences cited by Abrams and Gordon (2003) were that urban self-injurers faced challenges, including violent neighborhoods and poverty, while the suburban self-injurers cited issues with illicit drugs, body image and appearance. Both groups remarked they used self-harm to cope with family and relationship issues as well as to manage their stress.

A difference was seen in the meaning participants attached to their actions. Urban participants self-injured in response to unresolved anger towards others, while suburban participants used self-harm to deal with desolation and hopelessness (Abrams & Gordon, 2003). Both groups were united in their feelings that self-harm was method to release difficult emotions.

In 2002, Ross and Heath conducted research using two high schools which differed in terms of prominent ethnicity and socioeconomic status. They found the prevalence of self-harm was similar in both schools and reflected that, at both schools, the highest percentage of students who reported a history of self-injury were Caucasian. They concluded that self-harm was a growing epidemic which effected many races and social classes. They also found more females indicated that they had self-harmed than did males, regardless of ethnicity or socioeconomic

status. Ross and Heath (2002) attributed this to the socialization of women where the outward expression of anger was discouraged; therefore, it was more likely that a female would turn her anger and aggression inward. Males, on the other hand, had more freedom and social acceptance in displaying their anger outwardly (Ross & Heath, 2002). The importance of examining an individual's social context, when evaluating them for self-injurious behaviors, was vital with this population. The individual's religion, cultural and sub-cultural contexts impacted what was normal and what was self-harm in the individual (White Kress, 2003).

Tyler, Whitbeck, Hoyt and Johnson (2003) found a widespread prevalence of self-injury among homeless youth. This population had additional stressors not normally seen in the average adolescent, including stress related to leaving home at an early age, living on the street, victimization, and other deviant survival behaviors. This population saw higher rates of family abuse, sexual abuse and mental disorders. The research of Tyler et al's indicated 69% of homeless youth practiced some form of self-injury. Of that percentage, 49% rated cutting or carving of the skin as the preferred method of self-harm (Tyler et al, 2003). This population also had higher rates of post traumatic stress disorder and depression which have been identified as potential risk factors for self-harm (Tyler et al, 2003).

Haines and Williams (1997) studied self-injurers in prison and non-prison settings and found that there was little to suggest self-injurers have serious deficits in coping and problem solving skills, however, they did find that self-injurers perceived themselves as having less control over interpersonal problems than those who did not self-harm. This was additionally found to be true in both prison and non prison settings. The self-injuring group they studied was also found to have fewer cognitive resources which would allow them to maintain prolonged positive self worth. Because of this, the self-injurers had a more difficult time implementing

other coping and problem solving strategies. Most self-injurers gave compelling reasons for why they self-harmed but many also expressed an overwhelming sense of shame at what they had done (Himber, 1994).

Research on the prevalence of self-harm among gay, lesbian and bisexual adolescents was also limited. Skegg, Nada-Raja, Dickson, Paul and Williams (2003) found a strong relationship between same sex sexual attraction and increased incidents of self-injury in young adults. They found this to particularly true for the men they interviewed who reported higher occurrences of self-harm than the women they interviewed. Skegg et al (2003) further reported that those individuals who indicated a stronger same sex attraction also reported a higher number of self inflicted injuries.

One reason why gay, lesbian and bisexual individuals have been underrepresented in the literature may have been because often times self-injury has been mistaken for a suicide attempt. There was research to support that gay, lesbian and bisexual adolescents had higher incidents of suicide than their heterosexual cohorts (Skegg et al, 2003). It was possible many gay, lesbian, bisexual adolescents have been labeled suicidal rather than self injuring.

Given the different estimates of self-injurious behaviors, as well as the complexity in determining prevalence among adolescents, the pervasiveness of self-injury has been difficult to verify. However, self-injury has been prevalent enough so that researchers have been able to identify a profile of someone likely to self-injure.

Profile of the Self-injurer

The typical self-injurer was most likely female with low self-esteem who may have suffered episodes of depression (Cavanaugh, 2002; Crowe & Bunclark, 2002; Levenkron, 1998). He/she first began injuring him/herself as an adolescent. He/she has had trouble forming or

maintaining intimate relationships as well as difficulty relating to others (Milia, 1996). He/she had a difficult time articulating his/her needs, thoughts and feelings to others. He/she has had a strong need for love and acceptance (Alderman, 1997; Levenkron, 1998). As a child he/she did not develop positive coping skills or strategies to self soothe and came to rely on self-injury to relieve his/her pain and suffering. By turning emotional pain into physical pain, he/she was able to physically nurture and care for his/her wounds when he/she could not accomplish this for emotional wounds (Alderman, 1997; Conterio, et al, 1998; Milia, 1996). In terms of emotions, anything which was intense or uncomfortable had to be dealt with immediately, usually with some sort of action or behavior, which provided relief from the intense emotions (Abrams & Gordon, 2003; Cavanaugh, 2002; Favazza, 1996; Favazza & Conterio, 1988).

Favazza (1996) suggested that self-harm involved many biopsychosocial factors which function within our society. Statistics reported that the predominant group of people who self-injure were white, female and of average intelligence (Abrams & Gordon, 2003; Alderman, 1997; Conterio et al, 1998; Favazza, 1996; Ross & Heath, 2002; Strong, 1998). There were several cultural forces which influenced this predominance. In western society, the Caucasian culture experienced dissolution of the extended family. More so than any other cultural group, the Caucasian culture has relied less and less on the role of grandparents and extended families in the care and nurturing of their children (Conterio et al, 1998; Selekman, 2002). In addition, children have had less and less intimate time with one or both of their parents because one or both parents work. These children often didn’t learn how to effectively communicate with their parents (Selekman, 2002). The children of this culture have had few intimate relationships with members of their immediate and extended families and had fewer people to turn to in difficult times. In this “latch key kid” society, children turned to their cohorts for guidance and support

(Conterio et al, 1998; Selekman, 2002). These cohorts have been equally uneducated in how to communicate their emotions and thoughts. In recent decades children have been spending a disproportionate amount of time sitting in front of a computer or television and less time developing communication skills and solid friendships. Verbal expression and communication has taken a back seat to video games and technological gadgets (Selekman, 2002). Furthermore, this culture has emphasized the need for immediate gratification (Milia, 1996). There have been fast food restaurants and drive-thru everything to cater to this need (Conterio et al, 1998). This focus on instant gratification appeared to have played a major role in self-injurious behavior.

McLaughlin, Miller, and Warwick (1996) hypothesized that adolescents who have self-injured were more likely to report feelings of hopelessness regarding the future, even when their underlying depression had been addressed. Their research suggested that hopelessness was a strong contributing factor to the causality of self-harm. The three groups they studied were adolescents who have self-injured, a clinic control group of adolescents, who are at-risk to self-harm, and a school based control group of students. The adolescents who had self- injured did not report any additional problems, which were not also reported by the other control groups. They had, however, reported higher severity and distress over problems which involved family/boyfriend/girlfriend issues and school situations. The research concluded that self-injurers felt unable to generate problem solving strategies and had difficulty seeing alternative choices to deal with their issues. This inability to see options may have pushed them into a pattern of hopelessness and self-injury (McLaughlin, Miller & Warwick, 1996).

Favazza and Conterio (1988) used the Self-Harm Behavior Survey to gather information regarding self-harm. They collected two hundred and fifty usable surveys from individuals who previously identified themselves as self-injurers. Favazza and Conterio (1988) found the average

self-injurer exhibited low lethality and his/her direct self-injurious behaviors usually began in early adolescence. The condition became chronic over time, and there was a strong relationship between social isolation, drug abuse and self-harm.

Research on self-harm, including the work done by Favazza and Conterio (1988), has hypothesized and investigated the various reasons why one might turn to self-injury. Although there was no clear explanation which encompassed all self-injurers, there were commonalities involving the motivation to self-harm.

Etiology of Self-injury

Many counselors, psychologist and social workers have researched the causes and origins of self-harm. Although there was no clear diagnostic cause for these behaviors, research has found many commonalities among self-harming individuals that included: environmental influences, such as sexual and physical abuse, family makeup, suicide, as well as biological influences such as bio-chemistry, biological frailty and the contagion factor.

Suymeoto and MacDonald (1995) compiled an eight factor model on the motivation for self-harm. With this model Suymeoto and MacDonald offered commonalities among self-injurers. In developing this model they surveyed a national sample of psychologists and social workers who researched and treated self-injurers. Their research found the following common attributes: behavioral, systemic, suicidal, expression, control, boundaries and depersonalization.

Behavioral Factor

This focused on the environmental factors which may have initiated and reinforced self-injurious behaviors (Suymeoto & MacDonald, 1995). Special consideration was given to those self-injurers who harmed themselves as a way to manipulate others in order to gain attention, for

most often they did not possess the emotional maturity to understand how their actions affected others (Cavanaugh, 2002).

Systemic Factor

Self-harm has been viewed as a side effect of dysfunction that exists within a family (Suymeoto & MacDonald, 1995). A history of emotional neglect was a strong indicator or risk factor for self-injurious behavior (Cavanaugh, 2002). Younger adolescents frequently cited arguments with parents, peers or significant others as the trigger for acts of self-harm (Hurry, 2000).

Child abuse was a common thread among those who self-injured. Conterio et al (1998) stated “the child’s skin boundaries were not respected, so his/her recognition or appreciation of those boundaries could not develop normally” (p. 75). Children who have been abused often objectified their bodies (Milia, 1996). Their bodies were objects used to hurt them. There has been a dis-connection between their emotional and physical selves (Carroll & Anderson, 2002). Many self-injurers hated their bodies because it was the cause of their pain and suffering (Alderman, 2002; Conterio et al, 1998; Favazza & Conterio, 1989; Milia, 1996; Turell & Armsworth, 2003).

A recurring theme among those in treatment for self-harm has been a lack of attachment or bonding with their caregivers (Levenkron, 1998). It would take more than just abuse, divorce, neglect or difficult transitions to create a self-injurer. Many people have experienced difficult childhoods and have not self-injured (Conterio et al, 1998). A commonality among self-injurers has been a high level of emotional frailty associated with the caregivers and parents (Abrams & Gordon, 2003; Cavanaugh, 2002; Conterio et al, 1998; Favazza & Conterio, 1989; Levenkron, 1998). Other common themes in families of self-injurers were early loss, parental illness or

absenteeism, and illness in a sibling which required more parental attention (Levenkron, 1998; Turell & Armsworth, 2003). Other trends included rigid adherence to religious or moral codes of behavior which restricted expression of emotion. Children who were not allowed to act on or express emotion often lost the ability to communicate it as well (Conterio et al, 1998).

Conterio et al (1998) theorized a tendency towards self-harm was witnessed in the 'under-parented' and the 'over-parented' (Conterio et al, 1998). When under-parented, many children were forced to take on adult roles such as caregiver for younger children or for the parents themselves. He/she learned early that he/she must take care of him/herself because his/her parents were not available or were unwilling to do it for them. He/she learned not to expect care and attention from others. As an adolescent he/she may have resented the loss of his/her childhood and felt threatened by the impending separation from his/her families. The adolescent used self-harm to keep these difficult emotions at bay. This adolescent had already experienced a profound period of loss and separation and had acted out against the inevitable separation that occurs during adolescence. Self-harm helped the adolescent cope with these intense emotions. Since he/she experienced loss at such an early age, it was difficult for him/her to understand that autonomy and separation were a normal and natural part of growing up (Conterio et al, 1998).

Those who were over-parented, they lived with the opposite extreme: the overly rigid and strict parent. In these situations, the adolescent struggled for more autonomy and separation. There were too few boundaries between parent and child; any attempt at independence was often met with hostility (Conterio et al, 1998; Selekman, 2002). The adolescent would have engaged in self-harm as a way to set his/her own boundaries with the parent, or to push them away. This was also seen with adolescents who were over-extended in their activities and felt extreme pressure to

be successful academically, socially and/or athletically. His/her free time was micromanaged and dictated for him/her. Skin was the only thing that was exclusively his/her own; therefore it became the canvas of his/her independence (Conterio et al, 1998; Selekman, 2002).

Suicide Factor

This factor supported the idea that self-harm was an act of self preservation, not an attempt to end life (Suymeoto & MacDonald, 1995). Acts of deliberate self-harm by adolescents were often carried out during times of acute emotional turmoil which were thought to be suicidal acts rather than self-harm (Hurry, 2000). Favazza and Conterio (1988) remarked that self-injury was actually an act of self-help for the individual. The act of harming oneself offered relief from uncomfortable symptoms such as dissociation and distress which, if unimpeded, could have resulted in a true suicidal act or psychotic break.

A common assumption was that one who cuts their skin, particularly in the area of the wrist and neck that they must be trying to kill themselves. On closer examination, however, an act of self-injury was viewed as a way to save his/her life, not take it. Confusion and ignorance regarding self-harm have often impeded a self-injurer's attempt to obtain help since most often his/her self-injury was seen as a suicidal act.

Understanding that self-harm was not a suicidal act was especially important when dealing with the client, medical professionals and significant others of the clients (McAllister, 2003). By acknowledging to the self-injurer that his/her behavior was a survival strategy, the counselor would instill a sense of hope that the client was actually being heard. This was often the starting point for recovery (McAllister, 2003). Individuals who self-injured often experienced frustration with teachers, counselors and medical professionals who saw their acts of self-injury as suicidal acts when in reality they were acts performed to make the person feel more

alive. This misinterpretation of their acts often compounded his/her emotional difficulties in communication (Alderman, 1997; Conterio et al, 1998; Himber 1994).

Guertin, Lloyd-Richardson, Spirito, Donaldson and Boergers (2001) discussed a three point distinction between what was self-harm and what was suicidal. The three points were: lethality, repetition, and ideation. Generally acts of self-harm had consistently low lethality, ranging from superficial to controlled acts. The acts were also highly repetitive whereas acts of suicidal ideation were rare and not often repeated without a higher level of success. Guertin et al (2001) found that suicidal ideation, at the time of self-injury, was highly uncommon. Many who self-injured described acts of suicide as being out of control whereas acts of self-injury were being in control. Some self-injurers described hurting themselves as a way to prevent suicide (Solomon & Farrand, 1996).

Self-injury and suicide are not mutually exclusive (McAllister, 2003). One does not necessarily lend to the other. Many self-injurers have never attempted suicide and many individuals who have attempted suicide do not practice self-injury (Crowe & Bunclark, 2000). That was not to say a self-injurer cannot be or become suicidal. There have been instances when a self-injurer did attempt, or committed, suicide however that has not been a general rule for this population (Alderman, 1997; Cavanaugh, 2002; Crowe & Bunclark, 2000; Conterio et al, 1998). In contrast, Briere and Gil (1998) reported that some of what appears to be self-injurious behaviors were actually dry runs at suicidal attempts.

Sexual Factor

This factor emphasized the connection between self-harm, sexuality and sexual development (Suymeoto & MacDonald, 1995). The onset of menses often coincides with the beginnings of self-injury (Conterio et al, 1998). The age of first menses has been earlier and

earlier with each generation; therefore clinicians have been seeing self-injury at younger ages. On a positive note Conterio et al (1998) reported that younger self-injurers responded favorably to treatment and had a better likelihood of overcoming the behaviors. It also appeared that the earlier the behavior was discovered, the more favorable the outcome (Conterio, et al, 1998; Pipher, 1994).

Sexual maturation can be the starting point for some self injuries (Conterio et al, 1998). Puberty is a time of extreme turmoil for most adolescents; emotions can be overwhelming and confusing. If an adolescent already feels unprotected, puberty would elicit feelings of vulnerability. For a child who has been sexually abused, their ever present feelings of guilt, shame and fear are intensified. Often it was too much for them to handle (Conterio et al, 1998; Levenkron, 1998; Milia, 1996).

Very often the self-injurer experienced some sort of emotional, sexual or physical violence in childhood. As adolescents and adults, self-injurers who were sexually abused often began to self-injure in order to deal with their anxiety surrounding sexual tension and to manage shame and guilt over having been sexually abused (Alderman, 1997; Cavanaugh, 2002; Conterio et al, 1998; Favazza 1996; Zila & Kiselica, 2001). After harming him/herself the individual usually experienced some relief, but it was often tainted with shame and guilt so the relief was short lived (Conterio, et al, 1998).

For those who have survived sexual abuse or assault, the sense of control over their own body was damaged (Alderman, 1997). Using self-harm as a means of controlling what happens to them provided a sense of control (Cavanaugh, 2002). Some self-injurers reenacted the abuse or assault through self-injury. They took a passive event (their abuse) and made it active (self-

harm). In this sense they have relived the event and exerted some control over the situation (Cavanaugh, 2002; Conterio et al, 1998).

Self-harm can also be an act of cleansing (Cavanaugh, 2002). Abused and neglected individuals have been taught they are dirty or unworthy and therefore turned to self-harm as a form of punishment for their frailties and faults (Alderman, 1997; Cavanaugh, 2002). Self-harm was an attempt to atone for whatever sins they believed they committed to deserve the abuse and neglect (Conterio et al, 1998).

Children who are abused, both sexually and physically, have often been warned to be silent about the abuse (McAllister, 2003). Many carried the emotional and physical scars of their abuse for years. Years of silence promoted non-communication on the expression of feelings. Since these children could not speak about their experiences, they turned to acting them out on their skin (McAllister, 2003).

Very often the self-injurer has carved words into his/her body to demonstrate how he/she feels about him/herself and his/her body (Favazza & Conterio, 1989). Conterio et al, (1998) indicated that the most common words carved into flesh were “Fat” and “Ugly”. Conterio et al (1998) described this trend as “uglification” wherein the adolescent has struggled against the sexual pressures placed on him/her by the media and society in general. They also concluded that adolescents would tattoo, pierce and scar their own skin in order to hold off the sexual advances of others. This was especially true for individuals who had suffered sexual abuse as children. They grew up to hate their bodies (Zila & Kiselica, 2001). Alderman (2002) reported that many self-injurers, who were sexually abused, raped or molested, fantasized about cutting off their breasts and/or genetalia. They strived to be very thin or very overweight in order to appear

ambiguous in their appearance, thus sexless and, therefore, no longer a target for the sexual advances of others (Alderman, 1997; Conterio et al, 1998).

Turell and Armsworth (2003) conducted a long linear model test on the prevalence of self mutilation among survivors of incest and childhood sexual abuse. They found that self-injury was more frequently found when the sexual abuse was perpetrated by a member of the family of origin, where there was history of anorexia or bulimia and high levels of dissociation and depression.

Peters and Range (1996) also examined the prevalence of self-harm among women who were sexually abused as children. They found a common factor among these women was high levels of self blame. This supported Alderman's (1997) theory that individuals may self-harm to atone for their perceived faults and sins. High self-blame was also linked to depression and suicidal ideation (Peters & Range, 1996). High self-blame was thought to contribute to the self-injurer's inability to problem solve and find alternatives to self-harm (Peters & Range, 1996).

Although Briere and Gil (1998) reported a significant relationship between childhood sexual abuse and self-harm, they also believed these sexual abuse survivors were overrepresented in the literature regarding self-injurious behaviors. They contended that one reason why sexual abuse was so prevalent among self-injurers was that the sexual abuse created trauma-related stress which, they believed, triggered the self-injurious behavior. They concluded it was the post traumatic stress which triggered self-injurious behavior and not the abuse itself.

Expression Factor

Self-harm has been said to be a form of communication for the individual who cannot express his/her emotions, wants, and desires verbally (Suymeoto & MacDonald, 1995). The self-injurer often described instances where they felt they would explode if they could not relieve

their distress by injuring themselves (Milia, 1996). Seeing their own blood or feeling physical pain often grounded the individual and he/she was better able to cope with their day to day experiences (Alderman, 1997; Conterio et al, 1998; Milia, 1996). Favazza (1996) described this as the self-injurer's attempt to reestablish contact with reality. Self injurers have had trouble differentiating between emotions and often fixated on one single emotion, if they were even able to articulate their experiences (Conterio, et al, 1998). For much of the self-injurer's life, he/she may have felt misunderstood, unheard and neglected (Milia, 1996). With those experiences it was unlikely that he/she ever developed the language skills necessary to communicate emotions verbally. The emotional turmoil existed even when the language did not. After acts of self harm there was an immediate response from people where his/her previous verbal attempts had not evoked one (Cavanaugh, 2002; Conterio et al, 1998).

Control Factor

For those who self-injured the need to control their emotions overrode their need to express their emotions. By self-harming, the individual made his/her emotions concrete, therefore, easier to deal with (Suymeoto & MacDonald, 1995). Briere and Gil (1998) reported that the most frequently reported function of self-harm was to regulate emotions. According to their research, subjects indicated that self-harm reduced anxiety, tension, depression, loneliness, emotional emptiness, guilt, dissociation, and was helpful in regulating flashbacks and obsessive ruminations. Self-harm helped regulate affect by providing a distraction from the emotional distress, thereby reducing tension and the duration of these negative experiences (Cavanaugh, 2002; Favazza & Conterio, 1989). The acts of self-harm were thereby negatively reinforced by the reduction of tension and the likelihood of repeat occurrences of such behaviors increased (Briere & Gil, 1998; Haines & Williams, 1997).

Self-injurers often equated anger with violence (Milia, 1996). They believed it was better to hurt themselves than to act out their anger on someone else (Selekman, 2002). Performing an act of self-harm would also serve the purpose of seeking revenge on those who hurt them by evoking guilt, shock or anger in the person whom they were angry at (Abrams & Gordon, 2003; Conterio et al, 1998).

Boundaries Factor

For some, self-injury helped to create and reinforce boundaries of self, as well as boundaries between oneself and others (Suymeoto & MacDonald, 1995). Many individuals who self-injured were aware that their behaviors had a tendency to frighten and disgust those around them. This primarily served to reinforce their feelings of worthlessness and shame (Himber, 1994). Individuals who self-harmed were conscious of the responses their behaviors elicited (Zila & Kiselica, 2001). Self-injurers often admitted that their behaviors were damaging and dangerous, but were hesitant to give them up. They often perceived it as losing what little control they had over their emotions (Cavanaugh, 2002; Conterio et al, 1998). Others received comfort from their actions. They saw their wounds as battle scars from the war they waged on their emotions and the outside world (Abrams & Gordon, 2003; Alderman, 1997). For others it was a testament for others to see how painful their lives were. Those individuals often lacked to the ability to verbally communicate their emotions in a healthy and adequate way so they used self-injury as a means to demonstrate to others how they felt about themselves (Cavanaugh, 2002). Conterio et al (1998) described clients who would self-harm in order to test the boundaries and limits of a relationship, and to force a reaction out of another. They attributed this to years of feeling unheard and unacknowledged. Many who self-injured craved the attention of others, even if it was negative attention. When physical harm was done to the body, many would then rush to

the aid of the self-injurer; if the self-injurer had asked for time and attention, it would not have been given to the same degree (Alderman, 1997, Conterio et al, 1998). A verbal request, or a less dynamic gesture for attention, would have gone unnoticed and could have reinforced the self-injurer's feelings of being invisible, therefore his/her behavior may have escalated to the point where they could not be ignored (Conterio et al, 1998).

Depersonalization Factor

People who have self-injured often experience "dissociation". Dissociation is a psychological defensive process where emotional significance and affect are separated or detached from an action, situation or idea (Alderman, 1997). Overwhelming emotions have incited a state of dissociation and self-injury could then bring the individual back into a state of reality (Suymeoto & MacDonald, 1995), thus self-harm would end dissociation (Favazza & Conterio, 1989). Self-harm also helped the individual maintain a sense of identity during extreme emotional turmoil (Suymeoto & MacDonald, 1995). For some self-injurers, dissociation occurred as a result of the injury. In others, the act of self-harm offered relief from dissociation (Alderman, 1997; Milia, 1996). Many self-injurers described feeling numb prior to the act of harm. In fact, they injured themselves in order to feel and release pain. Other self-injurers described feeling numb, and a lack of pain during the act of self-harm, and therefore self-injured in order to escape the pain they normally felt (Alderman, 1997; Conterio et al, 1998; Milia, 1996).

There are other factors commonly associated with self injuring adolescents: poor coping strategies, self-esteem, and uniqueness. It has been found that around the age of nine, anxiety and stress began to change and increased in girls, therefore coping strategies inevitably shifted and changed as well (Byrne, 2000). Additionally, self-injury made the client feel unique and special,

and he/she believed that if he/she were to stop hurting him/herself then he/she would be just like everyone else (Stone & Sias, 2003). Girls who self-harmed often performed these acts to determine if someone actually cared about them (Froeschle & Moyer, 2004).

Self-esteem was also found to be an issue. Nearly all self-injurers reported low or non-existent self-esteem (Cavanaugh, 2002; Crowe & Bunclark, 2000; Levenkron, 1998). Adolescents have dealt with many issues on a day to day basis. Problems at home, school, and with friends have impacted their self-esteem. For many adolescents, self-esteem was more often discovered or enhanced through external attributes rather than internal ones. Self-esteem impacted how and if an adolescent respected his/her body. Adolescents with low self-esteem were more susceptible to engaging in self-injurious behaviors than individuals with average self-esteem (Cavanaugh, 2002; Crowe & Bunclark, 2000; Levenkron, 1998).

Occasionally, the aforementioned conditions did not apply, or exist, for an adolescent who self-injured. Researchers have examined other likely causes beyond the aforementioned psychosocial origins of self-injurious behaviors.

Bio-chemistry of Self-injury

No model or theory to date has sufficiently accounted for all of the social and biological factors associated with self-harm (Pies & Popli, 1995). Multiple factors have compounded the emergence of self-harm such as environment, genetics, personality and psychological distress (Swadi, 2004). There were many theories as to why adolescents have engaged in such behaviors. Some of the more prevalent theories involved serotonin irregularities and the endorphin rush associated with self-injury. This theory, in particular, reinforced the idea that addiction may have played a role in self-injurious behavior (Pies & Popli, 1995). Additional theories proposed that a

biological frailty or predisposition for self-harm existed in certain individuals and was the underlying cause for self-injurious behaviors.

Linehan (1993) perceived self-harm as a biological disorder. From a biological standpoint, self-injurers had a higher prevalence for emotional sensitivity and emotional disregulation from a faulty neurochemical pathway (Swadi, 2004). Research suggested the act of self-injury released endorphins in the brain which acted in a fashion similar to opiates on the system. This accounted for the self-injurer describing the “high” he/she obtained when self-injuring (Alderman, 1997; Conterio et al, 1998; Mehta, 2004; Swadi, 2004). Serotonergic dysfunction has also being researched as a possible link to self-injurious behaviors (Evans, 2000; Swadi, 2004).

Repeated acts of self-harm have generally been thought of as an addictive behavior (Cavanaugh, 2002; Crowe & Bunclark, 2000). Just as drug addicts would, the more a self-injurer tried to control his/her distress with self-harm, the more dependent on the self-injury and out of control he/she became (Cross, 1993). Many people who self-injured described a loss of control over their actions where at one time the behavior was a choice. At times they described their behavior as compulsory and that they no longer have power over it (Himber, 1994).

Self-harm has been be a cycle of abuse which quickly came addictive (Mehta, 2004). Cutters in particular would carry around their cutting instrument with them as a source of security until they could be alone and cut their skin (Mehta, 2004). Cutters felt they needed to make deeper, more dangerous, cuts to obtain the same rush, or endorphin high, which they received when they first began to self-harm (Alderman, 1997; Mehta, 2004). Suicidal acts were primarily seen when the addiction became more and more out of control (Cavanaugh, 2002). Even then, it was not a true suicidal act but a desperate attempt to attain the same endorphin rush

(Mehta, 2004). The more an individual cuts or burns themselves the more disconnected they were from their bodies (Levenkron, 1998; Mehta, 2004). Once the process of self-harm was established the symptoms were harder to control, and the behavior was no longer a choice, similar to what has been seen with drug addiction (Favazza et al, 1989).

Biological frailty. It was important to note that not all self-injurers reported a history of physical or sexual abuse. Abuse has not been a prerequisite for self-harm, just as not all individuals who have been sexually or physical abused have harmed themselves (Conterio et al, 1998). Largely, self-harm has been seen as having primarily environmental influences. In certain cases these environmental influences were not present and therefore did not contribute to the psychopathology. Conterio et al (1998) referred to these individuals as having had a biological frailty which was the contributing factor to the development of self-injurious behaviors. Resiliency was also be a factor in determining who was at risk for self-injurious behaviors (Ebata & Moos, 1994). A child, who has elicited positive responses from his/her environment, whether that environment was healthy or unhealthy, was less likely to develop self-injurious behaviors than their less resilient cohorts (Favazza, 1996; Levenkron, 1998). It would be difficult to understand how someone without a history of neglect or abuse could turn to self-harm. Temperament has been found to be an especially important factor in how children and adolescents moderate stress and emotions (Ebata & Moos, 1994). Individuals who were hypersensitive to emotions and stimuli often found certain situations and emotions too much to handle and use self-harm as a coping strategy to deal with their environments (Conterio et al, 1998).

There was an additional aspect of self-injurious behavior which has been of growing concern for school counselors and clinicians alike. Walsh and Rosen (1985;1988) referred to this

dilemma as the “contagion of self-injurious behaviors”. They concluded that single acts of self-injurious behaviors within a group of cohorts would be rare; that the self-injurious behavior of one student often sparks the initiation and imitation of self-injurious behaviors in others.

The Contagion Effect

Adolescents tended to imitate the behaviors of others to promote togetherness; this extended to the practice of self-injurious behavior. If a student already had risk factors for self-injurious behavior, the practice of these behaviors in a friend would often trigger an earlier onset of self-harm in the at-risk student (White Kress, Gibson & Reynolds, 2004; Walsh & Rosen, 1985). The problem of self-harm had become so prevalent, in clinical circles the epidemic has been called the “new anorexia” (Conterio et al, 1998; Edwards, 1998).

There have been increasing reports of individuals, adolescents in particular, who have adopted self-harming strategies from their classmates and friends. That was not to say every adolescent was in danger of becoming a self-injurer. It was more likely that these adolescents were already psychologically vulnerable to the behaviors (White Kress et al, 2004; Walsh & Rosen, 1985). These adolescents readily adopted self-injury as a new coping strategy to deal with already existing distress. Self-injury was now perceived as ‘in fashion’ and as a popular coping strategy among adolescents (Conterio et al, 1998).

The idea of self-harm should not be surprising in a culture where strength and tolerance for pain have been prized in its youth (Levenkron, 1998). In this culture athletes are praised when them played despite grueling injuries; accolades are poured on musicians and artists who portrayed self-injury in their lyrics and artwork (Conterio et al, 1998; Levenkron, 1998). Young people have connected with these individuals levels others cannot. Adolescents have identified

with the artist's pain then adopted similar strategies for dealing with their own emotional turmoil (Conterio et al, 1998).

Some adolescents who have self-harmed admitted that self-injury did not provide relief for their emotional states and that their main purpose in performing these acts was to feel part of the group (Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, & Helenius,1998). When one adolescent self-harmed, the incidents of self-harm in the cohort group increased (Taiminen et al, 1998). Self-injury has become an initiation rite for some cohort groups and ultimately strengthened the group's cohesion. This shared experience, although done singularly, promoted togetherness within a circle of friends (Taiminen et al,1998). Furthermore, Walsh and Rosen (1985) remarked when adolescents were informed that self-injury was often an act of imitation, there was a sharp reduction in the frequency of the acts within a peer group. They believed that during adolescence the child does not want to be seen as a follower.

Although self-harm was be seen in adolescents without a differential diagnosis, it has been more common to see it coupled with some form of psychopathology such as anxiety, depression, post traumatic stress disorder, obsessive compulsive disorder, eating disorders, body dysmorphic disorder and/or depression (Swadi, 2004).

Co-morbidity with Other Psychological Disorders

Briere and Gil (1998) found that most of the self-injurers whom they sampled had a variety of differential diagnoses such as: post traumatic stress disorder (73%); dissociative disorder, not otherwise specified (40%); borderline personality disorder (37%) and dissociative identity disorder (29%). Self-injurious behavior was often seen with borderline patients who concurrently had issues with traumitization and dissociation (Shearer, 1994).

When a self-injurer came to the attention of the medical profession they were often labeled with a differential diagnosis in order to receive treatment (Alderman, 1997; Crowe & Bunclark, 2000; Conterio et al, 1998). As yet, the DSM IV-TR (APA, 2000) does not have a separate purposeful diagnosis for someone who self-injures. Self-injury has been considered by some to be a side effect or a repercussion of some other disorder (Briere & Gil, 1998). Common disorders associated with adolescent self-injury were: bipolar disorder, major depressive disorder, psychosis, dissociative disorder and borderline personality disorder (Alderman, 1997; Conterio et al, 1998). There has also been a significant prevalence for self-injury among the autistic and other mental retardation populations (Alderman, 1997; Stein & Neihaus, 2001), however those instances were excluded from any statistical information or research included herein.

Self mutilation has been one of eight criteria used to diagnose borderline personality disorder (Favazza & Conterio, 1988). Self-injurious behaviors has also been seen in histrionic personality disorder and well as anti-social personality disorder (Favazza & Conterio, 1989). Personality disorders, when associated with anxiety issues, were by far the most common co-morbidity with regard to self-injury (Swadi, 2004). Affective disorders such as depression, anxiety, conduct and eating disorders were common occurrences in individuals who self-injured as well (Guertin et al, 2001). Depression has been a particularly important factor relating to the repetition of self-injury in adolescents, and has been seen as one of the best predictors of self-harm in adolescents (Alderman, 1997; Conterio et al, 1998; Hawton, Kingsbury, Steinhardt, James, & Fagg, 1999). It has also been suggested that adolescents who self-harmed tended to have a history of attachment issues and experienced high levels of rejection (Levenkron, 1998; Turell & Armsworth, 2003).

Suicidal self-injurers, when compared to suicidal individuals who have not self-harmed, were found to be more likely to have a differential diagnosis for oppositional defiant disorder, major depression and dysthymia, and reported higher levels of loneliness, anger, risk taking, alcohol abuse and hopelessness (Guertin et al, 2001). In light of this information these clinicians have urged mental health professionals to screen all suicidal patients for self-injurious behaviors even if the patients have not presented with this as an issue at the time of the referral (Guertin et al, 2001).

Many self-injurers had never come to the attention of the medical community. Although their behaviors had sometimes been dangerous and altogether physically unhealthy, the vast majority of self-injurers have been able to function well in society (Conterio et al, 1998). For many, self-injurious behavior has been viewed as a positive coping strategy and one that has allowed them to function at work, home or school and to be otherwise useful to society (Alderman, 1997; Conterio et al, 1998). Labeling someone who self-injures with some type of syndrome has often been counterproductive since the average self-injurer does not fit the diagnostic characteristics of any particular syndrome (Crowe & Bunclark, 2000).

Self-injurious behaviors have been found to have a strong link to eating disorders. Often in treatment, the client traded one maladaptive behavior for another. Many of the factors which influenced the development of self-injurious behaviors have also been found to have influenced the development of eating disorders.

Self-injury and Eating Disorders

Favazza, et al (1988) found that sixty-one percent of the self-injurers they surveyed either have or had an eating disorder. Eating disorders and self-harm have been seen as acts of revenge against a person or situation with which the self-injurer has been in conflict (Alderman, 1997).

They have been actions of control over their bodies and environments (Favazza et al, 1988). For many people, self-injurious behavior and eating disorders served the same purpose, providing control and calm during times of stress and anxiety (Cross, 1993). For individuals who have had an eating disorder, bulimia in particular, there has been a higher risk for developing self-injurious behaviors (Favazza et al, 1989). In fact, for some clinicians, eating disorders such as bulimia and anorexia have been thought to be indirect forms of self-harm whereas cutting, burning, and the like have been considered direct forms of self-harm (Favazza et al, 1989). While Alderman (1997) acknowledged the relationship between self-harm and eating disorders, she emphasized there has been no cause and effect relationship between the two. She purported they were separate choices for similar situations which appealed to the same individuals.

Self-harm was a behavior not a diagnosis; therefore, there has been no one treatment, intervention or medication which guarantees a cure (Evans, 2000). Self-injury was a learned behavior, and can be unlearned (Conterio et al, 1998). A gradual approach to reducing the behaviors was best. Asking a self-injurer to stop altogether may be too traumatic (Crowe & Bunclark, 2000). A gradual approach would allow for the client to make a choice in how to handle stressful situations, thus leaving the control with the client (Crowe & Bunclark, 2000). Self-injury was a choice; once the self-injurer has accepted that he/she has a choice not to injure him/herself, the healing process can begin (Conterio et al, 1998).

Treatment

Self-injurers can and do recover (Levenkron, 1998; Pipher, 1994). Recovery is a long and difficult path. Healing requires continuous self-reflection and examination. There are many interventions which can be helpful in treating adolescents who self-harm. Common treatments include psychodynamic therapy, cognitive behavior therapy, family therapy, drug therapy and

hospitalization. It would be time consuming and financially difficult for school counselors to provide all of the services which community clinicians provide to this population, however school counselors are in a position to provide individual and group therapy to these adolescents. Alternative modalities such as art and music therapy and support groups have also being used in clinical settings as well as in schools (Swadi, 2004). Individual and group interventions have been useful with this population, however, in addition to the self-harm, any underlying issues, such as abuse, divorce, depression, needed to be addressed for any long term reduction in self-harm to be successful (Froeschle & Moyer, 2004).

Individual Counseling

Early recognition of a tendency towards self-harm as well as investigation into precipitating factors have been important in the overall outcome of treatment (Cavanaugh, 2002). During treatment a positive therapeutic relationship needed to be established between the counselor and the client (Crowe, 2000).

Crowe (2000) encouraged using small steps in therapy. The minimization of self-harm has been a more realistic goal in the beginning than the complete absence of self-harm. As the client recognized gains in his/her treatment, more challenging alternative behaviors could be suggested including; postponing the self-harm by distraction, going for a walk, surrendering the instruments of self-harm to a family member or friend, developing creative alternatives such a painting or crafts, and having the client record a personal statement on tape to dissuade him/herself from self-harm in the future.

Clients would often test the limits and boundaries of the counseling relationship. There would need to be limits to what a counselor would allow a client to do without stronger consequences. Those boundaries should be made clear to the client at the start of treatment

(Crowe, 2000). When these boundaries have been crossed consequences needed to occur in a timely manner.

There has been little research into the effectiveness of different therapies used to treat self-injurers (Evans, 2000; Stone, 2003). Often these adolescents have had difficulty verbalizing emotions and needs (Suymeoto & MacDonald, 1995). Himber (1994) goes so far as to describe the communication skills of the self-injurer as preverbal, therefore a primary focus of therapy should be developing communication skills, and learning alternative behaviors. The most prominent, and most promising, form of counseling used to treat adolescents who self-harm was individual counseling utilizing cognitive behavioral techniques (Evans, 2000; Swadi, 2004).

Cognitive behavior therapy. Cognitive behavior therapy involves teaching clients how to change thoughts which interfere with self-esteem and self-image. Low self-esteem and poor self-image allow for self-injury to occur. By replacing thoughts dominated by negative qualities with those which focus on positive attributes, the client effectively relieved him/herself of the need to self-harm. When focusing on the positive aspects of the client's life, he/she was better able to protect their bodies from self-harm because the body was now seen as part of the whole person and not a disconnection (Bowman & Randall, 2005; Walsh & Rosen, 1988).

McLaughlin, Miller and Warwick (1996) suggested a model of cognitive therapy in dealing with self-injurers. It was their position that those who self-harm lacked the ability to see alternative choices of dealing with issues and feelings of hopelessness. Cognitive therapy has been useful in helping the client generate different options and solutions to the problems they faced, thus breaking the cycle of hopelessness and self-harm (Selekman, 2002). Stone and Sias (2003) suggested a bimodal approach to treatment. The first component involved individual therapy with the client to instill cognitive behavior strategies to counteract the distorted thinking,

as well as establishing substitutes for maladaptive behaviors. The second component involved a family systems approach where the interpersonal dynamics of the client were examined.

Cognitive behavior therapy focused on the individual's irrational thinking, assisting the client to understand the connection between his/her thoughts and self-harm (Zila & Kiselica, 2001, Pipher, 1994).With self-injury there have been several common thought patterns: self-injury was acceptable, they deserved this punishment, they had to self-harm in order to reduce unpleasant feelings, and explicit actions were needed to communicate effectively (Bowman & Randall, 2005; Swadi, 2004; Walsh & Rosen, 1988).

The first thought pattern, that self-injury was acceptable, was easily combated because the average person doesn't believe it to be true. However it was the mainstay of someone who self-injures. He/she may be conscious, or unconscious, of this idea but it was always been present and necessary with self-injurers. A major focus of cognitive behavior therapy has been to change this line of thinking and ultimately for the self-injurer to believe that it was not acceptable and it was unjustifiable (Stone & Sias, 2003; Swadi, 2004; Walsh & Rosen, 1988).

Along with feeling that self-harm was acceptable, the self-injurer often believed they were deserving of punishment and that self-injury was a way to fulfill that punishment (McAllister, 2003; Nospitz, 1994; Stone & Sias, 2003; Tatman, 1998; Walsh & Rosen, 1988). Self-injurers often have had negative ideas and have been overly critical of their bodies in particular. This self-hate was vital because it laid groundwork for giving them permission to violate their bodies through self-harm (Conterio et al, 1998; Stone & Sias, 2003; Walsh & Rosen, 1988). For individuals who self-harmed there was an inner voice which told them they were worthless and should suffer. It may have been difficult for these clients to recognize and enjoy any therapeutic success they achieved (Noshpitz, 1994). Treatment involved recognizing patterns of behavior

surrounding the self-harm, the acquisition of alternative coping skills and the development of interpersonal skills (Stone & Sias, 2003).

When under pressure or stress, the self-injurer believed some action on his/her part was necessary to relieve the stress (Bowman & Randall, 2005; Conterio et al, 1998; Favazza, 1996). Since cognitions existed which said self-harm was acceptable, and that his/her body was an object of loathing, it was an easy transition for the self-injurer to act against him/herself in order to relieve their stress. He/she knew that they would feel better if they cut themselves. The need to reduce tension has been one of the greatest barriers in treatment for self-injury (Bowman & Randall, 2005; Conterio et al, 1998; Favazza, 1996). Most traditional methods of stress reduction used in counseling were not action-oriented and therefore insufficient to provide the same relief found with self-harm. Traditional methods of stress reduction have also done nothing to combat the irrational thinking of self-injurers (Walsh & Rosen, 1988).

Many self-injurers used self-harm as a means of communicating to others the pain and stress they have been experiencing (Bowman & Randall, 2005; Conterio et al, 1998; Favazza, 1996). Without a physical display, the self-injurer feared his/her feelings were not understood (Alderman, 1997; Levenkron, 1998). It has also been common for an individual who self-injured to misjudge the feelings of others based on his/her thinking that without action the feelings cannot be demonstrated or understood (Milia, 1996; Walsh & Rosen, 1988).

Irrational thinking has been a vital aspect in the participation and continuation of self-injurious behaviors. These irrational thoughts provided justification and meaning to the acts. In order to diminish the need for self-harm, the irrational thoughts needed to be examined and changed (Bowman & Randall, 2005; Favazza, 1996; Walsh & Rosen, 1988). Walsh and Rosen (1988) described a four step process for the treatment of self-harm from a cognitive behavioral

standpoint. Step One involved establishing the connection between thinking and self-harm; helping clients understand how thoughts led to emotions and behaviors. They remarked that many self-injurers were unaware of the connection between what they thought and their behavior. Through counseling, the self-injurer came to understand the thoughts which preceded self-harm. The self-injurer was then encouraged to monitor his/her thoughts and how they influenced behavior. This would be facilitated by refocusing the client's attention away from the environment and onto feelings. This change in focus placed responsibility for self-harm on the client and away from the environment and implied that the client could exert control over his/her behavior (Walsh & Rosen, 1988).

Step Two entailed showing clients that self-harm was incompatible with self-respect and self-esteem. Since self-injurers believed self-harm was acceptable and that he/her deserved it, thoughts needed to be disputed and ultimately changed (Conterio et al, 1998; Favazza, 1996; Selekman, 2002; Walsh & Rosen, 1988). One way to accomplish this was to confront the client with the idea that people who respected themselves do not degrade and mutilate themselves (Walsh & Rosen, 1988). Self respect was demonstrated through care and protection of one's body; when a person viewed his/her body as disgusting, he/she would always be a target of their own abuse (Conterio et al, 1998; Favazza, 1996; Selekman, 2002; Walsh & Rosen, 1988). An additional technique used to change thinking that self-harm was acceptable was to label it as disrespectful. Each time a client self-injured, it would be treated as being disrespectful of his/her body (Walsh & Rosen, 1988).

Walsh and Rosen (1988) described the 'mind-body split" which has been common among self-injurers. Walsh and Rosen described how self mutilators often had a psychological detachment from their bodies and did not feel as if their mind and bodies were part of one being.

This detachment made it easier for them to do harm to their bodies since they did not see their bodies as part of themselves. Walsh and Rosen (1988) suggested the division between mind and body needed to be minimized so that the self-injurer could conceptualize the mind and body together as one unified person. When this concept was adopted by the self-injurer, other changes in thinking became achievable.

Enhancement of self-esteem has been critical to the treatment of self-injury (Alderman, 1997; Conterio et al, 1998; Favazza, 1996; Selekman, 2002; Walsh & Rosen, 1988). When an individual suffered from low self-esteem, he/she found it extremely difficult to focus on positive qualities or, at the very least, accept that he/she had any positive qualities (Bowman & Randall, 2005; Levekron, 1998; Walsh & Rosen, 1988). Counselors assisted clients to identify and focus on the positive qualities they possessed. This was explored through interviewing the client, worksheets, or through the day-to-day process of counseling. Sample questions include: “What kinds of things do you like about yourself?” “What are your talents?” “What kinds of things can you do well” “Are you a good friend?” and “Tell me about a success you have had.” Furthermore, the client was asked to explore what he/she thought others believed to be his/her positive qualities. Changing the focus to a client’s positive qualities triggered a reappraisal of his/her self-worth and self-esteem (Bowman & Randall, 2005; Walsh & Rosen, 1988).

Very often a self-injurer only focused on his/her negative attributes, paying little or no attention to his/her positive qualities (Levekron, 1998; Nospitz, 1994; Selekman, 2002;Walsh & Rosen, 1988). Walsh and Rosen (1988) suggested that counselors point out to the self-injurer that he/she had a negative view of him/herself, that he/she failed to see his/her positive qualities, that the focus of thought needed to shift to his/her positive qualities in order to have an accurate self

image and that the best way to do this was to focus on his/her positive traits more often than the negative traits (Walsh & Rosen, 1988).

Step Three involved restructuring the need to act in order to reduce tension. Many self-injurers reported that in times of tension and stress something needed to happen in order to survive the intense emotions (Alderman, 1997; Favazza, 1996; Selekman, 2002; Walsh & Rosen, 1988). It was crucial that clients came to understand that this was an irrational thought. The counselor would help the client realize that a change in thinking would reduce tension more readily than an act against oneself (Favazza, 1996; Selekman, 2002; Walsh & Rosen, 1988).

Self-injurers have a low tolerance for unpleasant emotions. Teaching a client to tolerate uncomfortable emotions was a difficult task (Alderman, 1997). Unpleasant emotions often led to frustration and the fear of being overwhelmed. The task at hand was to help the client restructure his/her thoughts about the uncomfortable feelings (Conterio et al, 1998; Favazza, 1996; Selekman, 2002; Walsh & Rosen, 1988). Once the thinking has been restructured, alternative methods for stress reduction was used. Furthermore it was important that the client recognized the type of feeling he/she was experiencing so that then he/she would be better able to focus on their emotions rather than on the need to act. Once the client has been able to identify his/her feelings he/she was better equipped to try and control the need to hurt him/herself (Conterio et al, 1998; Favazza, 1996; Levekron, 1998; Selekman, 2002; Walsh & Rosen, 1988).

Step Four involved assisting the client to re-evaluate how he/she thinks about communication and his/her relationships with others. There has been the fear that words cannot adequately communicate the turmoil that a self-injurer feels. He/she may have thought that others would not take him/her seriously without a grand gesture or action (Conterio et al, 1998; Favazza, 1996; Selekman, 2002). Self-injurers needed to begin to use language instead of action,

this has been something they needed to learn and practice in their day to day lives. They further came to understand that the communication of feelings could be successful without action (Walsh & Rosen, 1988). Treatment changed the nature of the relationships that self-injurers have with others. They may crave the attention they once received for hurting themselves or they have felt as though they miss the self-harm. At this point it was practical to focus on the advantages of not harming oneself and to examine how relationships have changed for the better (Walsh & Rosen, 1988).

Behavioral components. Both the client and his/her environment has reinforced self-harm. As with all behaviors they have been reinforced internally, externally, positively and negatively (Alderman, 1997; Briere & Gil, 1998; Favazza, 1996; Haines & Williams, 1997; Walsh & Rosen, 1988). With self-harm there have been several different ways that reinforcement occurred. Since the reduction of tension was a primary goal for many self-injurers, this behavior had internal negative reinforcement. By explanation, the tension was a reaction to an uncomfortable feeling such as anger, guilt or self hate. Since self-harm relieved that tension, or removed it from the environment, it was negatively reinforced thus the likelihood if repeating the behavior was higher (Alderman, 1997; Briere & Gil, 1998; Favazza, 1996; Haines & Williams, 1997; Walsh & Rosen, 1988). This reinforcement was powerful since the relief was so great; it created a strong pattern of behavior that was difficult to change. Self-harm was also externally reinforced because it produced strong reactions from others (Crowe, 2000; Walsh & Rosen, 1988). A client may have self-harmed in response to the anger or criticism of a significant other. That significant other would then withhold further criticism and anger in order to prevent the self-harm from happening again, thus externally reinforcing the behavior in the client. Lastly, self-harm had positive external reinforcement (Briere & Gil, 1998; Haines & Williams, 1997;

Walsh & Rosen, 1988). This occurred when the client became desperate for affection and closeness from others. The fear of being rejected from others was intense and self-harm was used to remove the uncomfortable emotion (fear). The client wanted affection and comfort from others but lacked the communication and social skills needed to elicit comfort from others (Favazza, 1996; Walsh & Rosen, 1988). After hurting themselves, the significant other provided physical and emotional comfort for the wound and the client never had to ask for affection. This form of self-harm was coercive and once the client received the comfort and affection he/she wanted, the self-harm was reinforced (Conterio et al, 1998). This form of reinforcement has been difficult to avoid. It is natural to want to help someone who is hurt. As a result of self-harm, the client got an abundance of comfort and attention from medical professionals, counselors and therapists as well as his/her significant others (Walsh & Rosen, 1988). Elimination of reinforcement has been a difficult task. Alternative responses to tension needed to be developed. Eventually those alternative responses were reinforced just as the self-harm was (Briere & Gil, 1998; Walsh & Rosen, 1988).

In addition to individual counseling, school counselors often provided group counseling for their students. This served several purposes. The school counselor could run a group specifically for individuals who self-injured but could also provide group counseling based on any other issue that may have contributed to the client's self-injurious behavior such as self-esteem, depression, body image and social skills, which would ultimately help increase appropriate coping skills.

Group Therapy

Group therapy has been useful when working with adolescents because it promotes and facilitates identity development and communication (Suymeoto & MacDonald, 1995). Group

therapy has also been productive in working with adolescents who self-injure because it provided intimacy and nurturing for the self-injurer (Walsh & Rosen, 1988). The goal for group therapy was to change how self-injurers use social interactions to fulfill their needs and to adapt healthy ways to communicate and express oneself. Other goals included finding additional ways to nurture oneself and so that intimacy could be achieved.

Group counseling has been beneficial because it provided ample opportunity for members to enhance their communication skills (Bowman & Randall, 2005; Wood, Trainor, Rothwell, Moore & Harrington, 2001). The counselor would guide the sessions to explore different emotions and reinforce verbal communication of the group members. The counselor would further monitor the support and nurturance of other group members (Walsh & Rosen, 1988). Since the basis of group therapy was talking, this was difficult for some self-injurers who have a hard time communicating their needs and emotions without the overt physical gesture of self-harm (Bowman& Randall, 2005, Conterio et al, 1998; Selekman, 2002). Many group members stated that talking about their needs, wants and emotions was unsatisfying for them initially (Conterio et al, 1998; Walsh & Rosen, 1988). With practice, the act of talking became more natural for them. The counselor was also aware when the group was not responding to a member's disclosure. Failure of a group to respond to a member's disclosure would reinforce to that member that no one would listen unless they harmed him/herself. The group should be encouraged to respond and utilize active listening to promote group cohesiveness (Walsh & Rosen, 1988).

Group therapy with adolescents enabled the self-injurer to identify with others who were dealing with similar issues or who have had similar coping strategies (Walsh & Rosen, 1988; Wood et al, 2001). However, group treatment could present a problem if one member used the

group format to outdo other members with outrageous behaviors (Taiminen et al, 1998; Walsh & Rosen, 1988). This would alter the group dynamic and place control of the group in the hands of that one member. In these instances the counselor needed to set firm and appropriate limits on the group and the behaviors of its members. Walsh and Rosen (1988) suggested that if a member threatened to do harm to him/herself or acts against him/herself in the group session, that member was removed for the remainder of the session. In a subsequent session the behavior of that member was discussed by the group and the member would need to explain what he/she was trying to communicate through his/her actions in the previous session. Furthermore, members who are making strides to resist self-injurious behaviors need special attention. This attention was important in reinforcing their progress (Walsh & Rosen, 1988). Occasionally there was pressure from other members of the group against resisting self-harm (Taiminen et al,1998). Most often this pressure came from group members who were not yet ready to give up their self-injurious behavior and felt threatened by those who did.

There were drawbacks to this form of counseling which can be overcome if recognized by the counselor and dealt with effectively. Some drawbacks included: the self-harm of one participant would trigger episodes in others; the individual members' desire to feel acknowledged and understood would be communicated through self-harm in the beginning stages of treatment, individual members would use self-harm to manipulate other members or to obtain a desired emotional reaction from others in the group, and lastly group members would use self-harm as a platform to gain higher status in the group (Taiminen et al,1998; Walsh & Rosen, 1988).

As previously discussed self-harm has been contagious among groups. The dynamic of the group was influenced by the self mutilation of its members. Other members of the group

would experience mixed emotions ranging from anger to jealousy when another member continued to self-harm. Group treatment was a valuable tool in helping self-injurers deal with the consequences of self-harm (Taiminen et al,1998; Walsh & Rosen, 1985;Walsh & Rosen, 1988).

There has been very little research into the effectiveness of group counseling versus other forms of counseling. However, Wood et al (2001) found that self-injurers who received both group therapy and routine care had fewer episodes of self-harm than individuals who received only routine care. Still, this area of treatment has been under-represented in the literature but can be valuable for counselors from a time and financial standpoint.

Interventions; What Works, What Doesn't

There is still no clear cut intervention which has been undoubtedly defined as successful with this population (Huband & Tantum, 1999; Stone & Sias, 2003). Since many individuals who have self-harmed have difficulties communicating verbally, a treatment plan involving alternative forms of communication has been helpful (Crowe & Bunclark, 2000). Creative writing, art therapy, drama therapy, and projective art have been useful in inpatient settings (Crowe & Bunclark, 2000). Traditional methods of interventions such as supervision and prevention were only temporary solutions to the problem. Often the behaviors returned and increased once the supervision and prevention were removed (Crowe & Bunclark, 2000).

Huband and Tantum (1999) surveyed 213 mental health workers regarding their preferences for interventions when working with this population. Although many items drew disagreement regarding effectiveness, the sample as a whole encouraged the use of engaging the client to voice unexpressed emotions. They discouraged the use of medication and hospitalization. Other research indicated that medication helped manage some symptoms but was not advised as a stand alone intervention (Stone & Sias, 2003). There were also strong

disagreements regarding no-harm contracts, family therapy and 24 hour phone availability of the therapist (Huband & Tantum, 1999). All agreed that effective interventions should aim to identify and remedy the underlying causes of the self-harm and develop replacement behaviors and strategies (Stone & Sias, 2003).

Warm, Murray and Fox (2002) conducted a survey of self-injurers which asked where they sought treatment. Over 73% of the responders stated they had sought treatment in the past through counselors, psychologists and psychiatrists. On the whole, the respondents were less satisfied with their treatment with psychiatrists, doctors and nurses while Self-help organizations received the highest approval ratings.

Treatment has been found to be most productive when the aim was to slowly reduce maladaptive behaviors rather than the immediate cessation of the self-harm (Warm, Murray & Fox, 2002). Warm et al (2002) found that nighttime access to support was crucial. For more self-injurers evenings were a difficult time and much of their self-harm took place at night when they were alone. Providing access to support systems after hours was advised (Warm, Murray & Fox, 2002). One form of support which has become more widespread and popular was that of internet support groups (Warm, Murray & Fox, 2002). These groups can provide 24 hour support where a counselor cannot.

Behavior contracts. For some clinicians, behavior contracts that eliminate the behaviors have not been productive (Himber, 1994). Many self-injurers have lied about their behaviors to therapists when their contract specified they must end all self-harm. Contracts which involved implementing other strategies before self-harm, or required the client to report feelings of escalation or dangerous self-harm, were more productive in treatment (Himber, 1994). Examples of other treatments which have been shown to be ineffective were: restraints, hypnosis,

chemotherapy, no-cutting contracts, faith healing, relaxation techniques, and family therapy (Favazza, 1996), although other researchers have found family therapy to be successful with this population (Selekman, 2002).

Counseling Issues with Self Injuring Middle School Students

Since these behaviors have a tendency to take hold in early adolescence, school counselors have been in a position to initiate treatment for this population (Warm, Murray & Fox, 2002). An important aspect of counseling someone who self-injures has been to accept his/her injuries as well as the individual. An adverse reaction to the wounds has reinforced the negative thinking the client has about themselves (Swadi, 2004).

It has been important for counselors to have a strong knowledge of self-injurious behaviors to aid with diagnosis and assessment (Alderman, 1997; White Kress, 2003). Assessment has been crucial in determining the severity and potential for danger as well as determining the appropriate intervention for the client (White Kress, 2003). Briere and Gil (1998) encouraged counselors to treat not only the self-injurious behaviors but to also focus on the underlying aspects which supported its continued use. They encouraged exploration into alternative methods of reducing distress which are less injurious or shame- inducing; the establishment of and reliance on support systems; teaching cognitive and behavioral techniques for dealing with stressful situations; and promotion of internal affect regulation. White Kress (2003) stressed it has been important for the counselor to try and understand the behavior from the client's perspective and encouraged the counselor to ask such questions as 'what do the behaviors mean to you' and 'what are your reasons for engaging in these behaviors'.

Parents and teachers have often seen self-harm as attention seeking behavior (Conterio et al, 1998). It may in fact be attention seeking however, that was rarely the primary reason or

intention of the self-injurer. Attention seeking may be a part of the equation, but there were many other aspects which were involved with the action itself (Abrams & Gordon, 2003; Cavanaugh, 2002; Froeschle & Moyer, 2004; Walsh & Rosen, 1988). Often self-harm has been an attempt to elicit caring responses from others. Self-injurers may have been seeking the compassion and nurturing that has been absent from their lives. What the self-injurer failed to see was that their acts of self-harm isolated them further, as well as incited fear and helplessness in others (Himber, 1994; Milia, 1996; Zila & Kiselica, 2001).

Teachers and other staff need to be educated about self-harm so they may better create and support an environment of empathy and recovery (Froeschle & Moyer, 2004). Involving the family has been very helpful. Educating parents on self-harm has been beneficial so they can assess self-harm behaviors at home (Froeschle & Moyer, 2004). A safety plan detailing self-injury triggers, physical cues and possible steps for the reduction of anxiety have been beneficial to the student as well (White Kress et al, 2004).

Clearly not all adolescents who come from difficult homes self-injure, just as the experiences of self-injurers differ from person to person. Soloman and Farrand (1996) suggested focusing on the context of the act and less on identifying commonalities may benefit counselors in the long run. This was not to say other contributing factors, such as abuse and depression, should be ignored. It was important to ascertain if the client was ready to do the work. Forcing someone to abandon behaviors he/she has come to rely on would be a huge undertaking (Warm, Murray & Fox, 2002). If the client has been mandated to seek treatment, and denial has been so far ingrained in the client, counseling may be futile (Noshpitz, 1994). When engaged in treatment the self-injurer may protect him/herself with an arsenal of defense mechanisms including denial, evasion, projection, rationalization, displacement (Noshpitz, 1994). Through

treatment the self-injurer can learn that self-injury was a severe psychological condition but was not a condemnation of the person who does it (Conterio et al, 1998).

Implications for School Counselors

Many times it was the school staff and counselors who first became aware of a student's self-injurious behavior. This knowledge came from physical observations, self reports from the student, comments from teachers or parents and the reports from the student's peer group (White Kress et al, 2004). School counselors handled these situation before, during and after the self-injury took place. The intervention at school often determined whether an individual received outside treatment for this problem (Froeschle & Moyer, 2004).

Moderate impulsive self-mutilation as described by Favazza (1996) has been the most common form of self-injury seen in schools today (Froeschle & Moyer, 2004). Parents should be educated as to the school's efforts to deal with self-injurious behaviors. If school policy has been implemented, then parents and the community should be informed of said policies (Capuzzi, 2002).

Often an adolescent who self-harmed did not seek help out of fear that his/her parents would be notified or that others would discover his/her secret. Glosoff and Pate (2002) encouraged counselors to be aware of how their own beliefs and values have influenced how they perceived a student's behaviors. Reliance on the age of the student to determine the level of danger has not been altogether appropriate since not all children were as mature as their age might suggest. Some children need more support than others and were incapable to handling situations that some of their peers coped with easily (Isaacs, 1999).

Rosen and Heard (1995) suggested development of a system of categorizing self-harm to aid in the decision whether or not to disclose information to the parents. This system included a

rating scale indicating the severity, location and method of the self-harm: Level 1: injuries were superficial, resulting in damage to first layer of skin, no medical intervention was required; Level 2: injuries have broken the skin with minor bleeding requiring minimal medical attention (band aid); Level 3: significant bleeding as a result of the injury, requiring stitches and the client should be seen by medical professional (emergency department); Level 4: injury was serious enough to require multiple stitches and was potentially disfiguring or life threatening (possible hospitalization). In turn, the school counseling staff would implement standards of practice with regard to when disclosure to parents is warranted.

School counselors have provided interventions and referrals for their students who self-injure (White Kress et al, 2004). It was important for school counselors to be aware of community agencies and private practitioners who treat clients who self-injure (Froeschle & Moyer, 2004). As always, any suspected, or disclosed, child abuse must be reported to authorities under state, federal and ASCA guidelines (Froeschle & Moyer, 2004; Glosoff & Pate, 2002).

Confidentiality

School counselors have played a crucial role in crisis intervention and management of at-risk students. This posed many ethical and legal challenges to the counselor. There has been little information about school policy and ethical consideration for dealing with students who self-harm. When working with self-harm, many questions came to mind such as what are the ethical obligations to the student and his/her parents with regards to confidentiality? What are the obligations of the school counselor, school administration and other staff once a child has been identified as a self-injurer? Can the school district be sued by families if a child’s self-injurious behavior requires hospitalization? Do schools need a self-injury prevention program?

Privacy and confidentiality has been important to the client's willingness to disclose personal information. Glosoff and Pate (2002) stated that clients who came to counseling did so with the idea that they wanted to be helped and that there would be an expectation of disclosure of some personal information. The information they shared was influenced by who they believed would be privy to the information they disclosed. Most students who sought help from their counselor assumed that any information told to the counselor was kept in confidence by the counselor with few exceptions (Glosoff, Herlihy & Spence, 2000). From an ethical standpoint student have a certain right to expect confidentiality in the counseling relationship, however from a legal standpoint parents and guardians have claim to limit the rights of the student (Ledyard, 1998).

Breach of confidentiality has been common with this population (Whotton, 2002). When working with children and adolescents it has been difficult to ascertain if a client was mature enough to understand dangerous situations and was able to handle said situations appropriately without the support of an adult. Areas such as drug use, sexual behavior, and self-harm have been difficult for school counselors to navigate (Isaacs, 1999). The danger in breaching confidentiality has been that it damages the role of the school counselor. It changes the dynamic between students and counselors and blurs the role of the counselor (Mitchell, Disque & Robertson, 2002). If a student believed a counselor would not uphold confidentiality, he/she was less likely to engage in a therapeutic relationship even if they would have benefited by it (Glosoff & Pate, 2002). Breach of confidentiality has, at times, placed the student in greater harm by creating an environment where an already isolated and insecure child felt exposed and unaccepted (Froeschle & Moyer, 2004).

Confidentiality is not unconditional (Glosoff et al, 2000). Counselors also have the additional duty to warn. It has been important for counselors to be aware of who they must warn as well as when (Glosoff et al, 2000). Collins and Knowles (1995) conducted research in which they surveyed students 13-18 years old. They discovered that 53% considered confidentiality to be essential but there was also general agreement that confidentiality should be breached in cases of imminent danger.

Glosoff and Pate (2002) recommended that school counselors begin each school year with a mailing of information to parents regarding the role of the counselor and to perhaps indicate where the rules of confidentiality fall with regard to their child. They further encouraged counselors to inform parents that they will be contacted at any time if the counselor feels their child is a danger, either to themselves or others. School counselors must clarify with their students the limits of confidentiality (Froeschle & Moyer, 2004). Isaacs (1999) encourages counselors to prepare, in advance, guidelines to follow when considering a breach of confidentiality such as: frequently checking for updates on local laws, district policies as well as the code of ethics for school counselors, examination of individual biases and judgments regarding ‘dangerous behavior’ and how the age and maturity level of the student factors into the situation, and then establish, in advance, the kinds of behaviors that would qualify for a breach of confidentiality.

Hendrix (1991) stated that when dealing with minors there were certain situations where the law regarding disclosure superseded the ethical code for confidentiality. They included reports of abuse, serious self-harm and the intention of harming another person. Some states have passed laws which protect the confidentiality of minors with regard to birth control, abortion, pregnancy and sexually transmitted disease testing (Corey, Corey & Callanan, 1998). With the

exception of the previous conditions, parents have legal control over their children (Lawrence & Kurpius, 2000).

Counselors have had the task of finding ways to honor the rights of children, but at the same time appropriately include parents in the process (Glosoff & Pate, 2002). Parents can be reminded that confidentiality is the cornerstone of the school counselor's job and if the student cannot trust the counselor's commitment to confidentiality, the child may not feel he/she can share openly. This may further disrupt the child's ability to trust other adults (Mitchell et al, 2002). Counselors need to be aware of the client's relationship with his/her parents and if disclosure to the parents would be in the best interest of the client. This, of course, needs to be weighed against the potential for harm to the client if there were no disclosure (Anderson, 1996; Ledyard, 1998). Mitchell et al (2002) suggests explaining the school counselor's code of ethics to parents which will further support the counselor's need for confidentiality with regard to their child. If possible, the student should be made aware of the parent's request for information. The client can be encouraged to disclose certain information to his/her parents and to make it the client's decision as to what information was shared with the parent (Mitchell, Disque & Robertson, 2002). Parents can also be encouraged to talk to their child about concerns which brought them to counseling. The school counselor may be in a position to offer skills and suggestions to the parent as to how to do this (Mitchell et al, 2002).

Although the therapeutic relationship exists within the school system, that does not entitle teaching and administrative staff any right to information disclosed during counseling sessions (Glosoff & Pate, 2002). As much as school counselors work within the educational setting, the student is their client, and not the teachers, the needs of the student should come first (Glosoff & Pate, 2002).

Ethical Codes

With regard to the American Counseling Association (ACA) and the American School Counselors Association (ASCA), the Laws and Codes of Ethics, as dictated by each organization, must be utilized in determining when confidentiality should be breached in order to help student who self-harmed (Froeschle & Moyer, 2004). The American Counseling Association states counselors should uphold a client's right to privacy and avoid unnecessary disclosures of information. However, both the ACA Code of Ethics (2005) and ASCA Ethical Standards for School Counselors (2004) stated counselors were ethically required to take action when it appeared a client may be a danger to themselves or to another (Glosoff et al, 2000). The dilemma for counselors has been determining what "a danger" is. There have been no set criteria, and it remains the individual counselor's discretion as to what qualifies (Glosoff & Pate, 2002; Isaacs, 1999). What appears to be very dangerous at the elementary or middle school level may not be considered dangerous for a high school student (Isaacs, 1999).

Much of the school counselor's job has been governed by ethical codes and legal doctrines. These professional obligations were not always harmonious (McCarthy & Sorenson, 1993). There has been a mixed message on what is proper and ethical to disclose to parents, according to the American School Counselors Association, which stipulates the school counselor must respect the rights of the student with regard to confidentiality but to make reasonable efforts to honor the wishes of parent to receive information about the student. (Glosoff & Pate, 2002; Mitchell et al, 2002).

Anderson (1996) remarks that some school counselors are bound by the provisions of the FERPA- Family Educational Rights and Privacy Act of 1974. This act was developed to protect the rights of the child. Under this act, the school counselor was not legally bound to disclose

information obtained through counseling session to a parent. This act governs all school districts which receive federal aid (Anderson, 1996).

In conclusion, the needs of students who present with self-injurious behavior can be very challenging to navigate. The issue of confidentiality has been greatly tested with this population. Often it was left to the individual counselor to decide when and if it is appropriate to disclose to parents their child has self-injured. A growing trend among individual schools and school districts has been to adopt a policy or procedure which stipulates when and if parents were contacted in cases of self harm. The following research examined this trend.

Goals and Objectives

The first goal of this research project was to provide the counseling staff and administration of the internship site with information which would support a proposal for establishment of a school-wide policy for dealing with students who self-injure. There was no policy in place at this site; often it is left to the individual counselor's discretion as to how, if and when the parents of the student are notified and what level of intervention was provided to the student. All of the present counseling staff had expressed an interest in the development of a school policy on self-injury and have articulated a need to have a common policy or procedure in place to help their students. In the process of collecting information, area school districts were contacted by mail and asked to complete a simple survey regarding the existence of policies or procedures in place to deal with students who self-injure. Additionally, there was the opportunity for those counselors contacted to offer his/her insight into this problem, or to give in greater detail his/her school's stance on self-injury. The information gathered from the surveys was then made available to the counseling staff at this internship site. Using this information, as well as the codes of ethics and guidelines of ASCA and ACA, the counseling staff began discussions

regarding the development of a unified procedure to be utilized by all counseling staff members at the internship site.

The second goal of this project was to provide comprehensive information regarding self-injury to the counseling staff, educators, administration, parents and students at the internship site. This was facilitated through the development of resource manuals which included interventions for individual and group counseling for student who self-injure, community resource information for counselors, teachers and parents, as well as the development of in-services for staff and educators as needed.

Method

Participants

Participants were chosen from Monroe County, the location of the internship site, and among five surrounding counties. A survey was sent to every public high school, middle, or junior high school in Monroe County. Four private high schools were also surveyed; three of which also operate middle schools at their location. A total of fifty-eight schools were surveyed within Monroe County with an additional twenty seven schools from surrounding counties, for a total of eighty-five surveys. Participants from surrounding county school districts were chosen based on enrollment numbers. Surveys were sent only to districts that had enrollment numbers greater than 1000 students in the district. Address, contact information and enrollment numbers were obtained through district websites, individual school counseling websites, and through the website www.greatschools.net. When no particular counselor was known the survey mailing was addressed to the school counseling office.

Procedure

A survey and letter of inquiry were developed to facilitate this objective. The letter of inquiry was addressed to the school counseling office of the selected school. The letter explained the purpose of the survey, provided pertinent statistics regarding the prevalence of self-injury among adolescents and further explained that neither the name of the counselor nor the school would be reported along with the results of this survey. It was explained that only the responses to the survey would be calculated and reported. The letter of inquiry and corresponding survey were assigned an identification number which was used to determine which schools had responded to the survey so that a follow up acknowledgement could be sent. A sample copy of the letter of inquiry is attached hereto as appendix A. A self addressed stamped envelope was included in the mailing for the return of the survey. There was no deadline indicated within the letter of inquiry, however the sample used in this research were received over a three week time frame.

Instrument

The survey consisted of brief definition of self-injury as reported by Abrams & Gordon (2003); Alderman (1997); Conterio et al, (1998); and Favazza & Conterio (1988). The participants were asked to indicate which statement most closely resembled his/her approach to confidentiality and self-injury. The two available choices were a) each situation is examined individually and the decision to involve parents or guardians is based on the severity of the self-harm; or b) whenever a student presents with self-injurious behavior parents or guardians are informed. The participants were further asked to indicated whether this procedure was a) his or her individual policy; b) the school's policy; or c) the district policy. The survey also provided

space for addition comments from the responding counselors. A sample survey is attached hereto as appendix B.

Results

Survey Results

Of the eighty-five surveys mailed out, a total of forty-seven (55%) were returned and completed within the three weeks after mailing. Overall, 64% of the surveys indicate that parents or guardians are always notified when the student presents with self-injury while 34% of the counselors indicate that each situation is examined individually to determine if parents or guardians should be contacted. One response (2%) indicated there was a policy in place but did not specify either of the options listed on the survey as to parent notification. Thirty-one percent (31%) of the counselors indicate their school has a policy in place. Within that group, 77% specify parents or guardians are always notified, while 23% evaluate each case individually. District policies are prevalent among 21% of the respondents. Within that group, 90% of the respondents report that parents and guardians are notified while 10% examine each instance individually. The largest subgroup, which accounts for 48%, include those counselors who had neither a school nor district policy. Within this group, 48% of counselors always notify parents or guardians versus 52% that look at each situation independently.

Internship Site Policy Implementation

The counseling staff at the internship site examined the information collected through the survey as well as the information provided in the literature review to draft and implement a procedure for dealing with students who self-injure. The survey indicates a definite trend towards school and district policies (52%). Additionally, several of the survey respondents indicate that policies for their schools/district are in the process of being implemented at the time of the

survey. After a discussion of the survey results, and a review of the literature on self-injury, the counseling staff concluded that further discussion and investigation is necessary in order to implement a protocol at the internship site. The staff is in agreement a procedure should be put in place to handle students who self-injure however the nature of the protocol has yet to be determined.

Compilation of Resource Manual

Since self-injury is a relatively new phenomenon at the internship site, it is important to provide the counseling staff with information and resources which can be implemented when working with self-injuring students. The manual provides risk assessment surveys; behavior contracts; activities for individual counseling sessions; a group counseling curriculum; listings of websites on self-harm; contact information for community counseling agencies; a PowerPoint presentation which can be utilized as an in-service for educators and parents and well as other additional resources such as books and journal articles on self-injurious behavior.
A copy of the resource manual can be found in appendix C.

Discussion

The survey offered a wealth of information regarding the prevalence of self-injury and the difficulties facing school counselors. The survey offered the opportunity for counselors to provide additional comments which many took advantage of. Several counselors indicated they worked in connection with a Mobil Mental Health Team to help their students who have self-injured. One counselor, in particular, enclosed a copy of his school’s procedure which was developed under the supervision of a Psychiatric Fellow at a local teaching hospital. Another area high school reported the school has an on-site health center which the counselors have utilized when evaluating students who self-harm.

Many of the counselors who responded indicated they employed the help of the school nurse when a student presented with self-injury. Several counselors further explained they had immediately referred the student to the nurse for evaluation and that it was usually the nurse who contacted the parents. For these counselors, this kept the confidential nature of their relationship intact since they were not the one who disclosed to the parent.

There were many additional comments with regard to contacting the parent. One counselor voiced strong objections to contacting a parent or guardian if there was a history of abuse, either physical or sexual, or in any situation where the student may be severely punished for this behavior. The safety of the students has always been a concern when contacting the parents. Other counselors stated they would work to gain the student's consent to call the parents before initiating the call. Additionally, it was pointed out by some counselors that the manner in which parents were notified could vary depending on the situation. In some situations, a face-to-face meeting was appropriate while in others a telephone call would suffice. Furthermore, many counselors reported that they preferred to have the student present when the parents or guardians were contacted so that the student was aware of what was, and was not, said regarding the situation.

The information gathered from this survey was used to promote discussion among the counseling staff at the internship site with the intention of eventually implementing policy and procedure with regards to self injuring students. When discussing the issue of self-harm, many differing points and suggestions were made by the counseling staff. One of the primary concerns about parent contact, when a child self-injures, was that it opened the door to having to implement policy for other situations such as smoking, drinking, drugs, and risky sexual behavior, all of which are situations that are harmful, but parent contact has not been mandated.

One suggestion made to help this situation was to make the bounds of confidentiality more clear to students, to discuss openly with all students situations where the counselor would have to break confidentiality. Until now, students have been aware that confidentiality would be broken if the student disclosed that someone was hurting them; they were hurting someone else; or if they were hurting themselves. It was suggested the last point be expanded to specify self-harm, smoking, drinking, drugs, risky sexual behavior as being situations where confidentiality would be broken. The counselors agreed that this information should be made available to the student body in a variety of ways including through one-on-one contact with the school counselor, during the code of conduct assembly, and also when counselors gave classroom presentations. During presentations, counselors should use that opportunity to reinforce this point to students so there would be no confusion or misrepresentations.

A primary argument against parental contact was the question of who was the school counselor's client: the student or the parent. Counselors agreed the needs of the student must come first, however ASCA guidelines stated the parent needed to be informed of harmful situations which involved his/her child. ASCA guidelines were open to interpretation as to what was considered harmful. If a child had minimal to non-existent superficial wounds, should that situation be weighed with the same degree as a child whose injuries require medical attention? Should parents be contacted in both situations or only in the situation of obvious harm?

If a counselor was aware of a student's self-injuring behavior and did not contact the parent there would be some responsibility on the part of the counselor to provide the treatment necessary to help this student. Treatment for self-harming individuals is intensive; it may not be practical for a school counselor to take on such responsibility. When a counselor's case load is 250-300 students, how intensive can the treatment be? There would be a further responsibility on

the part of the counselor if the student's behavior escalates to more harmful acts when under his/her care. Staff further discussed the liability of the school counselor if the student's behavior was discovered by the parents, and it was then revealed that the school counselor had prior knowledge of the behavior. There was the worry of how the parent and administration would react to such information.

All-in-all, the counseling staff agreed the implementation of a procedure or protocol was important, however, they concluded the establishment of a protocol was premature at this time and further discussion as to the construct of this protocol needed to take place. There were so many factors to consider when dealing with students who self-harm it was hardly a black and white issue. In order to truly serve the needs of the student, more discussion would be necessary to develop a procedure which best fits the particular population at this internship site.

The resource manual was developed as a tool for counselors to help students gain a better knowledge of themselves and how their behaviors influenced their lives. The manual was comprised of several sections which provided information for the counselor as well as specific interventions to be used when counseling students. This manual was not meant to replace treatment which can be provided through outside counseling agencies, but rather as a crisis counseling tool to help students stay on path should they become discouraged in school and contemplate self-harm.

This manual focused on understanding behavior, enhancing self-esteem and also provided risk assessments. These assessments would facilitate discussion between the counselor and student as well as allowing the student to recognize his/her self-harming behavior. The first assessment entitled "Could You Be a Self-injurer?" was adapted from the work of Karen Conterio, Wendy Lader and Jennifer Kingston Bloom (1998). They developed a program entitled

the S.A.F.E. (Self Abuse Finally Ends) Alternatives, based in Illinois. As used in the S.A.F.E. Alternatives program, the questionnaire contained 90 questions regarding self-harm. For adolescents, middle school students in particular, many of the questions were not applicable at this stage in the student's life, therefore, for the purposes of this manual the questionnaire was been adapted to reflect the circumstances of adolescents. In evaluating a student's responses to the questionnaire, the more "true" responses given points toward an individual who has been self injuring or was at risk for self-harming behaviors. The second assessment entitled "My Life Survey" developed by Susan Bowman and Kaye Randall (2005), was designed to assess the experiences of a student who has already identified him/herself as a self-injurer. Both assessments have been designed to be a self report by the student.

Research regarding the effectiveness of behavior contracts was mixed at best. Contracts have been commonly used by school counselors in a variety of situations. Alderman (1997) reported a behavior contract would be helpful if the contract specified a proactive behavior rather than the cessation of self-harm. The contract, if used, should be constructed by both the counselor and the student and should not limit the student's choices but rather provide appropriate alternatives. Sample wording for a behavior contract was provided in the manual.

School counselors may not be in a position to provide extensive treatment for students who self-injure. However, school counselors often find themselves faced with a student in crisis who may turn to self-harm as a way to cope with his/her tension and anxiety. Worksheets, diagrams and reflection exercises developed by counselors, psychologists, social workers and educators as brief interventions to help students better understand themselves and their self-harming behaviors were included in the manual. The "The A.W.A.R.E. Life Model" exercise was created by Susan Bowman, Ed.S, LPC and Kaye Randall, LMSW and has been adapted

from their book *See My Pain; Creative Strategies and Activities for Helping Students Who Self-Injure* (2005). This exercise has been designed to create a positive awareness of how a student viewed a difficult situation. This may help to de-catastrophize a situation so students can see healthy alternatives. Bowman and Randall (2005) also developed the interventions "The Strength Coaching Model" and "My Personal Strengths Are". These worksheets can be used to improve the student's self-esteem, help the student focus on what he/she has accomplished as well as his/her positive traits. The "Remember When Activity" (Bowan & Randal, 2005), would be used to distract a student in crisis to move away from the all-or-nothing thinking that often accompanied self-harm. This exercise helps to challenge negative self talk and to promote self-esteem and a sense of hopefulness and accomplishment. The "Impulse Control Logs" were created by Karen Conterio, Wendy Lader, Ph.D. and Jennifer Kingston Bloom and was adapted from their book *Bodily Harm: The Breakthrough Healing Program For Self-Injurers* (1998). This intervention is part of their S.A.F.E. (Self Abuse Finally Ends) program and was designed to help the student examine how and why the urge to self-injure begins so that the student can see a pattern to his/her behavior.

"The Five Alternatives", also developed by Conterio, Lader, & Bloom (1998), involves the student brainstorming alternative behaviors to initiate when the urge to self-harm emerges. Tracy Alderman, Ph.D. created the "The Addictions Model of Self-harm" and has been adapted from her book *Scared Soul; Understanding & Ending Self-Inflicted Violenc* (1997). This exercise helps the student understand the destructiveness of self-harm and how there is no end to the cycle, no real relief.

The Stress Busters Group Counseling Curriculum was developed by Matthew Selekman (2002) and was included in his book, *Living the Razor's Edge.* He developed this curriculum as

an intervention at a junior high school where there was overabundance of adolescent females who were self-injuring. Many of these young women were resistant to traditional therapy, so Selekman developed a group curriculum were these girls were celebrated as natural leaders who could help others who were dealing with stress and anxiety. The curriculum was designed to help these students manage emotional, family, social, and school stressors. Selekman reported that follow-up interviews with members from his first Stress Busters group reported that they had abandoned self-injurious behaviors and became more involved in helping others in junior high school and later in their perspective high schools.

Additionally, the resource manual includes website resources, books and journals articles on self-harm and a listing of community agencies that can provide further counseling for students and families dealing with self-harm issues.

Limitations and Recommendations for Further Study

The major limitation to this type of research was that it could not report how effective the existence of a policy would be on helping students who self-injure. With regard to implementing policy, there was no pre or post test information which would indicate whether a set procedure would be a benefit or a disadvantage to students. Furthermore, there was no information available as to whether or not the policy had an impact on the student receiving outside treatment for his/her self-injurious behavior.

An additional limitation to this study was the time commitment needed to establish policy for the internship site. In the end, the staff concluded that implementing policy at this time was not feasible due to the need for more discussion on the various issues regarding self-harm and confidentiality. A school counselor’s caseload is such that it doesn’t leave a lot of time to contemplate what may occur in the future with his/her students when there were so many issues

that were effecting those students in the present. Finding time to dialogue with the counseling staff regarding this issue was difficult at best. The commitment placed on counselors by students, parents, administration, and the district often limits the amount of time the counseling staff spends together to discuss issues of concern, such as self-harm. The internship counseling staff has a designated time to discuss caseloads each week but rarely were all staff able to attend these meetings and the present concerns of students often outweighed and outranked the time needed to discuss the implementation of policy.

One recommendation is to examine in depth the treatment outcomes of self-injuring students who are seen only by school counselors, and those students who receive support both in school and through an outside agency. An additional recommendation would be to investigate the effectiveness of school policy on getting a student outside treatment. Does mandated contact with the parent promote the initiation of outside counseling, or does it inhibit it? Does getting the parents involved early have an effect on the overall cessation of self-injuring behavior? These are issues that warrant further investigation and could greatly influence other school counseling departments in the implementation of procedure to help these students.

Summary

The aim of this research was to examine the prevalence of school/district policy for dealing with students who self-injure. In particular this research investigated the mandatory contact with parents when a student presents with such behavior. This information was then used to promote discussion regarding the implementation of policy at the internship site. An additional goal of this research was to provide the counseling staff with comprehensive information on self-injury, among adolescents, in particular. This was accomplished through a review of the literature and through the compilation of a resource manual which included counseling

interventions for individual and group counseling as well as community resources. In the end the internship site counseling staff chose not to implement a policy at this time but did commit to further discussion as to how to implement policy in the future, what that policy would entail and how to better serve their students who self-injure.

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Appendix A

Letter of Inquiry

C h r i s t e n H a r n d e n

155 Densmore Road
Rochester, NY 14609
Email: Christen_Harnden@eastiron.monroe.edu
(585) 339-1410

October 23, 2005

Name of School
Address of School
City, State, Zip Code
ATTN: School Counseling Office

RE: Self-harm Survey - GC20080

Dear School Counselor:

As a graduate student at SUNY Brockport in the school counseling program I am conducting research in the area of self-harm as part of my masters' thesis. My research intends to examine how the issue of self-harm impacts confidentiality and the role of the school counselor. Furthermore I am investigating the current trends in dealing with self-harm in our local school districts and how issues of confidentiality are weighed against the risk of harm to the student when determining appropriate action.

There is a growing concern among school counselors surrounding the increasing prevalence of self-injurious behaviors in adolescents. As recently as 2002, a research survey indicated that as much as 13% of adolescents sampled admitted to engaging in some form of self-injurious behavior. Research suggests that the prevalence for self-injury among middle and high school students is rising. Since these behaviors have a tendency to take hold in early adolescence, School counselors are in a prominent position to provide support for this population.

Enclosed you will find a brief survey and a self addressed stamped envelope. Should you choose to participate in this survey; neither your name, school nor your district will be identified in my research, only your response to this survey. There is an identification number on your survey which is for my records keeping purposes only. If you have any additional comments or questions please feel free to contact me at the above referenced telephone number or you may email me at Christen_Harnden@eastiron.monroe.edu. I will be happy to answer any questions you may have regarding this survey. Thank you in advance for your cooperation in this endeavor. I look forward to hearing from you.

Sincerely,

Christen Harnden
Graduate Intern
East Irondequoit Middle School

Enclosure: Survey

Appendix B

Self Harm Survey

Self-Harm Survey

(GC20080)

Alderman (1997) has developed key components to identify whether a behavior is self-injurious behavior. The behavior should meet these criteria in order to be considered an act of self-harm. Furthermore acts of self-harm are describes as being; a) done to oneself, b) performed by oneself, c) physically violent, d) not suicidal, and e) intentional and purposeful. Common forms of self-injury include: cutting of the skin, hitting, usually the head, thighs or stomach, excessive hair pulling, banging the head against a hard surface, scratching the skin till it bleeds, biting, burning, interfering with the healing of wounds, purposeful breaking of bones, excessive chewing of the tongue, lips, nails and fingers (Abrams & Gordon, 2003; Alderman, 1997; Conterio et al,1998; Favazza & Conterio, 1988).

With regards to students who present with self-injurious behaviors which of the following statement most closely resembles you or your's schools approach to handling confidentiality:

- ☐ Each situation is examined individually and the decision to involve parents or guardians is based on the severity of the self-harm.
- ☐ Whenever a student presents with self-injurious behavior parents or guardians are informed.

This practice is upheld by:

- ☐ Myself individually, other counselors I work with may practice differently.
- ☐ This is our school's policy.
- ☐ This is our district policy.

Additional Comments: Please feel free to use the back should you need more space.

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Appendix C

Resource Manual

But you don't have a cat...

A School Counselor's guide to helping students who self-injure

Christen C. Harnden
Graduate Intern
SUNY Brockport
December, 2005

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1.0 Understanding Self Injury

1.1 Sara's Story

I first became interested in the phenomenon of self injury many years ago when my husband was coaching a travel volleyball team. At the time we were traveling to a lot of tournaments and I would accompany the team as a chaperone. This gave me the opportunity to get to know the players better. One such player was Sara. Sara was a bright, energetic girl who was a talented athlete. Her parents were divorced and she spent the week at her mom's house and weekends with her father.

As the season progressed and the competition got harder, I began to see a different side to Sara. The once calm and collected young woman seemed to disappear and was replaced by an anxious and easily frustrated girl. I noticed too that her father's interaction with Sara also changed. Sara's father was very wealthy and could well afford to put his daughter through college but he expected her to get a full scholarship to college to a Division I school playing volleyball. The more demanding and forceful her father became, the more tense and anxious Sara appeared. Over the next few weeks I noticed that Sara would wear long sleeves to practice while the other girls wore tank tops. It was an unusually warm spring that year and it must have been uncomfortable playing in the long sleeves. When asked she would simply state that she was cold and need the extra clothing. At the next tournament I noticed that Sara had deep scratches on her left arm from her elbow to her wrist. I mentioned this to my husband and told me that he had noticed them too and had asked Sara about them earlier that day. She told him that she had been playing rough with her cat at home and the cat had scratched her. This sparked something in my memory from one of the many conversations I had with Sara. I turned to my husband and said "But she doesn't have a cat". He asked me what I meant by that and I told him that she told me several months before that she had always wanted a cat but her father didn't want any pets and her mother was allergic so it wasn't possible for her to have a cat.

When she was asked about this later she covered and said that she meant to say a friend's cat but it was clear that the scratches did not come from a cat. During the next tournament, Sara was not playing well. Sara's father reminded her that college scouts were watching her that day and that she had better "pull it together". This did little to help Sara's confidence or her playing. She continued to play badly. She was pulled from the game so she could collect herself. I watched her as she stood at the end of the bench. Not knowing anyone was watching her, Sara put her arms behind her back and dug her nails into her arm until she nearly drew blood. After the tournament I told my husband what I saw and he spoke to Sara about her scratches. He was careful not to scare her off or to have her feel like he disapproved, but they talked a long time about how to appropriately deal with her stress and frustration. My husband also had a long talk with her mother as well and discussed his concerns for Sara. He told me that it wasn't uncommon for athletes to self-injure. The pressure is often too much for adolescents to handle. This started me thinking. If this could happen to Sara, who else was dealing with this? What would make someone turn to self injury to handle stress?

1.2 Introduction

There is a growing concern among school counselors surrounding the increasing prevalence of self-injurious behaviors in adolescents. As recently as 2002, a research survey indicated as many as 13% of adolescents sampled admitted to engaging in some form of self-injurious behavior (Ross & Heath, 2002). Research has suggested the prevalence for self-injury among middle school students is rising, with an average onset at age eleven (Conterio, Lader & Bloom, 1998; Warm, 2002). Suyemoto and MacDonald (1995) found that most individuals, who do not qualify for an additional psychopathological diagnosis, typically cease these behaviors around the age of eighteen. Thus, school counselors are in the unique position to provide prevention, education and intervention for this population.

The phenomenon of self-harm is difficult for the average person to understand. Most people would never consider taking a razor to their skin or burning themselves as a way to reduce stress. Many would remark that the very idea sickens them. However, there is an ever-growing number of individuals, adolescents especially, who have resorted to this method of coping. Without understanding why, how, and who is engaging in these behaviors, it is difficult to undertake any intervention or treatment to help these adolescents. Since the average onset of self-injurious behaviors is now seen to be at the middle school level, school counselors, teachers, and administrators need to be poised to deal with the self-harming student, episodes of self-injury and the circumstances surrounding it.

Research has identified several reasons for engaging in self injurious behaviors including;

1. The need for concrete pain when psychological pain is too overwhelming,
2. The reduction of emotional numbness by creating physical pain,
3. the blocking out of traumatic memories and to keep them from present consciousness through distraction,
4. Emotional regulation,
5. To receive support and empathy from others,
6. Release of anxiety, anger, despair and disappointment,
7. To increase a sense of control,
8. Self punishment for "being bad",
9. The enhancement of self-esteem.

(Alderman, 1997; Conterio et al, 1998; Favazza, 1996; Himber, 1994; Shearer, 1994, Walsh & Rosen, 1985).

1.3 What Is Self Injury?

Alderman (1997) has developed key components to identify whether a behavior was self-injurious in nature. The behavior must meet these criteria in order to be considered an act of self-harm. Acts of self-harm must be: a) done to oneself, b) performed by oneself, c) physically violent, d) not suicidal, and e) intentional and purposeful. Common forms of self-injury include; cutting of the

skin, hitting, usually the head, thighs or stomach; excessive hair pulling; banging the head against a hard surface; scratching the skin until it bleeds; biting; burning; interfering with the healing of wounds; purposeful breaking of bones; excessive chewing of the tongue, lips, nails and fingers; amputation of limbs, genitals, breasts, fingers or toes; facial skinning; and injection or ingestion of sharp objects or toxic substances (Abrams & Gordon, 2003; Alderman, 1997; Conterio et al,1998; Favazza & Conterio, 1988).

Cutting and burning have been the most common forms of self-injury (Alderman, 1997; Briere & Gil, 1998; Cavanaugh, 2002; Conterio et al, 1998). Most often a self-injurer began cutting an area of the body people were unlikely to see. As the drive to self-injure became stronger and the person began to lose control, he/she began to cut in more obvious places. Very often those who have self-injured wore clothing which covered their mutilations (Briere & Gil, 1998; Conterio et al, 1998; Pipher, 1994). After cutting, burning was the next logical step for a self-injurer. Often a self-injurer escalated his/her forms of injury to gain the same rush from the pain. Seventy-five percent of all self-injurers have used more than one method of injury (Alderman, 1997; Favazza, DeRosear & Conterio, 1989).

Simeon and Favazza (2001) developed a four category system for classification of self-injurious behaviors. The first category was referred to as 'stereotypic'. It included behaviors such as slapping; head banging or hitting; lip, mouth and hand chewing; self biting and some forms of hair pulling. These behaviors were most typically seen in populations with organic mental retardation or disorders such as Touretts, Lesch-Nyhan Syndrome, Autism, Cornelia de Lange and temporal lope epilepsy (White Kress, 2003; Stein & Niehaus, 2001). The second category, 'major' self-injurious behaviors, encompassed more potentially life threatening behaviors such as limb amputation, castration and eye enucleation. These behaviors were uncommon in the general population and were generally seen with individuals who suffered from psychosis, personality disorders or intoxication (Simeon & Favazza, 2001). "Compulsive' self-injury, the third category, included repetitive skin picking, hair pulling and nail biting which were viewed as moderate to severe in nature. This category of self-harm was consistent with the diagnosis of trichotillomania and stereotypic movement disorder as seen in the DSM IV-TR (Simeon & Favazza, 2001). The final category was the 'impulsive' set of behaviors. These included skin cutting, burning and mild self hitting. These behaviors were seen as habitual and isolated (White Kress, 2003). Within this category there were two sub-types: episodic and repetitive. Episodic self-harm would happen only a few times throughout the individual's life. Repetitive self-harm involved re-occurring self-injury which was addictive in nature and difficult to control (Simeon & Favazza, 2001). This classification system was useful to school counselors in determining if the client requires additional services than were provided at the time by counseling staff or if a referral to an outside community health agency was warranted (White Kress, 2003). The most common form of self-injury in schools fell under the category of impulsive self-harm.

1.4 Profile of the Self Injurer

The typical self-injurer was most likely female with low self-esteem who may have suffered episodes of depression (Cavanaugh, 2002; Crowe & Bunclark, 2002; Levenkron, 1998). He/she first

began injuring him/herself as an adolescent. He/she has had trouble forming or maintaining intimate relationships as well as difficulty relating to others (Milia, 1996). He/she had a difficult time articulating his/her needs, thoughts and feelings to others. He/she has had a strong need for love and acceptance (Alderman, 1997; Levenkron, 1998). As a child he/she did not develop positive coping skills or strategies to self soothe and came to rely on self-injury to relieve his/her pain and suffering. By turning emotional pain into physical pain, he/she was able to physically nurture and care for his/her wounds when he/she could not accomplish this for emotional wounds (Alderman, 1997; Conterio, et al, 1998; Milia, 1996). In terms of emotions, anything which was intense or uncomfortable had to be dealt with immediately, usually with some sort of action or behavior, which provided relief from the intense emotions (Abrams & Gordon, 2003; Cavanaugh, 2002; Favazza, 1996; Favazza & Conterio, 1988).

Favazza (1996) suggested that self-harm involved many biopsychosocial factors which function within our society. Statistics reported that the predominant group of people who self-injure were white, female and of average intelligence (Abrams & Gordon, 2003; Alderman, 1997; Conterio et al, 1998; Favazza, 1996; Ross & Heath, 2002; Strong, 1998). There were several cultural forces which influenced this predominance. In western society, the Caucasian culture experienced dissolution of the extended family. More so than any other cultural group, the Caucasian culture has relied less and less on the role of grandparents and extended families in the care and nurturing of their children (Conterio et al, 1998; Selekman, 2002). In addition, children have had less and less intimate time with one or both of their parents because one or both parents work. These children often didn't learn how to effectively communicate with their parents (Selekman, 2002). The children of this culture have had few intimate relationships with members of their immediate and extended families and had fewer people to turn to in difficult times. In this "latch key kid" society, children turned to their cohorts for guidance and support (Conterio et al, 1998; Selekman, 2002). These cohorts have been equally uneducated in how to communicate their emotions and thoughts. In recent decades children have been spending a disproportionate amount of time sitting in front of a computer or television and less time developing communication skills and solid friendships. Verbal expression and communication has taken a back seat to video games and technological gadgets (Selekman, 2002). Furthermore, this culture has emphasized the need for immediate gratification (Milia, 1996). There have been fast food restaurants and drive-thru everything to cater to this need (Conterio et al, 1998). This focus on instant gratification appeared to have played a major role in self-injurious behavior.

Favazza and Conterio (1988) used the Self-Harm Behavior Survey to gather information regarding self-harm. They collected two hundred and fifty usable surveys from individuals who previously identified themselves as self-injurers. Favazza and Conterio (1988) found the average self-injurer exhibited low lethality and his/her direct self-injurious behaviors usually began in early adolescence. The condition became chronic over time, and there was a strong relationship between social isolation, drug abuse and self-harm.

2.0 Assessment-of-Risk Instruments

Risk assessment instruments can be helpful in assessing the future needs of a student who may self injure or who may be at risk to self injure in the future. Risk assessment instruments are not diagnostic tools and should not be viewed as a way to diagnose self injury in students. They are simply a tool that can be utilized to offer more information and to help students better understand themselves and their behavior.

The following assessment entitled "Could You Be a Self Injurer?" has been adapted from the work of Karen Conterio, Wendy Lader and Jennifer Kingston Bloom (1998). They developed a program entitled the S.A.F.E. (Self Abuse Finally Ends) Alternatives, based in Illinois. Within the S.A.F.E. Alternatives program the questionnaire contained 90 questions regarding self harm. For adolescents, middle school students in particular, many of the questions were not applicable at this stage in the student's life. Here the questions have been adapted to reflect the circumstances of adolescents. In evaluating a student's response to this questionnaire, the more "true" responses given may point towards an individual who is self injuring or is at risk for self harming behaviors.

The second assessment entitled "My Life Survey" was developed by Susan Bowman and Kaye Randall and was designed to assess the experiences of a student who already identifies him/herself as a self injurer. Both assessments were designed to be a self report to be filled out by the student.

2.1 Could You Be a Self Injurer?

(Adapted from Conterio et al, 1998)

T	F	I'm often told I need to be strong
T	F	There is not a lot of affection displayed in my family
T	F	Anger is a feeling that is most often displayed at home.
T	F	I don't feel like I can express my feelings to my family.
T	F	Sometimes my parents are overly involved in my problems.
T	F	I have been sexually abused by someone in my life.
T	F	I have been physically abused by someone in my life.
T	F	I have been emotionally abused by someone in my life.
T	F	Sometimes I feel like my parents are not there for me emotionally.
T	F	Sometimes I have been punished for expressing my emotions, being angry or for crying.
T	F	I have a very religious family.
T	F	One of my parents are unable to take care of me because of a physical illness or trauma.
T	F	Sometimes I get double messages from my parents.
T	F	I often think of myself as a "bad" person.
T	F	I often believe I am at fault for everything that going wrong.
T	F	I often think that everyone would be happier if I were dead.
T	F	I often believe negative attention is better than no attention.
T	F	I hate change.
T	F	I seem to have an all-or-nothing attitude.
T	F	I usually can't find words to explain how I feel.

T	F	I don't have many friends.
T	F	I am a perfectionist.
T	F	I think I am a burden to others.
T	F	I do not want to die; I just want to stop my emotional pain.
T	F	I get scared when I get close to anyone.
T	F	I could never intentionally harm anyone else.
T	F	I do not know how to get attention in positive ways.
T	F	I have a problem with drugs and alcohol.
T	F	I have exercised to the point that I have gotten sick or injured.
T	F	My parents/friends/doctor has told me that I am underweight, but I would still like to lose a few more pounds.
T	F	I am secretly happy when I skip a meal.
T	F	I have stolen things.
T	F	I often think about hurting myself.
T	F	Sometimes I can't explain how I got hurt.
T	F	I get anxious when my wounds start to heal.
T	F	I often believe that if I don't hurt myself, I'll go crazy.
T	F	No one can hurt me more than I can hurt myself.
T	F	I can't image life without hurting myself.
T	F	If I stop hurting myself, my parents win.
T	F	I often believe that if I don't hurt myself I will explode.
T	F	I often carry around with me something that I use to hurt myself.
T	F	I often hurt myself as a way to punish myself.
T	F	I often hurt myself to show others how bad I feel.

T F Hurting myself helps me feel like I'm in control.

T F I have carved words or symbols into my flesh.

T F I have used self harm to make others do what I want.

T F Seeing my blood comforts me.

T F Hurting myself helps me feel real.

T F Hurting myself helps me control my mind when it's racing.

T F Hurting myself helps me feel relaxed.

T F Hurting myself helps me feel less lonely.

T F Hurting myself helps me feel less depressed.

T F Hurting myself is like having a best friend.

T F The first time I hurt myself I didn't tell anyone.

T F I often have a routine when I self injure.

T F I have lost relationships because I have hurt myself.

T F I have missed school because I have hurt myself.

T F I like the attention I get from people when they find out I have hurt myself.

T F I believe I can't stop hurting myself.

T F Sometimes I hurt myself out of habit and not because I need to.

I have self injured :
Only once ___, 2-5 times ___, 6-10 ___, more than 10 times ___

My decision to hurt myself is usually made (check all that apply):
At that moment ____, An hour before ____, Several hours before ____,
A day before ____, A week before ____, More than a week before ____.

The amount of pain I feel when I hurt myself is:
None ___, A little ___. A moderate amount ____, A lot ____.

2.2 My Life Survey

(Adapted from Bowman & Randall, 2005)

Name: ____

1. How often do you self harm? (Circle one)
Never Sometimes daily weeklymonthly other: _______

2. How do you self injure: ____
____

3. Where on your body do you self injure: ____
____

4. How would you describe your injuries?
(Circle the level of severity on the scale below)
Minor..Serious
1 2 3 4 5 6 7 8

5. How do others react when you do this? ____
____

6. Describe your feelings before, during and after you self injure.
Before: ____
During: ____
After: ____

7. What other ways have you expressed these feelings? ____
____
____
____
____
____
____
____
____

3.0 Behavior Contracts

For some clinicians, behavior contracts that eliminate the behaviors have not been productive (Himber, 1994). Many self injurers will lie about their behaviors to therapists when their behavior contract specified that they must end all self harm. Contracts that involved implementing other strategies before self harm or require the client to report feelings of escalation or dangerous self harm were more productive in treatment (Himber, 1994).

Alderman (1997) reports that a behavior contract can be helpful if the contract specified a proactive behavior rather than the cessation of self harm. The contract, if used, should be constructed by both the counselor and the student and should not limit the student's choices but rather provide appropriate alternatives.

The following contract language has been adapted from Alderman's book *The Scared Soul,* 1997.

I, ____(student's name)______, agree to contact at least one person before I turn to self harm. This person could be my counselor ____(counselor's name)____, if I feel the need to hurt myself while at school. Outside of school I can contact ______(friend or support person)_____ or I can contact ____(friend or support person)_____. This contract will be effective for a period of (e.g. one week)_____, beginning on the date indicated on the bottom of this page.

______________________________ ______________________

Student's Signature Date

______________________________ ______________________

Counselor's Signature Date

4.0 Individual Counseling

Self-injurers can and do recover (Levenkron, 1998; Pipher, 1994). Recovery is a long and difficult path. Healing requires continuous self-reflection and examination. There are many interventions which can be helpful in treating adolescents who self-harm. Common treatments include psychodynamic therapy, cognitive behavior therapy, family therapy, drug therapy and hospitalization. It would be time consuming and financially difficult for school counselors to provide all of the services which community clinicians provide to this population, however school counselors are in a position to provide individual and group therapy to these adolescents. Alternative modalities such as art and music therapy and support groups have also being used in clinical settings as well as in schools (Swadi, 2004). Individual and group interventions have been useful with this population, however, in addition to the self-harm, any underlying issues, such as abuse, divorce, depression, needed to be addressed for any long term reduction in self-harm to be successful (Froeschle & Moyer, 2004).

Along with feeling that self-harm was acceptable, the self-injurer often believed they were deserving of punishment and that self-injury was a way to fulfill that punishment (McAllister, 2003; Nospitz, 1994; Stone & Sias, 2003; Tatman, 1998; Walsh & Rosen, 1988). Self-injurers often have had negative ideas and have been overly critical of their bodies in particular. This self-hate was vital because it laid groundwork for giving them permission to violate their bodies through self-harm (Conterio et al, 1998; Stone & Sias, 2003; Walsh & Rosen, 1988). For individuals who self-harmed there was an inner voice which told them they were worthless and should suffer. It may have been difficult for these clients to recognize and enjoy any therapeutic success they achieved (Noshpitz, 1994). Treatment involved recognizing patterns of behavior surrounding the self-harm, the acquisition of alternative coping skills and the development of interpersonal skills (Stone & Sias, 2003).

When under pressure or stress, the self-injurer believed some action on his/her part was necessary to relieve the stress (Bowman & Randall, 2005; Conterio et al, 1998; Favazza, 1996). Since cognitions existed which said self-harm was acceptable, and that his/her body was an object of loathing, it was an easy transition for the self-injurer to act against him/herself in order to relieve their stress. He/she knew that they would feel better if they cut themselves. The need to reduce tension has been one of the greatest barriers in treatment for self-injury (Bowman & Randall, 2005; Conterio et al, 1998; Favazza, 1996). Most traditional methods of stress reduction used in counseling were not action-oriented and therefore insufficient to provide the same relief found with self-harm. Traditional methods of stress reduction have also done nothing to combat the irrational thinking of self-injurers (Walsh & Rosen, 1988).

Many self-injurers used self-harm as a means of communicating to others the pain and stress they have been experiencing (Bowman & Randall, 2005; Conterio et al, 1998; Favazza, 1996). Without a physical display, the self-injurer feared his/her feelings were not understood (Alderman, 1997; Levenkron, 1998). It has also been common for an individual who self-injured to misjudge the

feelings of others based on his/her thinking that without action the feelings cannot be demonstrated or understood (Milia, 1996; Walsh & Rosen, 1988).

Enhancement of self-esteem has been critical to the treatment of self-injury (Alderman, 1997; Conterio et al, 1998; Favazza, 1996; Selekman, 2002; Walsh & Rosen, 1988). When an individual suffered from low self-esteem, he/she found it extremely difficult to focus on positive qualities or, at the very least, accept that he/she had any positive qualities (Bowman & Randall, 2005; Levekron, 1998; Walsh & Rosen, 1988). Counselors assisted clients to identify and focus on the positive qualities they possessed. This was explored through interviewing the client, worksheets, or through the day-to-day process of counseling. Sample questions include: "What kinds of things do you like about yourself?" "What are your talents?" "What kinds of things can you do well" "Are you a good friend?" and "Tell me about a success you have had." Furthermore, the client was asked to explore what he/she thought others believed to be his/her positive qualities. Changing the focus to a client's positive qualities triggered a reappraisal of his/her self-worth and self-esteem (Bowman & Randall, 2005; Walsh & Rosen, 1988).

Very often a self-injurer only focused on his/her negative attributes, paying little or no attention to his/her positive qualities (Levekron, 1998; Nospitz, 1994; Selekman, 2002;Walsh & Rosen, 1988). Walsh and Rosen (1988) suggested that counselors point out to the self-injurer that he/she had a negative view of him/herself, that he/she failed to see his/her positive qualities, that the focus of thought needed to shift to his/her positive qualities in order to have an accurate self image and that the best way to do this was to focus on his/her positive traits more often than the negative traits (Walsh & Rosen, 1988).

4.1 Activities for Individual Counseling

School counselors may not be in the position to provide extensive treatment for students who self injure. However, school counselors often find themselves faced with a student in crisis who may turn to self harm as a way to cope with his/her tension and anxiety. The following worksheets, diagrams and reflection exercises have been developed by counselors, psychologists and social workers and educators as brief interventions to help students better understand themselves and their self harming behaviors.

4.2 " The A.W.A.R.E. Life Model"

This exercise was created by Susan Bowman, Ed.S, LPC and Kaye Randall, LMSW and has been adapted from their book *See My Pain; Creative Strategies and Activities for Helping Students Who Self-Injure* (2005). This exercise creates a positive awareness of how a student may view a difficult situation. This may help to de-catastrophize a situation so students can see healthy alternatives.

4.3 "The Strength Coaching Model" and 4.4 "My Personal Strengths Are"

These exercises were created by Susan Bowman, Ed.S, LPC and Kaye Randall, LMSW and has been adapted from their book *See My Pain; Creative Strategies and Activities for Helping Students Who Self-*

Injure (2005). These worksheets can be used to improve the student's self-esteem as well as help the student focus on what he/she has accomplished as well as his/her positive traits.

4.5 "Remember When Activity"

This exercise was created by Susan Bowman, Ed.S, LPC and Kaye Randall, LMSW and has been adapted from their book *See My Pain; Creative Strategies and Activities for Helping Students Who Self-Injure* (2005). This worksheet can be used to distract a student in crisis to move away from the all-or-nothing thinking that often accompanies self-harm. This exercise helps to challenge negative self talk and to promote self-esteem and a sense of hopefulness and accomplishment.

4.6 "Impulse Control Logs"

This exercise was created by Karen Conterio, Wendy Lader, Ph.D. and Jennifer Kingston Bloom and has been adapted from their book *Bodily Harm: The Breakthrough Healing Program For Self-Injurers* (1998). This intervention is part of their S.A.F.E. (Self Abuse Finally Ends) program. It is designed to help the student examine how and why the urge to self injure begins so the student can see a pattern to his/her behavior.

4.7 "The Five Alternatives"

This intervention was created by Karen Conterio, Wendy Lader, Ph.D. and Jennifer Kingston Bloom and has been adapted from their book *Bodily Harm: The Breakthrough Healing Program For Self-Injurers* (1998). This intervention is part of their S.A.F.E. (Self Abuse Finally Ends) program. This exercise involves the student brainstorming alternative behaviors to initiate when the urge to self harm is developing.

4.8 "The Addictions Model of Self Harm"

This exercise was created by Tracy Alderman, Ph.D. and has been adapted from her book *Scared Soul; Understanding & Ending Self-Inflicted Violence* (1997). This exercise helps the student understand the destructiveness of self harm and how there is no end to the cycle, no real relief.

4.2 The A.W.A.R.E. Life Model

(Adapted from Bowman & Randall, 2005)

Directions: choose a current life situation and use this worksheet to create a more positive awareness for the way you think about the situation. For each AWARE word below write a specific plan to change your thoughts in helping you view your situation differently.

Life Situation: ______________________________

____

ATTITUDE

If I have a healthy attitude I will live a healthier life.

____

____

WISDOM

It takes wisdom to accept the things I cannot change and the courage to change the things I can.

____

____

AFFIRM

I will affirm myself daily.

____

____

RESTORE

I will replace any thoughts of self injury with healthier alternatives.

____

____

EMBRACE

I will embrace a world full of opportunities.

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4.3 The Strength Coaching Model

(Adapted from Bowman & Randall, 2005)

In the space below write your responses to the following model. Use the back of this paper if you need more room.

Share some of your successes

Personal strengths that helped you succeed are…

Explore how you can use these same personal strengths to help you get through difficult times.

Create a new, positive goal you want to accomplish.

Immediately act on this goal.

Allow yourself not to be perfect (it's okay to make mistakes).

Let at least one significant other person know about your goals and accomplishments.

Reflection:

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4.4 My Personal Strengths Are…

(Adapted from Bowman & Randall (2005)

Directions: Place a check before all the words that describe your personal strengths.

- ☐ Accepting
- ☐ Adventurous
- ☐ Appreciative
- ☐ Artistic
- ☐ Assertive
- ☐ Athletic

- ☐ Bold
- ☐ Bright
- ☐ Brave

- ☐ Calm
- ☐ Caring
- ☐ Cautious
- ☐ Clever
- ☐ Confident
- ☐ Considerate
- ☐ Cooperative
- ☐ Courageous
- ☐ Courteous
- ☐ Creative
- ☐ Curious

- ☐ Dedicated
- ☐ Disciplined
- ☐ Devoted

- ☐ Eager
- ☐ Efficient
- ☐ Encouraging
- ☐ Energetic
- ☐ Enthusiastic

- ☐ Fair
- ☐ Faithful
- ☐ Flexible
- ☐ Forgiving
- ☐ Friendly
- ☐ Fun-loving

- ☐ Generous
- ☐ Gentle
- ☐ Giving
- ☐ Good sport

- ☐ Hard worker
- ☐ Helpful
- ☐ Honest
- ☐ Humble
- ☐ Humorous

- ☐ Independent
- ☐ Insightful
- ☐ Interested
- ☐ Involved

- ☐ Laidback
- ☐ Leader
- ☐ Likable
- ☐ Loving
- ☐ Loyal

- ☐ Mature
- ☐ Motivated

- ☐ Neat
- ☐ Nurturing

- ☐ On task
- ☐ Open- minded
- ☐ Optimistic
- ☐ Organized

- ☐ Patient
- ☐ Perceptive
- ☐ Persevering
- ☐ Positive
- ☐ Prepared
- ☐ Punctual

- ☐ Quiet

- ☐ Reasonable
- ☐ Reliable
- ☐ Resourceful
- ☐ Respectful

- ☐ Self-Aware
- ☐ Sensitive
- ☐ Sharing
- ☐ Sincere
- ☐ Supportive
- ☐ Survivalist

- ☐ Team player
- ☐ Thoughtful
- ☐ Tolerant
- ☐ Trustworthy

- ☐ Understanding
- ☐ Unique
- ☐ Unselfish

- ☐ Warm
- ☐ Witty

4.5 Remember When Activity

(Adapted from Bowman & Randall, 2005)

Ask the students to reflect on the pleasant memories they have. They can do this verbally or in their journals. If written, have them share their reflections with the counselor or group.

Reflect on ……

- ❖A favorite memory of your family, friends.
- ❖Something you succeed at.
- ❖An exciting time in your life.
- ❖A time when you felt very proud of something you did.
- ❖A time when you made a decision not to hurt yourself.
- ❖A time you felt happy.
- ❖A pleasant memory of a person that you lost.
- ❖A time when you felt really connected to someone.
- ❖A time and a place where you felt safe.

Follow up: ask the student to share more details than they may have written or spoken about. Ask how these memories can help during times when they are struggling with self injury.

4.6 Impulse Control Logs

(Adapted from Conterio et al, 1998)

Time and Date	
Acting Out/ Thoughts about self harm	
Location (e.g. Bedroom)	
Situation (what was happening)	
Feelings	
What would self harm accomplish?	

4.7 The Five Alternatives

(Adapted from Conterio et al, 1998)

This exercise helps to identify and establish positive coping skills and strategies to replace the self harming behavior. Each student is asked to create a list of five activities (at least) that are comforting and that can provide a distraction for them.

Guidelines: the majority of these activities should be activities that can be done at anytime, or anyplace. These activities serve to district the student long enough so that rational thinking can replace the impulse to self injure. This further combats the all-or-noting thinking that stress and anxiety can only be alleviated by self harm and that there are other alternatives.

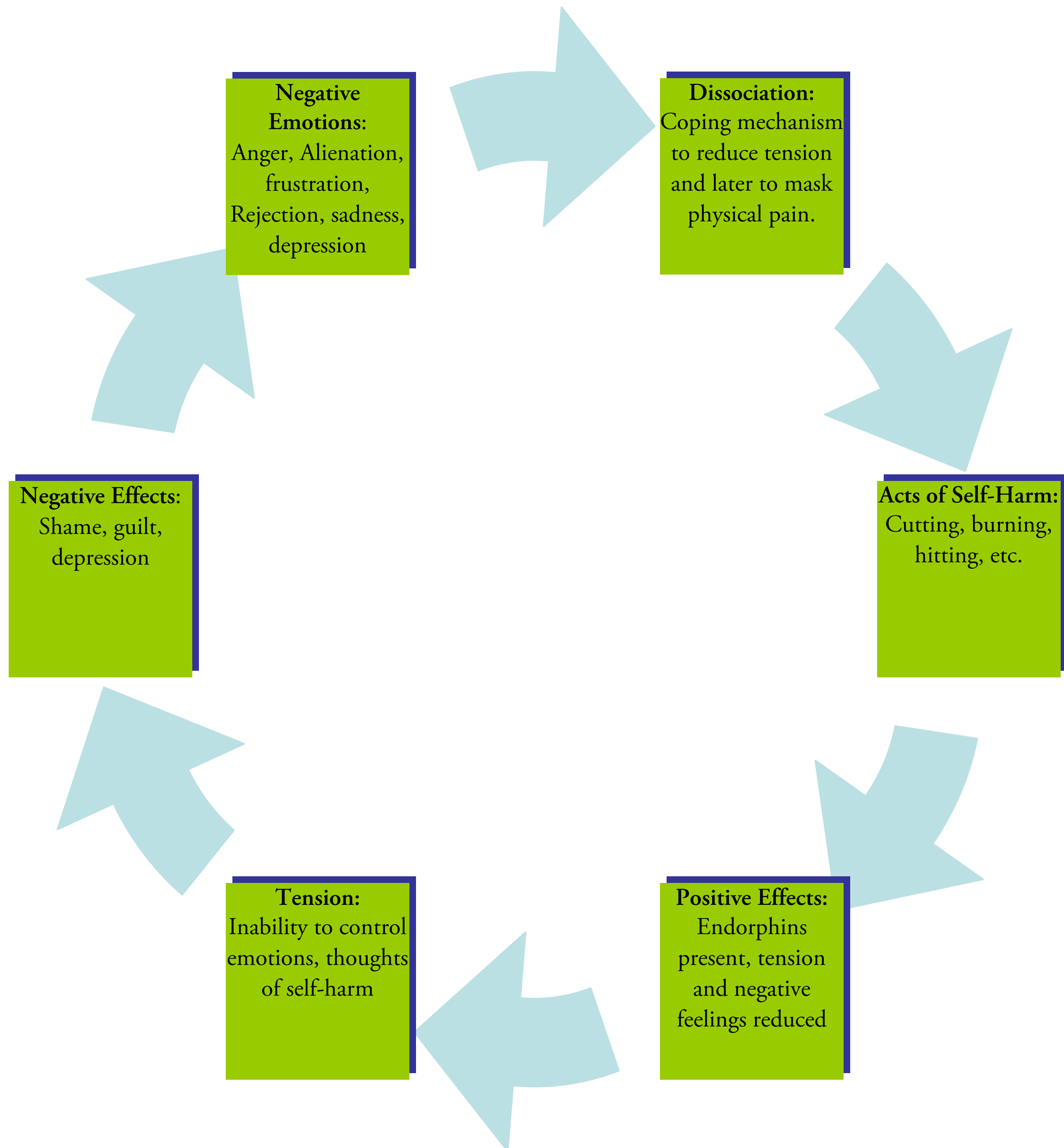
Some sample alternatives:

- ✓ Cooking a meal
- ✓ Writing in a journal
- ✓ Talking to someone you trust
- ✓ Challenging distorted thinking about yourself
- ✓ Just sitting and experiencing difficult emotions
- ✓ Taking a walk
- ✓ Listening to music
- ✓ Working on an art project
- ✓ Playing an instrument
- ✓ Filling out an Impulse Control Log

These alternatives will not offer the student the same adrenaline rush they would normal achieve with self harm. In the beginning of treatment it is generally difficult to find relief by using these alternatives. Over time, the alternative behaviors will feel more normal as the students becomes more comfortable with themselves and their emotions.

4.8 The Addiction Model of Self-Harm

(Adapted from Alderman, 1997)



4.8 The Addiction Model of Self-Harm- Cont.

Helping the student understand how his or her your own cycle of self-harm operates will help him/her later when he/she begins to change this pattern and decrease his/her self-injurious activities. Ask the student to think back to a specific time when he/she hurt themselves. He/she may want to use his/her most recent episode of self-harm since it is probably freshest in his/her memory. Ask the student to list in his/her journal three emotions he/she felt most intensely before he/she hurt him/herself. (If he/she is unable to remember, have them review the cycle of addiction chart) For example:

1. *Sadness*
2. *Anger*
3. *Disappointment*

Ask the student to describe in his/her journal or out loud how he/she felt when he/she began to think about hurting him/herself. How was he/she feeling when he/she got the idea to self-harm. Then how did he/she feel? Did he/she experience a change in his/her negative emotions? Did the student become tense or excited or nervous? Or did he/she become numb or dissociated? Did the student's feelings change even more as he/she got closer to injuring him/herself? What happened?

For example:

Once I decided to hurt myself I felt really excited and full of energy. I didn't feel sad anymore because I knew I was going to do something that would make me feel better. Right before I hurt myself I felt really zoned out, but even that was a calm and good feeling.

Ask the student to describe as best he/she can what you went through when he/she injured him/herself. Have the student write about what he/she did, what instruments (if any) he/she used, how long the process took, his/her experience of pain and/or dissociation, how he/she felt, and anything else he/she thinks is important. How did his/her feelings change throughout the process? When was he/she more tense, less tense, more dissociated? Does he/she have difficulty remembering the specifics of this stage of self-harm? Ask them to describe scribe whatever he/she felt or can remember.

Have the student reflect on what happened after he/she hurt him/herself. Have him/her describe in his/her journal what he/she went through afterward. How did it feel? Was he/she calm, peaceful, tired, anxious? (Again, you might want to refer to the preceding activity to him/her you remember some of these feelings.)

Because relief is one of the primary feelings resulting from self-harm, it is important to explore exactly how self-harm causes this experience and how the

student defines relief. In his/her journal, have the student list all the ways that self-inflicted violence gave him/her relief.

Finally, discuss with the student the ultimate stage of the self-harm cycle— the negative results and return of his/her negative feelings. Knowing when he/she might experience the return of negative feelings will be very important when he/she tries to stop hurting him/herself. Using the same episode of self-harm the student has been following throughout this activity; ask the student how long it took after hurting him/herself before he/she began to feel bad again. Was it minutes? Hours? Days? Weeks? Were the feelings the same as before he/she hurt him/herself? If they weren't, how did they change? Was it the intensity or the actual emotions that changed? How long does the student usually go between episodes of self-harm?

Hopefully, this activity will help the student to see how his/her self-harm activities follow the basic addiction model. By understanding his/her behaviors in terms of a model, he/she will be better able to control his/her self-injuries and prevent him/herself from engaging in these activities. Many of these activities ask the student to describe what he/she goes through when he/she self-harms. Although this process of describing the experience may seem redundant and unnecessary, it is actually designed to be helpful. Going over what he/she feels, think, and does when he/she self injurers not only enables him/her to remember more and more important details, but improves his/her ability to deal with self-inflicted violence. By repeatedly bringing self-harm into his/her consciousness; he/she lessens the impact of remembering these events. He/she will develop a much easier time thinking about specific times when he/she self injurers. The shame, embarrassment, and other emotions he/she feels loses some of their power as the student confronts them more often, which will be helpful when he/she begins to work on stopping self-harm.

5.0 Group Therapy

Group therapy has been useful when working with adolescents because it promotes and facilitates identity development and communication (Suymeoto & MacDonald, 1995). Group therapy has also been productive in working with adolescents who self-injure because it provided intimacy and nurturing for the self-injurer (Walsh & Rosen, 1988). The goal for group therapy was to change how self-injurers use social interactions to fulfill their needs and to adapt healthy ways to communicate and express oneself. Other goals included finding additional ways to nurture oneself and so that intimacy could be achieved.

Group counseling has been beneficial because it provided ample opportunity for members to enhance their communication skills (Bowman & Randall, 2005; Wood, Trainor, Rothwell, Moore & Harrington, 2001). The counselor would guide the sessions to explore different emotions and reinforce verbal communication of the group members. The counselor would further monitor the support and nurturance of other group members (Walsh & Rosen, 1988). Since the basis of group therapy was talking, this was difficult for some self-injurers who have a hard time communicating their needs and emotions without the overt physical gesture of self-harm (Bowman& Randall, 2005, Conterio et al, 1998; Selekman, 2002). Many group members stated that talking about their needs, wants and emotions was unsatisfying for them initially (Conterio et al, 1998; Walsh & Rosen, 1988). With practice, the act of talking became more natural for them. The counselor was also aware when the group was not responding to a member's disclosure. Failure of a group to respond to a member's disclosure would reinforce to that member that no one would listen unless they harmed him/herself. The group should be encouraged to respond and utilize active listening to promote group cohesiveness (Walsh & Rosen, 1988).

Group therapy with adolescents enabled the self-injurer to identify with others who were dealing with similar issues or who have had similar coping strategies (Walsh & Rosen, 1988; Wood et al, 2001). However, group treatment could present a problem if one member used the group format to outdo other members with outrageous behaviors (Taiminen et al, 1998; Walsh & Rosen, 1988). This would alter the group dynamic and place control of the group in the hands of that one member. In these instances the counselor needed to set firm and appropriate limits on the group and the behaviors of its members. Walsh and Rosen (1988) suggested that if a member threatened to do harm to him/herself or acts against him/herself in the group session, that member was removed for the remainder of the session. In a subsequent session the behavior of that member was discussed by the group and the member would need to explain what he/she was trying to communicate through his/her actions in the previous session. Furthermore, members who are making strides to resist self-injurious behaviors need special attention. This attention was important in reinforcing their progress (Walsh & Rosen, 1988). Occasionally there was pressure from other members of the group against resisting self-harm (Taiminen et al,1998). Most often this pressure came from group members who were not yet ready to give up their self-injurious behavior and felt threatened by those who did.

There were drawbacks to this form of counseling which can be overcome if recognized by the counselor and dealt with effectively. Some drawbacks included: the self-harm of one participant would trigger episodes in others; the individual members' desire to feel acknowledged and

understood would be communicated through self-harm in the beginning stages of treatment, individual members would use self-harm to manipulate other members or to obtain a desired emotional reaction from others in the group, and lastly group members would use self-harm as a platform to gain higher status in the group (Taiminen et al,1998; Walsh & Rosen, 1988).

As previously discussed self-harm has been contagious among groups. The dynamic of the group was influenced by the self mutilation of its members. Other members of the group would experience mixed emotions ranging from anger to jealousy when another member continued to self-harm. Group treatment was a valuable tool in helping self-injurers deal with the consequences of self-harm (Taiminen et al,1998; Walsh & Rosen, 1985;Walsh & Rosen, 1988).

There has been very little research into the effectiveness of group counseling versus other forms of counseling. However, Wood et al (2001) found that self-injurers who received both group therapy and routine care had fewer episodes of self-harm than individuals who received only routine care. Still, this area of treatment has been under-represented in the literature but can be valuable for counselors from a time and financial standpoint.

5.1 "Stress Busters"- Group Counseling

The Stress Busters Group Counseling Curriculum was developed by Matthew Selekman as a intervention at a junior high school were there was overabundance of adolescent females who were self-injuring. Many of these young women were resistant in traditional therapy, so Selekman developed a group curriculum were these girls were celebrated as natural leaders who could help others who were dealing with stress and anxiety. The curriculum was designed to help these students manage emotional, family, social and school stressors. Selekman reports that follow up interviews with members from his first Stress Busters group report that they have abandoned self-injurious behaviors and became more involved in helping others in junior high school and later in high school.

The following curriculum is taken directly from Selekman's work as published in his book *Living the Razor's Edge* (2002).

GROUP SESSIONS

Each session is an hour in length. The format consists of 15-20 minutes of an upbeat, interesting didactic presentation by the leaders, a 15- to 20-minute in-session skill-building exercise, and a stress-busting experiment offered to the participants at the conclusion of the session. The group meets eight times, with longer intervals between the sixth, seventh, and eighth sessions as a vote of confidence to the participants' progress in the group. The eight session topic areas covered in the group are:

1. What are my strengths and protective shields?
2. Mindfulness skills
3. Relationship-effectiveness skills

4. Mood-management skills
5. Self-soothing stress-busting skills
6. Navigating family minefields successfully
7. Effective tools for mastering school stress
8. Celebrating change: Congratulations stress-busting experts!

Session 1. What Are* My *Strengths and Protective Shields?

In the first group meeting, the leaders begin the session by establishing rapport with each group member. To become better acquainted with one another and learn about the participants' strengths and talents, the leaders ask each group member to respond to the following question: "If someone were to stop you on the street and ask you what two of your strengths are, what would you tell that person?" After each group member has had an opportunity to answer this question, the leaders shift gears and with great enthusiasm and excitement share with the participants how pleased they are about their decision to participate in the group, which is a great social cause. We also share with the group some of the meaningful, exciting projects graduates of the group have been involved with at their schools and colleges.

It is important for the group leaders to take the time to ask the participants about their expectations of us, of the group, and any other concerns they may have. We explain the session format to the participants and express our wishes that they fully cooperate with and try out all of the in-session exercises and the stress-busting experiments given at the end of each meeting. The leaders invite the members to come up with group rules and goals. After eliciting their problem stories and thoughts about their referral to the group, we use the miracle, presuppositional, and scaling questions to help them to articulate their short- and long-term treatment goals for themselves (de Shazer, 1988, 1991; O'Hanlon & Weiner-Davis, 1989).

In the next portion of the meeting, the group leaders give a short presentation called Resiliency Protective Factors. We present some of the most common protective factors found with resilient children and adolescents, including their: being creative and effective problem-solvers, having inspirational others, having at least one supportive, responsible adult caretaker in their lives, and succeeding in school. We then ask the group members to share with the group what they think their main protective factors are and specifically how they have been helpful to them in coping with past and present stressors in their lives. We like to refer to these protective factors as *protective shields* that help us to cope with stressful events in our lives.

The in-session exercise for this session is *visualizing movies of success* (Selekman, 1997). This exercise consists of having the group members close their eyes and capture in their minds movies of past sparkling moments in their lives when they successfully coped with painful life events or performed with excellence in high-stress situations. While group members are attempting to access their movies of success, we have them apply all of their senses to the images they come up with, concentrating on color and motion. After 10-15 minutes of visualizing, we invite the group members

to share their personal movies with one another. In the context of this discussion, the leaders ask group members the following questions:

- "Are you aware of how you did that?"
- "What did you tell yourself that helped you to manage that situation so well?"
- "What did you learn from this experience that you have already put into practice with similar types of situations?"

These types of questions can help to amplify and consolidate the group members' pretreatment changes. Finally, we share with the group the old adage "nothing succeeds like success," while pointing out how group members' past successes can serve as blueprints for future successes. To close the session, the leaders compliment each group member on their past successes, creativity, and strengths and resources. The first stress-busting experiment they are given is the *victory box* (see chapter 1).

Session 2. Mindfulness Skills

The second group meeting begins with the participants showing their victory boxes to the group and sharing with us two of their most noteworthy personal victories over the past week. To further empower and create possibilities with the group members, the leaders use regular and future-vision consolidating questions such as:

- "Are you aware of how you did that?"
- "After taking those big steps, do you view yourself differently now as opposed to how you used to view yourself?"
- "Let's say in our next group meeting you brought in a videotape of you taking further big steps with (peers, your parents, your sibling, your difficult teacher). What will we see you doing on the video?"
- "How- will those changes make a difference for you in your relationships with (peers, your parents, your sibling, your difficult teacher)?"

The leaders give a short presentation on Practicing Mindfulness Meditation. Many adolescents find this topic fascinating and usually become quite skilled at meditation techniques. We begin our presentation by pointing out how mindfulness meditation has its roots in an ancient system of Buddhist psychology in which human nature is viewed in a positive way and emotional problems are seen as temporary and superficial. In addition, we share with the group that mindfulness meditation increases our ability to see things just as they are from moment to moment, which can alter how we relate to and perceive emotional distress. The group members learn that by cultivating a capacity to quiet our minds and self-observe, we can gain wisdom from even the most stressful and painful life experiences (Benett-Coleman,2001; Goldstein & Kornfield, 1987). To help give the group participants an opportunity to experience the benefits of mindfulness meditation, we have them practice meditating for 15-20 minutes. The group members are to place one of their hands on their

abdomens and focus all of their attention on watching it rise and fall with every breath. If any unpleasant thoughts or feelings enter their minds while meditating, they are simply to label them to acknowledge their presence and center themselves by returning back to focusing on their breath (Davis et al., 1994). After the group members have had an opportunity to practice mindfulness meditation, we like to process with them what their unique experiences were like.

We conclude the group with compliments for each participant, by checking in with each member about how well they are doing at achieving their personal goals, and by giving a stress-busting experiment to do over the next week. The stress-busting experiment is for group members to practice mindfulness meditation twice a day for 1 5-20 minutes. We recommend that they have their meditations first thing in the morning and either right after school or before they go to bed.

Session 3. Relationship-Effectiveness Skills

We begin the third group meeting by exploring with participants what their personal experiences experimenting with mindfulness meditation were like. Often group members report that this form of meditation helped them to "chill" when they were stressed out. Others may report that their minds were so cluttered with disturbing emotions and intrusive thoughts that they had difficulty entering a meditative state. We suggest that these group members try the following the next time they practice meditating: Label and acknowledge the painful emotion or intrusive thought they are experiencing and remind themselves that they can dis-empower painful emotions and intrusive thoughts by viewing them as temporary and as masking their essential goodness (Chodron, 2001). To illustrate the powerful effects of our emotional patterns and self-defeating thoughts, Bennett-Goleman (2001) likes to use the example of the scene from the *Wizard of Oz.* Up to this point in the story, they viewed the wizard as a powerful, terrifying entity —until Dorothy's dog Toto calmly pulls back the curtain to reveal a little old man stooped over the controls, manipulating a huge wizard image. Emotional patterns and self-defeating thoughts are like that —if you see them clearly for what they really are, you take the power away from them. Group participants have found this example from the *Wizard of Oz* to be most helpful to them in seeing the benefits of mindfulness meditation.

Finally, for the group members who found the sitting meditation "boring" or not very useful, we recommend the raisin food meditation described in chapter v. One of the group leaders demonstrates how to do this simple food meditation.

We strongly encourage group members to keep practicing and further honing their mindfulness meditation skills so that they can get into a relaxed state more quickly and disengage from their disturbing emotions, intrusive thoughts, and stressful life events.

The leaders give a short presentation on the Politics of Gender as part of their discussion on relationship-effectiveness tools. We use video clips from popular movies and TV shows and magazine

photos to trigger group discussion and to graphically depict how the images in the media have a powerful effect on how young women view themselves and how males view and relate to them. Furthermore, we discuss the role of patriarchy in how women are socialized to act and look. Last, we like to use the Russian literary critic Bakhtin's metaphor of the ventriloquist and his dummy to illustrate how young women's thoughts, feelings, and actions cannot be separated from their audience or the patriarchal lens through which they are filtered (Brown, 1998). Bakhtin (1981) calls the process of one voice speaking through another voice *ventriloquism*. As part of our group discussion, we explore with the participants in what ways they already resist falling prey to the feminization process, challenge the patriarchal traditions imposed on them, and maintain their unique voices.

Some of the relationship-effectiveness tools we teach are: resisting, assertiveness, communication, and problem-solving skills. Using the real-life experiences of the group members, the leaders demonstrate through role-playing how they would apply each of these tools in their unique relationship difficulties.

The in-session exercise consists of having group members select a partner to practice these relationship-effectiveness skills. They are to give their partners constructive feedback on how well they did at applying their selected tools in the scenarios. Following the exercise, the leaders process with the group what they found most helpful, explore with them if they learned anything new about themselves or their situations, and ask them where they are feeling stuck.

Prior to concluding the group meeting, we compliment each participant on how she shined in the exercise and on any other important changes that have occurred with her situation. The group is given two stress-busting experiments that are geared to further strengthen their relationship-effectiveness skills. They first are encouraged to further experiment with the relationship-effectiveness skills they found most helpful in their role-plays. We then ask them to experiment with stepping outside of themselves and observing themselves in social situations from a bubble high above. From this vantage point, they are to pay close attention to what they are doing successfully in the social encounters, as well as what they are doing that is self-defeating. With each important or stressful social encounter, they are to document daily in pocket-sized notebooks what they learned from their experiences.

Session 4. Mood-Management Skills

The leaders begin the fourth group meeting processing with the participants their unique experiences with both of the prescribed stress-busting experiments. With every personal victory or positive step group members report, the leaders respond with cheerleading and amplify and consolidate their gains. Scaling questions can also be used to further elicit group members' news of a difference. At this stage of the group, participants often begin to spontaneously compliment one another.

The presentation in this group session is called Changing Your Self-Defeating Thoughts and Emotional Patterns. The leaders illustrate on a whiteboard the A-B-C formula of cognitive therapy to show how self-defeating or irrational thoughts trigger our emotional reactions and behaviors (Ellis, 1974). To bring the A-B-C formula to life for the group participants, we have one of the members of the group apply it to a stressful life event or situation they are struggling to cope with. As part of this discussion, we introduce the therapeutic tools they can use to break the chain connecting their thoughts, feelings, and actions.

We teach them the following cognitive tools: disputation skills, thought-stopping techniques, searching for evidence to support their self-defeating or irrational thoughts, and shifting their emotional states (Beck, 1995; Ellis, 1996; McMullen, 2000; Seligman, 1995).

In order to help the group members become more proficient in using these tools in the context of their unique problem situations, we have them find a partner and practice the tools for 15-20 minutes. After the exercise, we process with the group members what they found helpful and field any questions or concerns they still may have about managing their moods.

The leaders end the group by complimenting each group member and giving the next stress-busting experiment. The group members are asked to practice using the cognitive tools they found most interesting and helpful on a daily basis whenever they are faced with a stressful event or being pushed around by a self-defeating thought or a disturbing emotion.

Session 5. Self-Soothing Stress-Busting Skills

The leaders begin the fifth group session by inviting group members to share the sparkling moments they experienced as a result of the cognitive tools they experimented with over the past week. With every positive step the participants report, we cheerlead and amplify and consolidate their gains. One way we help to solidify participants' gains is by asking them questions like:

- "What would you have to do to go backwards?"
- "Let's say you have a slip over the next week. What steps will you take to get back on track quickly?"

We give the group a short presentation on Caring for Your Soul. In the context of this presentation, group members learn the following self-soothing strategies: visualization techniques, soul work, cleansing rituals, and relaxation training. After reviewing the visualizing-movies-of-success experiment, we teach the group the visiting-your-special-place and creating-your-guardian-angel visualization strategies. We stress to the group the importance of nurturing oneself daily by making time for free play, creative expression, and pleasurable, meaningful activities, in the context of this discussion, group members often spontaneously share with one another their unique soul work activities and their best methods for pampering themselves. Finally, we teach the group *deep breathing* techniques. As an in-session experiment, group members are asked to select one of the visualization strategies and spend 15-20 minutes practicing it. After they have completed their practice

sessions, we spend ample time processing their experiences with the visualization exercise and offer pointers and support to the group members who had a difficult time visualizing.

After we compliment each group member, we give the group two stress-busting experiments to do over the next week. With the first experiment, the participants are to practice their favorite: visualization strategies twice a day for 15-20 minutes. They are also asked to devote some daily time to engaging in some form of soul work.

Session 6. *Navigating Family Minefields Successfully*

In the sixth group meeting the leaders open by exploring with the participants how their experiments went and by finding out what further progress they are making in general at better managing stressors in their lives. We amplify and consolidate their gains and use scaling questions to secure a quantitative measurement of how satisfied group members are with their progress and what they envision as their next steps in reaching an even higher level on their scales (de Shazer, 1991).

The leaders give a short presentation on Family Politics. The topics covered in this presentation are: family roles, parenting styles, triangles, problem-maintaining patterns of interaction and beliefs, intergenerational patterns, cultural traditions, and gender power imbalances. We invite the participants to share with the group which aspects of their own family politics trouble them the most. As part of this discussion, we explore with group members what they do to avoid getting triangulated into coalitions and how they constructively manage their emotional reactions to their parents' troubling behaviors (such as nagging, yelling, or invalidating them). It is also helpful to elicit from them how they get trapped in family members' webs or by their ploys. Group members have an opportunity to compare notes, hear that their fellow participants are experiencing similar family difficulties, and learn from one another about how to get through family minefields unscathed. Finally, we teach the group members the *do-something-different task* (de Shazer, 1985, 1988, 1991) as an effective tool that will help them to successfully navigate family minefields.

The fun and illuminating experiential exercise we like to use in this group session is *family choreography* (see chapter 4). The amount of time left in the group meeting determines how many family choreographies we can do. Typically we can squeeze in at least two of the group members' family choreographies. The members that volunteer to do choreographies are free to use objects in the room as props and are to pick other participants in the group to represent family members. We encourage the choreographers to allow their creativity to run wild in terms of how they depict their families as moving sculptures. After showing the group how they currently see their families, the choreographers are to show the group how they would like their families to look in the future. When each choreographer is done, we invite the other group members to share their thoughts and insights. Sometimes we have a few of the nonparticipating group members listen and observe as if they were one of the family members portrayed in the volunteer's family choreography. These participants are asked to

give their unique perspectives and possible new insights about the family situation. The leaders present their reflections on the volunteers' family choreographies as well.

To close the group meeting, the leaders compliment each participant and the next stress-busting experiment is given. The group members are asked to try the *do-something-different task* (de Shazer, 1985, 1988, 1991) whenever they feel like a family member is attempting to engage them in a coalition or a conflict or is using them as a confidant. They are to keep track of what they do that seems to help them successfully counter family members' ploys and record their creative strategies in their pocket-size notebooks. The group is given 2 weeks to test out this experiment and as a reward for their hard work both in and out of the group.

Session 7. Effective Tools for Mastering School Stress

My colleagues and I look forward to the seventh group meeting, during which the group members talk about all of the creative, positive steps they took when they were experimenting with the *do-something-different task* (de Sha/.er, 1985, 1988, 1991). With even positive and big step that group members report, we respond with cheerleading and amplify and consolidate their gains. For the participants who still found themselves getting triangulated into coalitions, clashing with particular family members, or being unable to step out of the confidant role, we use the brain power and creativity of the group to generate solution strategies. We first may do a dramatization of the stuck participant's problem situation. It is also helpful to explore with other group members what unique coping and problem-solving strategies they employ to manage similar situations in their families. After the group has generated a number of potential solution strategies on the whiteboard, the stuck participant is free to select which of the strategies she would like to experiment with.

If the stuck group member describes the problem situation as oppressive or having a life of its own, we may attempt to externalize it (White & Fpston, 1990). Finally, if we are picking up on some strong affect with this stuck participant, we may ask conversational questions to give her more room to share her painful story or the "not yet said" (Anderson & Goolishian, 1988). Some examples of conversational questions we may ask in these situations are:

- "Just before you came to the group for the first time, was there something you told yourself that you would not talk about in the group?"
- "What is your greatest fear if you talk about it? How does not talking about this untold story allow it to continue presenting problems for you or others?"
- "Were there any aspects of our discussions about families either today or last week that you found to be most upsetting to you? What aspects?"
- "What can we do as leaders or as a group to best help you out with this upsetting situation?"

The short presentation given to the group is called Survival Tips for Managing School Stress. In this presentation, the leaders discuss strategies for resolving conflicts and difficulties with teachers and peers, how to stay on top of schoolwork, and effective ways to make a difference in school.

Regarding the last topic, we discuss how group members can get involved in teen leadership, student empowerment activities, and peer counseling. We share our hope with the participants that they will take all of the knowledge and expertise they have gained from their group experience and provide prevention workshops on stress management both at their home schools and at other schools or public places in their communities. The in-session experiential exercise offered to the group provides the participants with the opportunity to constructively manage peer harassment and rejection. We have the participants break up into groups of four. One of the group members dramatizes her problem situation of being harassed by a particular female peer at school. Another group member plays her. Another group member plays the role of harassment (Lewis & Cheshire, 1998). Finally, the last group member plays the role of the young woman who has been spreading nasty rumors around the school about the volunteer. By externalizing the problem in this way, all participants in the role-play have the opportunity to gain new insights about these types of problem situations. Harassment itself teaches them about all of its tricks and brainwashing methods and about how the harasser it has trained may also be a victim in this relationship drama. In addition, the volunteer may learn powerful countering tactics that she can use to stand up to harassment and not allow it to push her around (Lewis & Cheshire, 1998). When processing this exercise with the group, participants not only report having enjoyed doing it but also find that their views of their problem situations have changed. Group members often report feeling a sense of liberation from their peer problems as a result of this exercise.

We conclude the group with compliments for each participant and give the next stress-busting experiment. As a vote of confidence, the participants are given a 3-weck vacation from the group. While on vacation, the group members are asked to experiment with some of the new ideas and tactics they learned from the peer-rejection and harassment exercise.

Session 8. Celebrating Change: Congratulations Stress-Busting Experts!

The leaders begin this meeting by exploring with group members what further progress they made while on vacation from the group. We check if any of the participants had the opportunity to stand up to peer rejection or harassment. After dialoging about the group members' experiences and amplifying and consolidating their gains, the leaders' launch a festive celebration party to honor the participants' outstanding work in the group. We present them with achievement certificates and a nicely decorated sheet cake that has on it: "Congratulations Stress-Busting Experts!" The group members are asked to give speeches reflecting on how things were for them individually, with their families and peers, and at school prior to their participation in the group and how things are different for them now. Often group members spontaneously cheerlead for one another and give each other compliments in response to their personal speeches. To further amplify and consolidate their gains, the leaders ask the following types of questions:

- "If we were to invite you to our next stress-busters' leadership group as expert consultants, what helpful pointers or words of wisdom would you share with this group?"
- "Let's say we had a 1-year anniversary party for this group. What further positive changes w ill each

of you be eager to report to the group at the part)?"

Following the group members' speeches, the participants are inducted into the Stress-Busters' Expert Consultants' Association. As members, they are expected to engage in some of the following activities: be available to provide presentations on stress management to schools and for other groups and organizations in their communities; offer consultation to school social work staff and other personnel and provide support to schoolmates who are grappling with self-harming and other stress-related problems; and contribute articles to a *Stress-Busters' Quarterly* publication that is circulated around their schools. At some of the more progressive schools, we have been able to secure some office space once or twice a week for the graduates to establish an onsite Stress-Busters' Leadership Institute to provide training and workshops on stress management for interested students and support services for stressed-out kids at school.

For the group members who wish to have further counseling at the conclusion of the group, the leaders carefully assess with them what their unique needs are and make themselves available to provide individual, couple (with their partners), or family therapy. They can decide how often they want to be seen and which combination of people they wish to have attend the sessions. Often this clinical work is not long-term due to the extensive positive gains they achieved during the group sessions.

6.0 Websites on Self Injury

http://www.palace.net/~llama/psych/injury.html

http://www.self-injury.net/

http://www.siari.co.uk/

www.selfinjury.com – official website for the S.A.F.E Program.

http://www.sisupport.org/

www.focusas.com

www.healthyplace.com

www.teenhealthcentre.com

www.selfinjury.org

7.0 Community Agencies

The Henrietta Youth Bureau
475 Calkins Road, Henrietta, NY 14467
359-2540
Individual and Family counseling, legal related counseling and drug and alcohol counseling

New York State Division For Youth
109 South Union Street, Room 302, Rochester, NY 14607
263-4333
Family Court referrals for counseling

Park Ridge Youth Outreach (Unity Health Systems)
59 Henry Street, Hilton, NY 14468, 392-5945
And
269 Ogden Center Road, Spencerport, NY 14559. 352-3050
Individual and Group counseling, family problems, drug counseling, court related problems, runaway assistance, sexual concerns, child abuse and neglect.

Rochester Police Department – FACIT (Family Crisis Intervention)
Public Safety Building, Civic Center Plaza, Rochester, NY 14614
428-7183
Crisis Intervention and short term counseling

Teen Challenge
75 Alexander Street, Rochester, NY 14620
325-7123
Christian Based counseling for "life controlling problems"

Threshold Center for Alternative Youth Services, Inc
80 St. Paul Street, 4th floor, Rochester, NY 14604
454-7530
Counseling, health care. Educational and vocational community outreach.

The Youth Services Program
Urban League of Rochester
265 North Clinton Avenue, Rochester, New York 14605
325-6530
Counseling for school drop outs, teen parents, career development, employment referrals, job readiness training, housing programs, and victims of violence.

Catholic Family Center
25 Franklin Street, 7th Floor, Rochester, NY 14604
546-7220
Individual and Family Therapy, refugee resettlement programs, substance abuse counseling, elderly/youth outreach.

Family Services of Rochester
30 North Clinton Ave, Rochester, NY 14604
323-1840
Individual and Group counseling (primarily drug abuse and sexual abuse counseling)

Jewish Family Services of Rochester
441 East Avenue, Rochester, NY 14607
461-0110
Individual and group counseling (open to everyone)

Lewis Street Center
120 Ontario Street, Rochester, NY 14605
546-3230
Individual, Family and group counseling for sexuality, parenting, survival, and employment.

Montgomery Neighborhood Center
10 Cady Street, Rochester, NY 14608
436-3090
Short term individual and family counseling

Rochester Mental Health
Rochester General Hospital
490 East Ridge Road, Rochester, NY 14621
544-5220
Psychiatric counseling, substance abuse, geriatric, children and youth counseling.

St. Mary's Mental Health Center
835 West Main Street, Rochester, NY 14611
436-4840
Individual, family, single, marriage and parent counseling, school adjustment problems, crisis intervention, geriatrics and group counseling.

8.0 In-service for Educators

Slide 1

Self Injury

It's called many things – self-inflicted violence, self-injury, self-harm, parasuicide, delicate cutting, self-abuse, self-mutilation.

Slide 2

Prevalence

- As recently as 2002, a research survey indicated that as much as 13% of adolescents sampled admitted to engaging in some form of self injurious behavior (Ross & Heath, 2002).
- Research suggests that the prevalence for self injury among middle school students is rising with an average onset at age eleven (Conterio, Lader & Bloom, 1998; Warm, 2002).

Slide 3

Research has identified several reasons for engaging in self injurious behaviors including;

- The need for concrete pain when psychological pain is too overwhelming,
- The reduction of emotional numbness by creating physical pain,
- The blocking out of traumatic memories and to keep them from present consciousness through distraction,
- Emotional regulation,
- To receive support and empathy from others,
- Release of anxiety, anger, despair and disappointment,
- To increase a sense of control,
- Self punishment for "being bad",
- The enhancement of self esteem.

- (Alderman, 1997; Conterio et al, 1998; Favazza, 1996; Himber, 1994; Shearer, 1994, Walsh & Rosen, 1985).

Slide 4

What makes it Self-Injury?

- Alderman (1997) has developed key components to identify whether a behavior is self injurious behavior. The behavior must meet these criteria in order to be considered an act of self harm. Acts of self harm must be;
- a) done to oneself,
- b) performed by oneself,
- c) physically violent,
- d) not suicidal,
- e) intentional and purposeful.

Slide 5

It's not self-injury if the primary purpose is:

- Sexual gratification
- Body decoration (e.g., body piercing, tattooing)
- Spiritual enlightenment via ritual
- To Commit Suicide

Slide 6

Common forms of self injury include:

- cutting of the skin,
- hitting, usually the head, thighs or stomach,
- excessive hair pulling,
- banging the head against a hard surface,
- scratching the skin till it bleeds,
- biting,
- burning,
- interfering with the healing of wounds,
- purposeful breaking of bones,

Slide 7

Extreme forms of Self- harm include:

- amputation of limbs, genitals, breasts, fingers or toes,
- facial skinning,
- injection or ingestion of sharp objects or toxic substances

- These variations of self-harm are generally seen only in individuals with an additional diagnosis of psychopathology.

(Abrams & Gordon, 2003; Alderman, 1997; Conterio et al,1998; Favazza & Conterio, 1988).

Slide 8

Self-Harm and Suicide

- Self harm is an act of self preservation, not an attempt to end life.
- Acts of deliberate self harm by adolescents are often carried out during times of acute emotional turmoil which can present itself as a suicidal act rather than self harm
- Self injury is actually an act of self help for the individual.
- The act of harming oneself offers relief from uncomfortable symptoms, such as dissociation and distress, that if unimpeded could result in a true suicidal act or psychotic break.

Slide 9

Self-Harm and Suicide Continued…

- It is easy to assume that one who cuts their skin, particularly in the area of the wrist and neck that they must be trying to kill themselves.
- This is often the assumption made when dealing with a self injurer.
- On closer examination an act of self injury can be viewed as a way to save his/her life, not take it.
- Confusion and ignorance regarding self harm often impedes a self injurer's attempt to get help for him/herself since most often his/her self injury is seen as a suicidal act.

Slide 10

What kinds of people self-injure?

- Self-injurers come from all walks of life and all economic brackets.
- People who harm themselves can be male or female; straight, gay, or bisexual; Ph.D.s or high-school dropouts or high-school students; rich or poor; from any country in the world.
- Some people who self-injure manage to function effectively in demanding jobs; they are teachers, therapists, medical professionals, lawyers, professors, engineers.
- Some are on disability.
- Their ages range from early adolescence to early 60s.

Slide 11

Common Themes Associated With Self-Harm

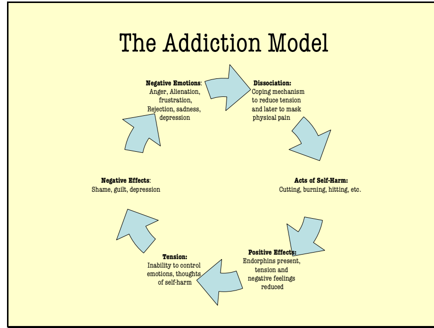
- Children who are socially isolated
- Family History of Drug Abuse
- Family History of Child Abuse and/or Sexual Abuse
- Attachment Disorders
- Early loss
- Parental illness or absenteeism
- Rigid religious upbringing that restricts expression of emotions
- Under-parented children
- Over-parented children
- Poor coping strategies
- Low self esteem
- Need for uniqueness

Slide 12

Bio Chemistry

- It is important to note that not all self-injurers report a history of physical or sexual abuse.
- Abuse is not a prerequisite for self harm, just as not all individuals who are sexually or physical abused will harm themselves
- Multiple factors can compound the emergence of self harm such as environment, genetics, personality and psychological distress.
- There are many theories as to why adolescents engage in such behaviors.
  - Some of the more prevalent theories involve serotonin irregularities and the endorphin rush associated with self injury.
- This theory in particular reinforces the idea that addiction may play a role in the self injurious behavior (Pies & Popli, 1995).

Slide 13



Slide 14

Biological Frailty

- Additional theories propose that a biological frailty or predisposition for self harm exists in certain individuals and is the underlying cause for self injurious behaviors.
- Other theorists conclude that certain individuals are pre-disposed to this type of behavior or have what is termed as a biological frailty for self-harm.

Slide 15

The Contagion Effect

- Adolescents tend to imitate the behaviors of others to promote togetherness; this extends to the practice of self injurious behavior.
- If a student already has risk factors for self injurious behavior, the practice of these behaviors in a friend often triggers an earlier onset of these behaviors in the at-risk student (White Kress, Gibson & Reynolds, 2004; Walsh & Rosen, 1985).
- The problem of self harm is now so prevalent that in clinical circles this epidemic is called the “new anorexia” (Conterio et al, 1998; Edwards, 1998).

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Contagion continued

- There have been increasing reports of individuals, adolescents in particular, who have adopted self harm strategies from their classmates and friends.
- That is not to say that every adolescent is in danger of becoming a self injurer. It is more likely that these adolescents were already psychologically vulnerable to these behaviors (White Kress et al, 2004; Walsh & Rosen, 1985).
- These adolescents readily adopted self injury as a new coping strategy to deal with already existing distress.
- Self injury is now perceived as 'in fashion' and as a popular coping strategy among adolescents (Conterio et al, 1998).

Slide 17

Suffering in Silence

- Almost 90% of self-injurers say they are discouraged from expressing emotions.
- Almost 50% report past physical or sexual abuse.

Slide 18

How Can I Help?

- Teachers can listen to their students and acknowledge their feelings. (In other words, teachers can validate feelings – not necessarily the student's behavior.)
- Teachers can serve as role models in the way they deal with stressful situations and traumatic events, in how they respond to other people, by not allowing abuse or violence in the classroom,

Slide 19

Do's and Don'ts

- Do's
  - Try to approach the student in a calm and caring way.
  - Accept him/her even though you may not accept the behavior
  - Let the student know how much you care about him/her and believe in his/her potential
  - Understand that this is his/her way of coping with the pain that he/she feels inside.
  - Refer the student to his/her school counselor, social worker or nurse.

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Do's and Don'ts Continued…

- Do
  - Offer to go with that student to see the professional helper.
  - Listen! Allow the student to talk. Be Available! (you may be the only one in the students life who does listen)
  - Discover what the student's personal strengths are and encourage him/her to use those strengths.

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Do's and Don'ts Continued…

- Don't
  - Say or do anything to cause the student to feel guilt or shame.
    - e.g. "what did you do to yourself?" "How could you do such a thing?"
  - Act shocked or appalled by his/her behavior (it took a lot of guts to admit it to you in the first place).
  - Talk about the self-harm in front of the class or around his/her peers.
  - Try to teach him/her what you think he/she should do.

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Do's and Don'ts Continued….

- Don't
  - Judge the student even if you do not agree with his/her behavior.
  - Tell the student that you won't tell anyone if he/she shares self-harming behaviors with you.
  - Use punishment or negative consequences if a student self-harms.
  - Make deals in an effort to get the student to stop self-harming.
  - Makes promises to the student you cannot keep.

Slide 23

Where can I find More information?

- http://www.self-injury.net/
- http://www.siari.co.uk/
- www.selfinjury.com – official website for the S.A.F.E Program.
- http://www.sisupport.org/
- www.focusas.com
- www.healthyplace.com
- www.teenhealthcentre.com
- www.selfinjury.org

Slide 24

Where can I find More information?

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