

**Cutting: What School Counselors Should Know About  
Students Who Self-Injure**

by

**Katie A. Schiller**

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Carol Johnson Ph.D.

**The Graduate School  
University of Wisconsin-Stout**

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**The Graduate School  
University of Wisconsin-Stout  
Menomonie, WI**

**Author:** Schiller, Katie A.  
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ABSTRACT

The popularity of self-injury continues to rise among adolescents. This trend presents problems for the school counselors as they seek ways to identify students who self-injure and suggest treatment options and coping strategies to diminish cutting among students. The purpose of this study is to review current research and gain insight from literature pertaining to self-injury among the adolescent population as well as to aide school counselors with guidelines for warning signs and intervention with students who engage in self-injurious behaviors. Information is also included to address prevention while maintaining confidentiality issues. Various aspects of self-injury included in this literature review are the following: typical characteristics of self-injurers, possible reasons for why adolescents self-injure, warning signs for self-injury, treatment options, and recommendations for school counselors who work with self-injurers. Recommendations are also made for parents and other educators in managing adolescents who engage in self-injurious behaviors.

The Graduate School  
University of Wisconsin Stout

Menomonie, WI

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## Chapter I: Introduction

Allison is a twelve-year-old girl who was raped by an older boy who was friends with her brother. She attempted to tell her parents of this horrific act, but her parents saw her pleas as childish and believed that boys were just being boys. With no one to talk to and no support network, Allison soon felt as if her life was spinning more and more out of control. As a result, Allison started to cut her arms, legs, and abdomen with a sharp razor blade. She had so much anger and guilt inside her that she felt she literally had to rip away layers of her skin to feel better. She had strong desires to cut herself that came out of nowhere and only a sharp razor blade would calm her down and give her a sense of relief. When she entered high school, she was not only cutting herself, but also had developed a mild case of anorexia. She used food as a way of maintaining control over her body (Austin & Kortum, 2004).

Throughout her high school years, she grew increasingly attached to cutting herself. She relied on a razor blade for support and a means to release her emotional pain. More importantly, it was a way for her to gain control over her life, which she desperately needed. She could control how deep the razor blade cut into her skin. The blood that dripped from the deep cuts on her arms, legs, and abdomen was her way of expressing her anger and frustration. It was the only way she felt like she had a voice. She started to cut more and more and as a result she had to cut more deeply to get the same feeling of relief she once had. She went through many different therapists to help her gain control over her life. It was the help of her husband that helped her gain control of her life after years of engaging in self-injurious behavior (Austin & Kortum, 2004).

Situations such as Allison's are not uncommon. Self-injurious behavior has become an alarming problem in recent years. It is apparent that self-injurious behavior is a problem in

today's society. "It is estimated that three million Americans suffer from self-injury, and one in every 200 teenagers suffer from chronic self-injury" (Austin & Kortum, 2004, p. 2). Adolescence is a period where individuals undergo many developmental changes. According to Santrock, "Adolescence is the period of transition between childhood and adulthood that involves biological, cognitive, and socioemotional changes" (2005, p. 20). These changes can be very challenging and confusing for some individuals. As a result, engaging in self-injurious behavior is a strong possibility.

"Self-injurious behavior is defined as deliberate, repetitive and impulsive harming of one's body" (Onacki, 2005, p. 400). Self-injury is often referred to as self-mutilation. Because self-injury and self-mutilation are described in similar ways, these two terms will be used interchangeably throughout this paper.

Self-injury includes acts of cutting, scratching, reopening wounds, burning, inserting objects into body openings, and breaking bones (Onacki, 2005, p. 400). Self-injurious behavior excludes "self-stimulating behaviors, such as self-biting and head-banging" (Woldorf, 2005, p. 196) that are common to mental retardation and developmental disabilities. "Culturally sanctioned behaviors" are also not considered as self-injurious. These include acts such as body piercings, tattoos, and forced scarring due to religious rituals (Woldorf, 2005).

According to Austin and Kortum (2004), research indicates that cutting is the most common means of adolescents' self-injurious behavior. Cutting is usually done with razor blades and knives. Most common areas of the body that adolescents injure are: the forearms, wrists, upper arms, thighs, abdomen, breasts, and calves. Clothing conceals these areas, which is significant for the victim. Keeping the self-injuries hidden from others allows the victim to

engage in harmful behaviors more frequently, without interruption, and without being noticed by others.

Self-injurious behavior has been documented to occur with individuals as young as 6 years old to individuals who are 90 years old. Self-injury is also reported to be more prevalent in girls and women than boys and men (Woldorf, 2005). According to The Brown University Child and Adolescent Behavior Letter (2004), “girls are almost four times more likely to engage in self-injurious behavior than boys” (n.p.). “It is estimated that one out of every 200 teen girls between the ages of 13 and 19 regularly practice this self-abusive behavior with a reported 2 million cases in the U.S. alone” (PageWise, 2002, n.p.). According to Michelnan and Eicher (1991), social culture is revealed for both genders through dress and body markings. For example, boys may use self-injury as a way of passing through manhood and as an attempt to establish self-awareness and cultural acceptance. Girls may self-injure to overcome issues related with the commencement of menstruation and/or prior sexual abuse. According to Zila and Kiselica (2001), males and females who engage in self-injurious behavior may have difficulty in establishing positive and lasting relationships with the opposite sex.

Research suggests that individuals self-injure as a way of coping with stressful situations or problems they encounter in life. Therefore, self-mutilation can be seen as a “coping strategy” (Haines & Williams, 2003, p. 1098). Individuals may experience an insurmountable amount of tension, which in turn may lead to negative emotions. As a way of coping with these negative emotions, some individuals begin to disassociate before they self-injure. Although the injuries may be severe, many individuals indicate that they feel no pain when they self-injure. Self-injuring brings relief for many individuals, however, the feeling of relief is soon replaced by



“guilt, embarrassment, self-hatred, and anger” (Woldorf, 2005, p. 197). These feelings lead individuals to self-injure again. Therefore, self-injury can be an addictive behavior.

For some individuals, self-injurious behavior is very private. Individuals will go to extreme lengths to conceal any indication of cutting, not wanting anyone believing s(he) is engaging in the behavior. However, others choose not to hide their wounds or scars. Individuals who do not conceal their injuries are assumed to be making a “cry for help” (Woldorf, 2005). Some individuals attribute self-injurious behavior as being part of their identity. Some identify themselves as a “cutter” or “burner” (Favazza & Rosenthal, 1990).

Deliberate self-harm is strongly associated with suicide. According to Self-Abuse Finally Ends Alternatives (n.d.), an organization committed to helping individuals stop self-harm, “Self-injurers often become desperate about their lack of self-control and the addictive-like nature of their acts, which may lead them to true suicide attempts”(n.p.). According to research,

Of the known risk factors for completed suicide, deliberate self-harm has the strongest correlation with the suicide rate being a hundred times greater in the self-harmer than that of the general population in the year following a non-fatal act of deliberate self harm. (Whotton, 2002, p. 12)

Suicide is one of many risk factors associated with self-injury or deliberate self-harm. According to The Brown University Child and Adolescent Behavior Letter (2004), causes for the desire to self-harm may include: childhood abuse, witnessing an abusive relationship in the home during childhood, parental divorce, incarceration, and family history of alcoholism and mental illness.

It is important to recognize early warning signs of self-injurious behavior and establish necessary interventions in order to reduce suicide rates. Warning signs include: mood swings, low self-esteem, poor impulse control, sadness/tearfulness, anger, and anxiety. Wearing long

sleeves and long pants during hot weather, and avoiding participating in activities that require skin exposure, are also indicators. Those who cut may exhibit a reluctance to participate in physical education classes, dressing out for sports, and not participating in summer, skin-exposing activities (The Brown University Child and Adolescent Behavior Letter, 2004).

Parents, teachers, and school counselors should be able to recognize the warning signs of self-mutilation and should be prepared to provide the individual with options to get help and proper care to stop the harmful behaviors. It is critical that teachers and school counselors have additional training to recognize self-mutilation. It is vital for a school counselor to read, research, and attend workshops on self-injury. The counseling field is constantly changing and school counselors need to stay current on important issues in order to be effective in the field.

School counselors work with a variety of students each day. Because of the likelihood that a school counselor will encounter students who engage in self-injurious behavior, it is important for school counselors to be well-informed. A school counselor may be the first professional to offer assistance to a self-injuring student. Therefore, it is vital for the school counselor to be familiar with how to address effectively the student's needs.

### *Statement of the Problem*

The topic of self-injury is important to school counselors as the number of students engaged in self-injurious behavior is increasing. Recognizing the warning signs and finding options for helping students is a priority for school counselors. Therefore, the problem is what can school counselors do to recognize the warning signs and how can they best help students who are self-injuring?

### *Purpose of the Study*

The purpose of this comprehensive literature review is to explore research on the definitions, reasons for self-injury, warning signs and helping strategies for school counselors

who encounter students who self-harm. This study was executed in order to increase knowledge and understanding regarding self-injury and the individuals who self-injure. Literature will be reviewed during the spring of 2008.

### *Research Questions*

Specifically, this study will include current research to address the following questions:

1. What is the definition of self-injurious behavior and self-mutilation?
2. What warning signs do students who are harming themselves through cutting and self-mutilation exhibit?
3. What can school counselors do to intervene with students who self-harm?
4. What options are available for students who need assistance in bringing self-injurious behaviors to an end?

### *Definition of Terms*

For clarity of understanding the following terms need to be defined.

*“Self-injurious behavior* is defined as deliberate, repetitive, impulsive, and nonlethal harming of one’s body” (Onacki, 2005, p. 400). Self-injury includes acts of cutting, scratching, reopening wounds, burning, inserting objects into body openings, and breaking bones (Onacki, 2005).

*Disassociation* is defined as “the separation of whole segments of the personality (as in multiple personality disorder) or of discrete mental processes (as in the schizophrenias) from the mainstream of consciousness or of behavior” (Merriam-Webster Online Dictionary, 2005, n.p.) According to Strong (1998), some teenagers appear as if they are catatonic or hallucinating while they are cutting.

*Internal locus of control* means individuals believe they have control over their life (Whotton, 2002).

*External locus of control* assumes that individuals feel they have little or no control over what happens to them. Adolescents who have external locus of control believe others make decisions for them and therefore, they don't have control over their future (Whotton, 2002)

#### *Assumptions*

One assumption is that the literature was readily available. However, with time as a limiting factor, all resources may not have been reviewed. It was assumed that the literature was from scholarly sources.

#### *Limitations of the research*

One limitation of this review of literature is the researcher made an attempt to review much research on self-injury and that some may have been overlooked. A second limitation is that not all forms of self-injury were represented in this paper, such as eating disorders, self-biting and head-banging.

## Chapter II: Literature Review

### *Introduction*

This chapter will consider the literature and research relevant to self-injury. This chapter will include a discussion of the reasons why self-injury occurs, followed by a discussion of warning signs associated with self-injury and the importance of recognizing self-injurious behavior. The chapter will conclude with a discussion on treatment and the role of the professional in treating people who self-injure.

### *Definition of Self-Injury*

Self-injury is defined as the “deliberate, repetitive, impulsive, and nonlethal harming of one’s body” (Onacki, 2005, p. 400). Researchers have classified self-injurious behavior into four categories: Major Self-injurious Behavior, Stereotypic Self-Injurious Behavior, Compulsive Self-Injurious Behavior, and Impulsive Self-Injurious Behavior (Kress, 2003).

Stereotypic Self-Injurious Behavior includes behaviors such as head banging, self-hitting and face-slapping, lip and hand chewing, self-biting, and hair pulling. These behaviors are most commonly seen in individuals with mild mental disorders or developmental delay. These behaviors generally produce mild to severe tissue damage due to the behaviors being repeated over periods of time (Kress, 2003).

Major Self-Injurious Behavior is more severe and potentially life-threatening. These behaviors include castrations and limb amputation (Kress, 2003). According to Austin and Kortum (2004), Major Self-Injurious Behavior is the rarest form of self-injury and permanent disfigurement typically occurs. Generally these extreme behaviors occur when a person is suffering from severe psychosis, intoxication, or severe character disorder. “Self-injurious behaviors of psychotic people differ from the other forms of self-injurious behavior in that the

person injures in response to profound disorders of perception or thought and does not recognize the irrationality of the behavior” (Kress, 2003, p. 491).

According to Kress (2003), the most common type of self-injurious behavior is Impulsive Self-Injurious Behavior, which includes skin cutting, burning, and self-hitting of a mild to moderate severity. There are two types of self-injurious behavior including episodic and repetitive. Episodic self-injury occurs only a few times throughout a person’s life. For example, a cheerleader who did not have success at the final tryout session learned she did not make the cheer squad for her senior year in high school. She was deeply hurt and humiliated that she was not good enough this year and younger girls on the squad had higher scores than she had. An example of Episodic Impulsive Self-Injurious Behavior occurs when she cuts herself out of frustration and disappointment. She feels the pain and it was a one-time event. She never does it again and talks to a parent or friend to find other ways to deal with her emotions.

Repetitive Impulsive self-injury is related to self-injury that reoccurs throughout a person’s life. This type of behavior is considered addictive and is integrated into a person’s life and personality. Repetitive Impulsive Self-Injurious Behavior usually begins in adolescents and develops into a chronic behavior in adulthood. An example of Repetitive Self-Injurious Behavior would be an adolescent in a violent home. Whenever he hears his parents fighting, he retreats to his room and burns himself with a lighter. It hurts, but it covers that pain of hearing the violence in his home and takes the focus off the anger and abuse in his life. It is a coping method that he repeats every time he needs to reduce the anxiety of fighting. For some individuals, Impulsive Self-Injurious Behavior is a self-help strategy. It can be helpful for some because it provides relief from unpleasant experiences and “may prevent temporary psychotic episodes and suicidal

acts” (Kress, 2003, p. 491). Impulsive Self-Injurious Behavior is also linked with childhood sexual abuse and consequent Post Traumatic Stress Disorder (Kress, 2003).

Compulsive Self-Injurious Behavior includes repetitive hair pulling, skin picking, and nail biting. The severity of these behaviors ranges from mild to moderate severity. Individuals who engage in this type of behavior are compelled to carry out the impulse, but may try to resist it. Some are successful in resisting the behavior, while others are not. Classifying self-injurious behavior is helpful when considering and selecting appropriate diagnosis and effective interventions for the behavior (Kress, 2003).

#### *Suggested Reasons for Self-Injury*

There are many reasons why adolescents self-injure. According to Whotton (2002), these reasons may include: “feelings of hopelessness or desperation to escape from a situation, physical and sexual abuse, bullying, poverty, alcohol and drug misuse, custodial sentence, attention seeking behavior, wanting to punish loved ones, or acting on a split-moment decision” (p. 12). Existing mental illnesses can also be a reason adolescents self-injure (Whotton, 2002). According to Onacki (2005), self-mutilation has been strongly tied with the diagnoses of clinical depression, borderline personality disorder, obsessive-compulsive disorder, and anxiety disorders.

#### *Emotional Pain of Self-Injury*

It is apparent that self-injurious behavior is a problem in today’s society. It is difficult to understand why individuals self-injure. Teenagers seek coping mechanisms as they navigate their way through life. Some teenagers are unable to cope with intense feelings, so they turn to self-injury as a way to express their feelings and emotions.

According to Austin and Kortum (2004),

Many will cope with stress in their lives through unhealthy habits such as smoking and drinking..., or even through self-injury, for all bring a sense of relief, forgetfulness, empowerment and security. Self-injury however, is more visible and more socially unacceptable. It is a disorder that needs to be understood and discovered. (p. 522)

Self-Injury is a way to change a mood-state by focusing and controlling pain in one area of the body. The average person starts to self-injure at age 14 and continues with increased severity into her/his late 20s. For example, consider a male child who engaged in an argument with his parents. The child then recklessly rides his bike to escape from the noisy argument. While riding his bike, the child still feels angry and upset; however, if he falls off the bike and skinned a knee, the primary concern suddenly becomes focused on the knee and not on the anger. Falling off the bike made the child focus on the physical pain of falling off the bike and the injured knee. The emotional pain caused by the argument is no longer there (Austin & Kortum, 2004).

Many teenagers stated that the reason they engage in self-injury is because they feel “out of control.” Some teenagers appear as if they are catatonic or hallucinating while they are cutting. This is known as disassociation. Strong (1998) cited in Austin and Kortum (2004) stated, at the core of dissociation and “behind all of the symptoms of traumatic stress, from numbness to loss of control, is the range of painful childhood experiences. Because the combination of pain, shame, and grief from these early experiences often remain unresolved, feelings of dread and emptiness can build up and quickly grow to unbearable proportions” (p. 519). As a result, it is common for a self-injurer to feel disconnected from his or her own body and the only way to feel



real again is by cutting. As a way for teens to manage their inner problems, they engage in self-injurious behaviors (Austin & Kortum, 2004).

Whotton (2002) stated that there are different opinions of why individuals self-mutilate. Some believe it is because they have an internal locus of control, which means they believe they have control over their life. Some would believe the individual has an internal locus of control because they have made a conscious decision to self-injure. Others believe individuals who self-injure have an external locus of control, which assumes that individuals feel they have little or no control over what happens to them. Adolescents who have external locus of control believe others make decisions for them and therefore, they don't have control over their future. This may lead them to self-injure.

#### *Risk Factors Associated with Self-Injury*

Self-injury can become an addictive behavior and the severity of the self-injury can increase over time because the self-injurer can become resilient to smaller wounds. This means that a self-injurer has to cut deeper over time to create the same relief they once had from smaller, less frequent cuts. A self-injurer could accidentally commit suicide because of the increased severity of the self-injury (Austin & Kortum, 2004).

#### *Why Self-Injury?*

More than half of self-injuring teens reported being sexually abused as a child. Self-injury can be used as a coping mechanism for individuals who have survived being sexually abused. Mutilating one's body is one way to assure the victim has control over at least one aspect of his or her life. Victims of sexual abuse feel like they had everything taken from them, but their bodies. Self-mutilation is a way for the victim to reclaim their body (Strong, 1998).

Physical and sexual abuse, existing mental illness, bullying, poverty, and alcohol and drug misuse are some of the more common reasons why adolescents engage in self-injurious behavior. According to Kehrberg (1997), teenagers engage in self-injurious behaviors more frequently when experiencing events such as a recent loss or death, peer conflict, intimacy problems, impulse disorder, and a rejection of human interconnection. The combination of these multiple stressors and the lack of availability and accessibility to a support system are important issues (Whotton, 2002).

There is a strong correlation between a child who self-injures and a home where family members fail to communicate effectively with one another. When a child feels like he/she cannot discuss a problem with a parent, that anxiety frequently is turned inward. In cases where the child feels emotionally neglected, self-injurious behaviors are likely to occur as another form of communication. Self-mutilation provides a way for teenagers to express themselves when they are unable to verbalize their feelings. It is a way for them to express the pain they feel inside (Austin & Kortum, 2004).

#### *Treatment of Self-Injurious Behavior*

According to The Brown University Child and Adolescent Behavior Letter (2004), there are different levels of self-injury treatment. One level of treatment includes counseling. The self-injurer should attend individual counseling. Family and group counseling can also be helpful in treating the behavior. According to Self-Abuse Finally Ends Alternatives (S.A.F.E.), cognitive-behavioral therapy and interpersonal therapy are used often when treating an individual who self-harms. According to S.A.F.E., "Cognitive-behavioral therapy helps individuals understand and manage their destructive thoughts and behaviors. Interpersonal therapy assists individuals in gaining insight and skills for the development and maintenance of relationships" (n.d., n.p.).

Parents may also need individual counseling support in order for them to work appropriately with a self-harming teen.

Another level of self-injury treatment described by The Brown University Child and Adolescent Behavior Letter (2004) consisted of therapy strategies. Therapy techniques focus on communication skills and coping strategies that can be helpful in aiding individuals to avoid self-injury. Therapists may use a variety of techniques, including music therapy, journal writing, and role-playing in order to teach self-injurers these skills and keep them engaged.

Medication is the last level of treatment. Anti-depressants or mood stabilizers may be helpful to individuals who have not had success at previous levels of treatment. Medication can be used in combination with therapy if needed. Although medication is not needed by all self-injurers, it can be helpful for some.

### *Providing Alternatives*

The Brown University Child and Adolescent Behavior Letter (2004) suggested that in order to stop the self-injurious behavior, it is important to address the underlying issues contributing to the behavior. Providing alternatives to self-injury can be helpful when counseling an individual who engages in harmful behaviors. Providing alternatives is used as a first step in the counseling process and attempts to reveal underlying causes of the client's harmful behaviors. These alternatives provide safer methods that clients may use to acquire similar feelings or sensations they experience when they self-harm, without causing bodily harm. Alternatives provide momentary relief for self-injurers. It enables the individual to refrain from engaging in harmful behaviors, while the counselor and client work toward discovering the underlying reason for the self-injurious behavior. Wester and Trepal (2005) suggested that "alternative behaviors should be matched to clients' reactions and emotions, what they need at a

specific point in time to cope, or to the emotions or feelings they typically have prior to self-injury” (p. 183).

Wester and Trepal (2005) suggested another alternative for individuals who are cutting their arms repeatedly as an attempt to regulate uncontrollable feelings, is to draw on his/her arm with a soft marker or slash lines on a piece of paper. If it is the sensation the individual is seeking, Wester and Trepal (2005) suggested that the counselor have the client brush his/her skin with a toothbrush. This is a safe way for the clients to control their feelings without causing tissue damage that a razor would.

#### *Warning Signs of Self-Injurious Behavior*

Due to their inability to communicate effectively, children may or may not like to go to professionals for help with their problems, so it is extremely important that teachers, principals, school counselors, healthcare professionals and parents become aware of the signs of self-injurious behaviors and act accordingly. Austin and Kortum (2004) described some personality traits including: “look for perfectionist tendencies, a dislike of body or body shape, and the inability to tolerate intense feelings” (p. 521).

Austin and Kortum (2004) also discussed some psychological symptoms, which include withdrawal, moodiness, and depression. The authors also suggested looking for obvious signs including cuts or burns to one’s skin. They indicated that it may be difficult to recognize these because most teenagers are ashamed of their harmful behavior and they will go to great lengths to conceal their injuries. Therefore, it is important to look for signs including a preference for wearing concealing clothing at all times, avoiding situations where revealing skin or removing clothing may be expected, or frequent complaints of accidental injuries.

### *Professional Help*

Parents, teachers and school counselors should know these warning signs and be able to recognize them in order to identify individuals engaging in self-injurious behavior. Upon recognizing the warning signs, parents, teachers, and counselors should be prepared to handle the situation to the best of their ability. When working with a self-injurer, the school counselor or teacher should follow a few guidelines suggested by Austin and Kortum. One of these guidelines described by Austin and Kortum (2004) is to not take the self-injurer's behavior personally. The purpose of self-injury is not intended to make people feel bad or guilty. The professional should be trained on recognizing self-injury in an attempt to better understand the behavior. It is also important that the professional try not to force the client to stop self-injury. The behavior can be suppressed for a period of time; however, it will most likely resurface with more severity than it had been before.

When working with a self-injurer, the professional should also express compassion and understanding. It is important to discuss the severities of the behavior. Counselors should realize that self-injury is a way for individuals to cope with pain they could not otherwise deal with. It may be helpful for the professional to discuss possibilities of treatment and other methods for coping with their client's emotional pain or issues and be patient with them. Austin and Kortum (2004) found that treatment is a long process and clients can undergo many setbacks. Therefore, it is important to be patient with the self-injurer.

### *Best practices for school counselors*

A school counselor should become familiar with community agencies and private practitioners who specialize in the treatment of self-mutilators before the information is needed. Developing a list of credible resource materials, outside agencies, and helpful professionals to

contact will enhance the counselor's ability to assist students and their families. Parents should be provided with resources regarding these community resources. When coming in contact with a self-injurer, other professionals should be consulted and students should be referred to outside agencies when appropriate. Individual and group counseling strategies should be developed to assist students who exhibit self-mutilation patterns. Counseling strategies may also include dialog on issues pertaining to self-injury such as self-esteem, grief, loss, divorce, assertiveness training, and anger management. Froeschle and Moyer (2004), also suggest that Cognitive counseling and behavior-mood modifications are also helpful in assisting self-injurers. Counselors should also implement alternative techniques for empowerment, while still establishing support for the self-injurer's dignity.

A supportive environment should be created. The self-injurer must have a safe space to vent and reflect when experiencing negative emotions too difficult to handle publicly. In an effort to help students, staff should be encouraged to release students from class to visit privately with the building counselor when these negative emotions occur.

Classroom presentations that focus on issues related to self-injury such as drug and alcohol abuse, violence, self-esteem, and possible exposure to infection and diseases should be implemented. (Froeschle & Moyer, 2004). It is also important to educate adolescents on self-injurious behavior and the seriousness of the behavior, because peers can be a commanding force in influencing a friend who is self-injuring to seek professional help (The Brown University Child and Adolescent Behavior Letter, 2004).

Teachers and other staff should also be informed regarding the importance of listening and empathizing with students. Information and resources should be shared with staff so they can

both assist students and determine the differences between suicidal and non-lethal self-mutilation (Froeschle & Moyer, 2004).

School counselors should encourage verbalization. It is important for a self-injurer to be able to communicate pain as an alternative of engaging in self-injurious behavior (Froeschle & Moyer, 2004). Family of self-injurers should be involved in counseling when possible.

Improvements in communication and attachment issues are resolved best when including the people with whom the student is close. Parents should also be educated on self-mutilation in order to identify and assess the behavior at home (Froeschle & Moyer, 2004).

#### *Legal and ethical considerations*

Counselors must consider legal responsibilities when making ethical decisions regarding students who engage in self-injurious behavior. It can be difficult to decide at which point confidentiality should be breached when encountering a self-mutilating student. What is communicated in counseling is expected to remain confidential; however, this expectation appears to be critical to the client's willingness and ability to self-disclose. According to the American Counseling Association (ACA) (2006), "counselors respect their clients' right to privacy and should avoid illegal and unwarranted disclosures of confidential information" (n.p). Therefore, every effort must be made to disclose information when ethically feasible. As required by law, school counselors are to report suspected child abuse and threats to harm self or others to proper authorities. The counselor should notify parents and appropriate personnel when a student is engaging in self-harmful behaviors and then document the report.

Counselors do have a duty to warn or protect others in society from potential harmful behaviors. Vernon (1993), as cited in Froeschle and Moyer (2004), "believes the student's age and capability, the possible consequences of disclosure on therapeutic progress, and the legal and

ethical policies within a particular school district should govern the decision regarding violation of confidentiality” (p. 234).

There appears to be a lack of consensus regarding a parent’s right to access confidential information shared by their son/daughter in a counseling session. Huey and Ramley (1988) believed that parents have a right to information shared in a counseling session, whereas Fischer and Sorenson (1996) believe school counselors have the right to uphold confidentiality in regard to sharing content with parents. It is important for a counselor to establish and uphold appropriate boundaries and maintain confidentiality in order to sustain client’s trust. However, limits of confidentiality must be discussed. (ACA, 2006). When in doubt, check the school district policy or legal consultation options.

According to Jacob and Hartshorne (2007), a student who is a minor has no legal right to confidentiality independent of the parents; therefore, it is critical that a counselor discuss confidentiality and its limits with parents when seeking consent when working directly with a minor. It is important to indicate to the parents of the child that it is imperative that confidentiality exist for a therapeutic relationship to develop. The counselor may request an agreement from the parents that the counselor will not disclose specific information without the child’s consent to do so. It is also important for the counselor to reassure the parents that they will inform them of any situation that suggests that the child is in any danger (Jacob & Hartshorne, 2007). As a result of unclear expectations, it is crucial for a school counselor to clarify the limits of confidentiality with students and parents based on consultation with legal expertise.

Counselors have an ethical and legal responsibility to educate themselves about issues such as self-mutilation and to execute a plan of action for students who are at risk for such



behavior. In summary, it is critical for school counselors to consider the following: collaborate with other professionals, education on self-injurious behavior for all staff, parents, and students, implement classroom guidance lessons on self-injury and issues related to the behavior, and conduct helpful counseling strategies in an effort to make a positive impact on self-injuring students. It is also imperative to clarify limits of confidentiality with students and other parties prior to counseling sessions as the threat to harm may require disclosure.

### Chapter III: Summary and Recommendations

This section will summarize findings from the literature review pertaining to Self-Injurious Behavior. Contributing factors, warning signs, treatment and strategies and confidentiality will be discussed. The chapter will conclude with recommendations for school counselors and suggest ideas for further research on this important topic.

#### *Summary of Findings*

It is difficult to understand why individuals self-injure, yet there are many factors that contribute to self-injury. According to Onaacki (2005), "Self-injurious behavior is defined as deliberate, repetitive and impulsive harming of one's body" (p. 400). Most adolescents report that they engage in self-injurious behavior as a means to cope with intense feelings of hopelessness or desperation to escape from a situation. Situations of physical or sexual abuse, existing mental illness, bullying, poverty, and alcohol and drug misuse are also strongly correlated with self-injury. According to Kehrberg (1997), teenagers engages in self-injurious behaviors more frequently when experiencing events such as a recent loss or death, peer conflict, intimacy problems, impulse disorder, and a rejection of human interconnection.

Self-injury is a growing problem with today's youth. Therefore, it is important that parents, teachers, and school counselors recognize the problem by becoming aware of the signs of self-injurious behavior. Recognizing warning signs will allow school counselors, teachers and parents to assist the individual in receiving the proper care in order to minimize the harmful behaviors. Warning signs include: mood swings, low self-esteem, poor impulse control, sadness/tearfulness, anger, and anxiety. ("Self-Injury: Is this troubling behavior a growing problem in adolescents" 2004).

Austin and Kortum (2004) also discussed some psychological symptoms, which include withdrawal, moodiness, and depression. The authors also suggested looking for obvious signs including cuts or burns to one's skin. They indicated that it might be difficult to recognize these because most teenagers are ashamed of their harmful behavior and they will go to great lengths to conceal their injuries. Therefore, it is important to look for signs including a preference for wearing concealing clothing at all times, avoiding situations where revealing skin or removing clothing may be expected, or frequent complaints of accidental injuries.

There are a variety of levels of treatment plans that an individual can receive in coping with the self-injurious behavior. In order for the treatment to be effective, the underlying cause of the behavior must be determined. Once that happens, the individual may be able to refrain from self-mutilation and live a healthy lifestyle.

#### *Recommendation for School Counselors*

It is important for a school counselor to be familiar with community agencies and other professionals who work with self-injurers in order to collaborate and refer students to outside agencies when appropriate. Staff, parents and students should be educated on self-injury and issues associated with the behavior, such as self-esteem, grief, and loss. Classroom guidance lessons should be implemented on issues related to coping strategies in order to prevent self-injury. It is also beneficial to conduct individual and group counseling sessions in an effort to make a positive impact on self-injuring students.

School counselors should instill a supportive and open environment by encouraging verbalization. Whenever possible, the families should be involved in the counseling process to better assist the self-injurer.

Limits of confidentiality must also be discussed and clarified with students and other parties prior to counseling sessions as the threat to self-harm may require a school counselor to disclose information.

### *Recommendations for Further Research*

After reviewing the literature on the issue of self-injury, it is recommended that more information in addressing this problem is needed. With the rapid increase in adolescents engaging in self-injurious behavior, it is important for school counselors to be aware of warning signs and treatment options. Self-injury should be a topic that is addressed together with other mental disorders that affect adolescents in the school. This would help aid in the understanding of self-injury. In doing so, school counselors may become more effective in working with adolescents who engage in self-injurious behaviors.

Another recommendation for further research would be to evaluate the amount of knowledge currently known by individuals who are in helping professions, such as teachers, school counselors and principals. This would indicate if more training is needed with school professionals. A survey could be completed asking questions pertaining to self-injurious behavior of students.

A final recommendation for future research would evaluate the possibility of including a self-injury category placed in an upcoming version of the Diagnostic and Statistical Manual of Mental Disorders. Further research needs to be completed on other contributing factors related to self-injury. Children's lives are valuable and important. Self-harm is a poor way to cope with feelings and emotions and with further research, solutions may be found to help children reduce or eliminate this harmful trend of self-cutting.

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