

**AN INSIGHT INTO THE WORLD OF SELF-INJURY**

by

**Leah D. Johnson**

**A Research Paper**

**Submitted in Partial Fulfillment of the  
Requirements for the  
Master of Science Degree  
With a major in**

**Guidance and Counseling**

**Approved: 2 Semester Credits**

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**Investigation Advisor**

**The Graduate School  
University of Wisconsin-Stout  
May, 2003**

**The Graduate School  
University of Wisconsin-Stout  
Menomonie, WI 54751**

**ABSTRACT**

<hr/>	Johnson	Leah	D.
<b>(Writer)</b>	<b>(Last Name)</b>	<b>(First)</b>	<b>(Initial)</b>
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<u>An Insight Into the World of Self-injury</u>			
<b>(Title)</b>			
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Guidance and Counseling	Amy Gillett	May 2003	34
<b>(Graduate Major)</b>	<b>(Research Advisor)</b>	<b>(Month/Year)</b>	<b>(No. of Pages)</b>
<hr/>			
<u>American Psychological Association (APA) Publication Manual – 5<sup>th</sup> edition</u>			
<b>(Name of Style Manual Style Used in this Study)</b>			

The purpose of this paper was to provide general information regarding self-injury in the adolescent population. This paper addressed various aspects of self-injury including the following: typical characteristics of self-injurers, possible reasons as to why individuals self-injure, treatment options, and recommendations for those who work with self-injurers. Also included in this paper are a critique of the current research and recommendations for future research. One of the recommendations is to research the possibility of including self-injury as a separate classification in the *Diagnostic and statistical manual of mental disorders*. Another recommendation for future research is to classify self-injurious behavior according to the motive behind the behavior (i.e. manipulative intent or tension release). A third recommendation for future research is to focus on the reactions of those involved who work with self-injurers (i.e. parents, school counselors, and siblings). The reaction of these individuals may influence self-injurers in a positive or negative way.

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## CHAPTER ONE

### Introduction

Self-injury is a growing concern among parents, teachers, counselors, and other school and medical personnel. Self-injury is also a topic that is receiving more interest from the press (Ross & Heath, 2002; Alderman; Pedersen; Pipher; Schappell; Steinem; Todd; cited in Zila & Kiselica, 2001). According to the Self-Abuse Finally Ends (S.A.F.E.) Alternatives® Program (2002), approximately 1% of the population self-injures on a regular basis. According to Ross and Heath (2002), self-injury occurs in one out of ten high school-aged students. More importantly, self-injury is a topic that is confusing due to lack of encompassing definitions, multiple causes for the behavior, shortage of information, scarcity of programs, and the need for more understanding on behalf of parents and professionals.

Self-injury has many names. These names include, but are not limited to the following: self-mutilation (Clarke & Whittaker, 1998; Zila & Kiselica, 2001), self-cutting (Greenspan & Samuel; Himber; Suyemoto & MacDonald; cited in Zila & Kiselica, 2001), and self-destructive behavior (Van der Kold, Perry, & Herman; cited in Zila & Kiselica, 2001). Martinson (cited in Anderson & Preuss, 2002b) believed that many self-injurers dislike terms such as self-mutilation. She suggested other terms such as self-injury, self-harm, and self-inflicted violence. Due to the fact that self-injury is described in many different ways by different researchers, all terms will be used interchangeably in this paper. The two most commonly used terms will be self-injury and self-mutilation.

Self-injury also displays itself in many different forms. One of the most common forms is cutting (Anderson & Preuss, 2002a; Ross & Heath, 2002; S.A.F.E.

Alternatives® Program, 2002; Zila & Kiselica, 2001). There are many other forms including burning (Anderson & Preuss, 2002a; Favazza & Conterio; Pattison & Kahan; Pipher; Van der Kolk, et al.; cited in Zila & Kiselica, 2001), scratching to excess, ingesting sharp and/or toxic objects, self-hitting (Ross & Heath, 2002), head banging, and amputation of body parts such as arms, legs, fingers, and breasts (Anderson & Preuss, 2002a). These forms are a few of the many that self-injurers have used. The S.A.F.E. Alternatives Program® (2002) stated that many self-injurers use several forms of self-injurious behavior. Yet, in a study done by Ross and Heath (2002), the majority of adolescents reportedly used only one form of self-injury. As Zila and Kiselica (2001) suggested, self-injurers will use whatever means he/she can devise.

Self-injury, according to most research, is more common in women than in men. According to Conterio and Lader (1998), there are several possible reasons why there are more female self-injurers than male self-injurers. In many instances, it is more socially acceptable to males to act outwardly than it is for females, leading females to express anger towards themselves (Ross & Heath, 2002). One reason is that males are more likely to be aggressive towards others or participate in other forms of risk taking behavior (Ross & Heath). Conterio and Lader (1998) also stated that men are less likely to seek professional help and are more likely to participate in the use of drugs and alcohol. Due to scarcity in research regarding male self-injurers, female self-injurers will be the topic of this paper.

Another pressing concern involves the characteristics of self-injurers. Self-injurers cannot be confined to one simple category. One characteristic of self-injurers is that they are primarily female. Self-injurers are present in upper, middle, and lower class

families, but the “typical” self-injurer is a middle class female (Anderson & Preuss, 2002a). There are no racial or educational boundaries identified in the research (Anderson & Preuss, 2002a). The “typical” self-injurer often has an average to high range level of intelligence. A self-injurer will typically begin injuring herself at the onset of puberty (Anderson & Preuss, 2002a; Zila & Kiselica, 2001). According to Martinson (cited in Anderson & Preuss, 2002b), self-injury can occur from puberty through the sixties and possibly older. Self-injurers often have low self-esteem (Anderson & Preuss, 2002a; Nichols, 2000; S.A.F.E. Alternatives® Program, 2002). According to the S.A.F.E. Alternatives® Program, approximately 50% of self-injurers have been physically, sexually, and/or mentally abused. Ninety percent of self-injurers were not allowed to express their feelings. The S.A.F.E. Alternatives® Program also stated that over 50% of self-injurers have some form of an eating disorder. In addition, there is a high correlation of alcohol and other substance abuse (S.A.F.E. Alternatives® Program, 2002; Zila & Kiselica, 2001).

Self-injurers also have different reasons and situations that have led them to self-injure. As stated above, many self-injurers have had some form of abuse in their past. As they get older, the repression of feelings as a child can often cause them to feel empty and unable to express their feelings (Anderson & Preuss, 2002a; Nichols, 2000; S.A.F.E. Alternatives® Program, 2002). Many describe the inability to form relationships and lack feelings of being loved and accepted (Anderson & Preuss, 2002a; Nichols, 2000; S.A.F.E. Alternatives® Program, 2002). Martinson (cited in Anderson & Preuss, 2002b) believed that self-injurers might be trying to stop flashbacks or ideas of self-hate.

Martinson also stated that self-injurers might have a biological predisposition to hurt themselves.

One of the most important distinctions that must be made is that self-injurers are not attempting suicide. The S.A.F.E. Alternatives® Program (2002) defined self-injury as the following: “The behavior is defined as the deliberate, repetitive, impulsive, non-lethal harming of one’s self” (n.p.). Another definition given by Martinson (cited in Anderson & Preuss, 2002b) stated: “Most researchers agree that self-injury (SI) is self-inflicted harm severe enough to cause tissue damage or marks that last for several hours, done without suicidal intent or intent to attain sexual pleasure” (n.p.). In some instances, self-injurers may kill themselves (Nichols, 2000), but according to Conterio and Lader (1998), the self-injurers who committed suicide suffered from long-term and severe forms of depression. Another reason stated by Conterio and Lader (1998) and Nichols (2000) was that a self-injurer might accidentally cut too deeply, resulting in a suicide. Conterio and Lader described several differences between suicide attempts and self-injury. They described self-injury as a way to prevent suicide because it helped the self-injurer cope with their current needs. Plus, the authors stated that most self-injury was superficial and not the normal means of ending one’s life. They also stated that many self-injurers were offended when accused of attempting suicide.

Self-injury is a very misunderstood condition. Martinson (cited in Anderson & Preuss, 2002b) suggested that doctors and emergency workers should treat these injuries as accidental. Martinson stated that denying services or making ill comments is not in the best interest of the patient. The patient will not feel comfortable returning to the hospital

if they are mistreated, which can lead to other complications such as infections or future injuries (Martinson, cited in Anderson & Preuss, 2002b).

### **Statement of the Problem**

The purpose of this study was to gain a better understanding of the current research regarding self-injury in adolescents.

### **Rationale**

The justification behind this study is to increase knowledge and awareness about self-injury and the individuals who self-injure.

### **Research Question**

There is one question this study will attempt to answer. The question is as follows:

1. What is the current research information on adolescents who self-injure?

### **Definition of Terms**

There is one term that needs defining in order to clarify the nature of this paper.

This term is:

Self-injury:

The behavior is defined as the deliberate, repetitive, impulsive, non-lethal harming of one's self. Self-injury includes: 1) cutting; 2) scratching; 3) picking scabs or interfering with wound healing; 4) burning; 5) punching self or objects; 6) infecting oneself; 7) inserting objects in body openings; 8) bruising or breaking bones; 9) some forms of hair pulling, as well as other forms of bodily harm

(S.A.F.E. Alternatives® Program, 2002, n.p.)

This term does not include self-injury related to sexual pleasure (Martinson, cited in

Anderson & Preuss, 2002b). This term also does not include eating disorders. Tattooing and piercing are not considered self-injury, unless physical “high” and repetitive needs are gained through the tattooing and/or piercing.

### **Limitations**

One limitation of this study is that not all forms of self-injurious behavior are included, such as drug and alcohol abuse and/or dependency and eating disorders.

## **CHAPTER TWO**

### **Literature Review**

#### **Introduction**

This chapter will focus on influencing factors that may lead to self-injury. These reasons will include: childhood abuse, psychological disorders connected with self-injury, substance abuse, eating disorders, body image, and maladaptive coping styles. The other focus area will be on forms of treatment for self-injurers, including medications, residential or inpatient placements, and some outpatient therapy. The chapter will conclude with recommendations for individuals who work with self-injurers.

#### **Influencing factors**

Many self-injurers have a history of abuse. According to Favazza and Conterio (cited in Zila & Kiselica, 2001), approximately 62% of their participants reported abuse during childhood and adolescence. The two most common forms of abuse reported by self-injurers were sexual and physical abuse. Some self-injurers reported emotional abuse or neglect as well. In many situations it is a combination of two or more forms of abuse. In a comparison study of sexually abused self-mutilators and non-mutilators, those who self-injured were over 50% more likely to have their father as the abuser (Turell & Armsworth, 2000). According to the same study, self-injurers suffered abuse earlier in life and for a longer period of time. Turell and Armsworth (2000) also discussed the importance of emotional abuse in their study; the participants were:

Nine times as likely to feel not wanted by their family, ten times more likely to feel a burden to their family, five times as likely to wish they hadn't been born,

twice as likely to feel isolated and alone, and over three times more likely to identify as the family scapegoat. (p. 242)

An important distinction must be made regarding abuse and the occurrence of self-injury. Not every person who self-injures was abused and not every person who was abused self-injurers. Self-injurers have different reasons for engaging in this behavior and it is not fair to them, as individuals, to assume that there is an “umbrella reasoning” for their behaviors.

Conterio and Lader (1998) discussed an important link between self-injury and abuse. In “normal” circumstances, a bond forms between a parent and a child at the time of birth. In instances where a child was abused, this bond may not have been established. According to Conterio and Lader, this bond can be damaged for several reasons. The mother may have suffered from depression or other psychiatric illness. Conterio and Lader also discussed other reasons that may contribute to difficulties at some point in the bonding process. These reasons include: divorce, moving to a new location, and a death or life-threatening illness of a family member (Conterio & Lader, 1998; Turell & Armsworth, 2000). Many families encounter situations similar to these, but Conterio and Lader (1998) distinguished abusive parents as being emotionally fragile. Parents who are emotionally fragile are unable to give their child adequate care, including touching and holding the child. Conterio and Lader believed that those who self-injure do so because their “skin boundaries were not respected, so her recognition or appreciation of those boundaries could not develop normally” (p. 75). Clarke and Whittaker (1998) described the skin distinction as the following:

Skin is symbolically important not only because it is the barrier upon which damage is inflicted but also because it portrays by its color and condition a gamut of emotions: rage, fear, embarrassment, and so on. In many ways, it is the border between the outside world and the inner world, the environment and the self (Favazza & Rosenthal, cited in Clarke & Whittaker, 1998), a living canvas by which a person-by marking or damaging-communicates a range of ideas and emotions. (p. 130)

Another way to address this connection is that the body serves as a boundary between what is part of oneself and what is not. If an individual injures the body, they are able to distinguish what is a part of them and what is part of the environment (Zila & Kiselica, 2001).

According to Conterio and Lader (1998), self-injury is not a separate classification in the *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> edition). Self-injury is a part of several other diagnoses, but self-injurers may or may not be diagnosed with a disorder. There are several diagnoses under which self-injurers may be classified (Conterio & Lader). Two of these disorders are depression and bipolar disorder. Many self-injurers suffer from depression. In a study done by Ross and Heath (2002), it was found that many of the students who self-injure reported higher levels of depressive symptoms. This study suggested that the levels of depressive symptoms might be used to differentiate self-injurers from those who do not self-injure. Some self-injurers may be misdiagnosed as having bipolar disorder because of intense mood swings.

Other self-injurers are classified under another category, anxiety disorders. Conterio and Lader (1998) stated many self-injurers often suffer from panic attacks,

tension, and are easily agitated. In a study done by Ross and Heath (2002), students who self-injured had higher levels of anxiety symptoms. Conterio and Lader (1998) believed that some caution should be exercised when self-injurers are diagnosed as having an anxiety disorder. The main caution involved the use of medication and the need for many self-injurers to “numb” their feelings, which may lead to an accidental or intentional overdose.

Conterio and Lader (1998) stated that self-injurers could suffer from thought disorders, such as schizophrenia or have symptoms of thought disorders, such as hallucinations or delusions. Some self-injurers who were abused may be given the diagnosis of Post Traumatic Stress Disorder (PTSD). In a study done by Albach and Everaerd (cited in Turell & Armsworth, 2000), 25% of their incest survivor participants suffered from PTSD and self-injured. Two other disorders that self-injurers may be diagnosed as having are depersonalization disorder and dissociative identity disorder (formerly known as multiple personality disorder).

The most common diagnosis assigned to self-injurers is Borderline Personality Disorder (BPD) (Clarke & Whittaker, 1998; Conterio & Lader, 1998). Some characteristics of BPD include: impulsivity, mood swings, feelings of emptiness and boredom, disturbances in identity, and a history of unstable relationships (Conterio & Lader, 1998).

Another commonality in self-injurers is the abuse or dependence on alcohol and other drugs. This issue can be seen from different viewpoints. According to Pattison and Kahan, and Graff and Mallin (cited in Zila & Kiselica, 2001), issues with drugs and alcohol can predispose someone to self-injure. On the other hand, Ross and McKay (cited

in Zila & Kiselica, 2001) believed that abusing alcohol and drugs is a form of self-injury. Either way, some individuals who self-injure have difficulties and concerns with drug and alcohol abuse/dependency.

In some cases, self-injury and eating disorders occur concurrently or one form will replace another form (Zila & Kiselica, 2001). For example, a person may start with an eating disorder and complete a treatment program, but will replace the eating disorder with another form of self-injurious behavior. In a study done by Favazza and Conterio (cited in Zila and Kiselica, 2001), 61% of their study participants had an eating disorder at some point in their lives.

According to Conterio and Lader (1998), individuals who self-injure and have an eating disorder are often trying to make themselves as unattractive as possible so they will not be raped or violated again. They are either trying to starve themselves or make themselves obese to hide feminine attributes to increase their unattractiveness. Conterio and Lader also stated that eating disorders and self-injury are a way to seek revenge for the cruel injustices during their life.

For some of the same reasons that women self-injure and restrict or increase food intake, they also have other ways to increase unattractiveness. Some may shave their head or pull out their hair (Conterio & Lader, 1998). They may also wear baggy clothes or masculine attire to hide their bodies (Conterio & Lader).

There is a strong link between body image and self-injury. According to the patients of Conterio and Lader (1998), many hate their bodies and hate having a menstrual cycle. Individuals with abnormal menstrual cycles are more likely to self-injure (Zila & Kiselica, 2001). Favazza and Conterio (cited in Conterio & Lader, 1998) stated in

their study “34% strongly hated their breasts, 58% strongly hated their periods, 56% strongly hated pelvic exams, 19% said they would be better off without a vagina, and 10% sometimes injured in an attempt to stop their periods from occurring” (p. 107). According to Conterio and Lader (1998), some women will insert sharp objects into their vagina in case they are attacked. Even though this hurts, they would rather hurt themselves than have someone inflict injury on them. One of Conterio and Lader’s patients, Rosa, stated the following with regards to herself: “I have never been comfortable with my body. I didn’t like being short and stocky. I have not particularly felt it okay to be a woman, to be feminine, to be sexy” (p. 109).

Self-injurers are often at odds with their sexuality. According to Zila and Kiselica (2001), individuals who self-injure are sometimes unable to handle their sexuality because it may be inhibited from current or previous unwanted sexual attacks. Some are unsure of their sexual identity (Conterio & Lader, 1998; Ponton, cited in Rochman, 2000), and some do not receive pleasure from sexual intimacy (Conterio & Lader, 1998). Due to being uncomfortable with sexuality, Conterio and Lader stated that many of their patients prefer contact, such as cuddling, to genital contact.

There are many reasons why a person may resort to self-injury. Childhood abuse, eating disorders, psychological disorders, and body image can influence a person’s need to self-injure. Another possible reason that can lead to self-injury is maladaptive coping styles. Self-injurers often lack a positive home environment where parents have appropriate coping skills. Therefore, these individuals do not learn to model appropriate coping skills. Often, they are left to their own devices and ultimately choose self-injury as a way to alleviate their stress and unwanted feelings (Haines & Williams, 1997; Nichols,

2000). According to Briere and Gil (1998), self-mutilating behavior acts as a negative reinforcer because they are “rewarded by their capacity to reduce distress, and thereby increase the likelihood that it will be used in the future” (p. 610).

One self-injurer, Kelly, described her self-injury as being a poor, self-preservation tactic that allowed her to release pain and gain control (Rochman, 2000). Nichols (2000) and Pattison and Kahan (cited in Clarke & Whittaker, 1998) stated that self-injury is an effective coping mechanism that becomes addictive. Conterio and Lader (1998) described a theory called the “pressure cooker theory.” This theory is a fallacy, but is often used to describe self-injurers who need to rid themselves of uncomfortable thoughts and ideas. This causes them to release their anger in an explosive manner by punching a pillow, purging their food, or cutting their skin (Conterio & Lader).

## **Treatment**

Needless to say, self-injury may be cathartic for the individual who uses it to help with their feelings. A goal of many therapies is to help the self-injurer handle her feelings in appropriate ways. In the following section, the focus will be on different forms of treatment. These forms will include medication, and inpatient and outpatient treatment.

The first form of treatment discussed will be medication. Conterio and Lader (1998) believed that medication is not the answer to self-injurious behaviors. They believed that psychotherapy is the best form of treatment, but medication can work to alleviate symptoms that correspond with some disorders. If a self-injurer suffers from depression or bipolar disorder, they may take medication to help alleviate their depressive or manic symptoms. One form of medication that can be prescribed is antidepressants. Some of the more common antidepressant medications are Zoloft, Paxil, and Prozac.

Conterio and Lader (1998) discussed some of the positive benefits of mood stabilizing medications in patients with or without bipolar disorder. These medications include: Lithium, Tegretol, Depakote, and Neurontin.

Another group of medications that self-injurers may use are called anxiolytics. Medications under this category are used to lessen the anxious feelings in those who suffer from anxiety disorders. Conterio and Lader (1998) warned against the use of these drugs because self-injurers may accidentally or intentionally overdose because of the “numbing” feelings that the medication produces. Conterio and Lader also cautioned the use of Xanax because it may increase the occurrence of self-injurious behaviors.

Antipsychotic medications can be used with individuals who suffer from thought disorders, such as schizophrenia or obsessive-compulsive disorder. An antipsychotic medication, like Clozapine, is a newer medication that does not have as many side effects as older antipsychotic medications (Conterio & Lader, 1998).

Dissociative disorders such as depersonalization disorder and dissociative identity disorder can benefit from medications as well. According to Conterio and Lader (1998), Naltrexone can be prescribed to patients who dissociate. The medication can cause a self-injuring individual to feel the pain while they are injuring themselves. Conterio and Lader stated that self-injurers might stop taking the medication in order to continue their self-injurious behavior.

There are no medications specifically aimed at alleviating symptoms associated with personality disorders, such as BPD or any of the other personality disorders. Taking medications, such as anti-anxiety medication to relieve some of the anxiety components of the personality disorder, have been shown to be helpful (Conterio & Lader, 1998).

There are many concerns, both from patients and staff, regarding the treatment of self-injurers. A study done by Smith (2002) analyzed a small population of self-injurers and individuals who work with self-injurers in different settings. The self-injurers in this study felt they were not listened to, they were considered failures by the staff because they continued to self-injure, and they were treated in a negative manner by the staff. Many of the surveyed hospital staff also believed that individuals who self-injure are treated in a negative manner. One of the possible reasons is because of the lack of information available on the subject. Another source of frustration for the staff may be a result of confusion as to where individuals who self-injure will be best served. Many agree that they are not best served in an emergency hospital setting. Some believe that self-injurers will benefit from a crisis house because admission into the crisis house does not involve the stigmatization that an admission to the hospital does. Yet, community health workers are unsure if they want to work with a population that is outside the realm of severe mental illnesses because they are already involved with so many other individuals. Instead, the best possible situation for working with self-injurers might be to involve several resources to gain the best possible help and treatment for these individuals.

One inpatient therapy program is at the Bethlem and Maudsley Hospital in London, England. This therapy program was established in 1992 and is used primarily with self-injurers who burn and cut. According to Crowe and Bunclark (2000), the program will allow patients to receive supportive medications, such as antidepressants, but only when deemed necessary. Crowe and Bunclark described two basic tenets of self-understanding in their patients. The first is that individuals need to accept responsibility

for their actions. Crowe and Bunclark stressed the need to let patients make their choice of self-injuring or choosing a different coping mechanism. The second tenet of understanding is therapeutic risk-taking, which may occur because these individuals usually do not take responsibility for their actions.

Crowe and Bunclark (2000) stated that patients are automatically admitted for six months. This unit follows a psychosocial model and addresses the personal and social levels and needs of each patient. Crowe and Bunclark stressed the importance of providing limits in the ward to ensure safety. Crowe and Bunclark also discussed the necessity of time and having the ward mimic the “outside world.”

Individual and group counseling sessions are run Monday through Friday, with a weekly group on coping skills. According to Crowe and Bunclark (2000), many self-injurers have difficulty with verbal communication. Therefore, other forms of therapy are utilized, such as art therapy. These individuals need to learn how to have fun and learn how to handle social situations. There are nightly activities, such as games, in which residents are invited to participate (Crowe & Bunclark). Another weekly group involves recently discharged patients. They are allowed to participate in groups up to three months after discharge and return to discuss concerns and problems they are having. This helps current and former patients realize that there is not an instant cure, but there is a goal they can achieve (Crowe & Bunclark). Family therapy is also offered for residents in hopes that families can offer support when the residents are discharged.

Crowe and Bunclark (2000) addressed the importance of staff and patient collaboration where they learn from each other. In this program, they do not address former abuse issues. Instead, they focus on how the abuse situations are relived in their

current situations. This program also focused on addressing alternatives to self-injury, such as art therapy or postponement tactics, like going for a run or reading a book.

According to Crowe and Bunclark (2000), individuals may self-injure, but the staff and other residents are told to be neutral about the situation. For example, many residents are told to take care of their own wounds, if possible (Crowe & Bunclark). If an individual crosses certain self-injurious boundaries, such as burning oneself with an open flame, they are suspended from the program (Crowe & Bunclark).

Overall, this program provides individuals with a needed level of support and freedom. The residents are well informed of the boundaries of care and what types of incidents can have them suspended from the unit. Staff members know the rules and are very supportive of the residents. The staff members are referred to as parents and act in a role similar to a parent who is neither too permissive, nor too restrictive. This form of treatment is relatively new and further research studies need to be conducted on the effectiveness of this program.

The second program is called the S.A.F.E. Alternatives® Program and is located in Oak Park, Illinois (Conterio & Lader, 1998). This program is considered both an inpatient and a day patient program. A determination will be made as to which program will be more beneficial to the patient. Conterio and Lader described this program as significantly different from other programs and treatment options. Most treatments focus on the act of self-injury and what it does to your body, as well as how it effects those around you. Most often, sharp objects are taken away from self-injurers and they are sometimes tied or forced into four-point restraints to restrict them from injuring themselves. This self-injurer feels frustration, humiliation, and an overall sense of not

having control over their actions. Often, individuals who self-injure are also told to utilize other ways to replace their self-injury, such as drawing on themselves with markers, breaking eggs over their skin, or submerging their limbs into ice cold water (Conterio & Lader).

The S.A.F.E. Alternatives® Program differs from many of the traditional means of treatment. Clients are treated in a respectful manner and the responsibility of choosing to not self-injure is placed in the hands of the self-injurer (Conterio & Lader, 1998). This program is ideally set-up for thirty days, but patients have the right to leave whenever they want. One of the most important aspects of this program is that admission is not done on an emergency basis. The admission is planned ahead of time and is not a post-event reaction to the event of self-injuring. In addition, they are able to use sharp objects under the condition that they are used for what they are intended to be used for. Individuals who enter the program are also required to sign a No-Harm contract. There are occasional violations of the contract, of which repeated violations can lead to discharge from the program. The staff is available to help these individuals through every stage of their stay at the facility (Conterio & Lader).

Another unique aspect to this program is that patients are discouraged from showing their scars; because each time they show their scars, they are reliving the event. It prevents the individuals from using appropriate coping skills because they are just replacing their emotions into another venue (Conterio & Lader, 1998). This program does not allow individuals to use other forms of “injuring” themselves, such as breaking eggs onto their arms or drawing on their limbs with markers. This idea is called the Pressure-Cooker theory where every feeling has a physical reaction associated with it (Conterio &

Lader). In many instances, a physically alternative way of handling your emotions cannot be accomplished in everyday society because there is not a quick way to handle everything in life. The S.A.F.E. Alternatives® Program helps patients find appropriate ways to acknowledge their feelings and think through their thought processes, ridding themselves of the “all or nothing” type of thinking (Conterio & Lader).

The goal of therapy is to help the individual find ways to act and think at an appropriate age level. According to Conterio and Lader (1998), this is accomplished through “education, setting limits, enforcing consequences, offering encouragement and praise, and holding patients responsible for their actions” (p. 224). The first part of this process involves a change in attitude, which leads the patients to realize they have control over their behavior. The second aspect is that every feeling does not have a physical reaction associated with it. In some instances, this is the first time these individuals have been in a safe environment that is free from abuse; knowing that this type of environment does exist, it is important to recognize the feelings and concerns of others (Conterio & Lader).

The S.A.F.E. Alternatives® Program has a S.A.F.E. toolbox, which includes several items. One of the first items is the No-Harm contract, often co-authored by the patient, which is signed by the patient and therapist stating that they understand what is expected of them, as well as what is expected of the program or therapist (Conterio & Lader, 1998). Another useful tool is the impulse control log where the individual writes down feelings, thoughts, situations, etc. that are related to the thought of injuring themselves. The hope of the impulse control log is to have the individual draw a connection between their thoughts, feelings, actions, and reactions. The third tool utilized

by the program is called “ the five alternatives” (Conterio & Lader). This is a list of five alternatives to self-injuring, such as going for a walk, writing in a journal, or working on a creative project. The fourth tool in the toolbox is writing assignments. The S.A.F.E. Alternatives® Program requires patients to complete fifteen written assignments that are given in a sequential order. These assignments help the patient focus on the following areas: “self-awareness, identification of feelings, family/relationship issues, and gender/body image issues” (p. 259-260). Examples of writing assignments are writing an autobiography, the anger inside, the person I want to be, and future plans (Conterio & Lader). Another idea utilized by many patients is journaling, as long as they are used in an appropriate way, not in a self-demeaning manner (Conterio & Lader).

An important aspect of the program is to review progress and work towards moving forward, which includes analyzing what has happened in the past and use it to apply to situations in the future. Some ways to accomplish this is to discuss the topic with your therapist and/or review your impulse log (Conterio & Lader, 1998). The next step as patients is to express feelings without injuring themselves, knowing that their feelings will not harm them. The next step is to work on a plan that does not include self-injury, but realizing that relapse may happen. The S.A.F.E. Alternatives® Program believes that relapse is part of the process, but that it can be prevented by the choice the patient makes (Conterio & Lader). When patients are discharged from the inpatient program, there is an outpatient program that focuses on real-world issues and what is going on in their lives (Conterio & Lader).

### **Recommendations for individuals who work with self-injurers**

Nichols (2000) described several reasons that individuals may self-injure and different recommendations for school personnel who work with these individuals. One of the most important recommendations from Nichols is that school personnel assume the responsibility of supporting a professional outside of the district who is working on an ongoing basis with these individuals. Most school counselors are not adequately trained, nor do they have the amount of time needed to work with these individuals on an ongoing basis. Nichols has offered some suggestions for school staff to work as a supportive professional with these students. These recommendations are based on the expressed reasons for why the individuals use self-injury.

The first recommendation is for individuals who utilize self-injury as a stress reliever. Be aware of students who self-injure because some may openly display their wounds, but others will try to hide them. If self-injury is suspected, contact a local professional and devise a plan to discuss the situation with the student and parents. One caution in working with these individuals is to remind them the limits of confidentiality, while keeping in mind their fears about the situation (Nichols, 2000).

The second type of self-injurer is one who self-injures as the result of poor coping skills (Nichols, 2000). One way to work with this type of self-injurer is to start groups that teach appropriate coping skills, such as relaxation techniques and friendship skills. Working in small groups with this type of client is beneficial to helping the students focus on the issue at hand and not reliving their personal history (Nichols).

Another reason for self-injury aligns with poor coping skills and that is poor problem solving skills. Those who have poor problem solving skills tend to be very

impulsive in their decision-making. Nichols suggests a step-approach to helping these students. The first step is to brainstorm possible solutions, then make a choice. The next step is to devise an action plan and then follow through with the plan (Nichols).

Another type of self-injurer is one who is unable to express her thoughts in an oral form because this student has often been told that her comments and feelings do not mean anything to anyone (Nichols, 2000). These students benefit from assertiveness training, which helps them express their emotions. These students also benefit from recognizing and regulating their negative self-talk (Nichols).

Another type of self-injurer is one who injures in order to gain attention, but the goal of this behavior may not be manipulative in intent (Nichols, 2000). Due to their need for attention, it does not matter whether the attention is good or bad. One recommendation for working with these individuals is to give them the attention that they need at the appropriate times. Another suggestion is that a counselor could check with teachers to discover accomplishments that student has made within the classroom and use these compliments to give the student the needed positive attention (Nichols).

Some self-injurers resort to injury because they have an irrational belief system, such as self-injury is okay (Nichols, 2000). School personnel can help reinforce that this is not appropriate by doing several things. One is to inform students that self-injury is not acceptable, but provide the student with support, not condoning or approving of their self-injury. Another suggestion is to evaluate what message the school has about appearances (Nichols). One way to assess this is to evaluate the school's harassment policy and ensure that it is the type of policy used to help all students instead of benefiting a small percentage of the student population. A third suggestion is to help

these students find words to express their situations. One way to help find these words is in a social skills group or class (Nichols).

There is also a type of self-injurer who injures in order to find unification with a group of individuals because it increases self-esteem (Nichols, 2000). Schools can help these students by utilizing their talents and interests to increase self-worth. A group of students who self-injure are more difficult to work with because they develop a “gang” mentality. One way to work with these students is to discuss problem solving techniques and to involve them within the school community to increase their self-worth (Nichols).

Another reason for self-injury is found in those who dissociate and are unable to recall important information (Nichols, 2000). This form is most often found in those who have experienced childhood trauma, such as sexual abuse. The best course of action within a school is to refocus their attention back to current tasks. Other suggestions may be obtained from a therapist (Nichols).

Poor body image is another trigger for self-injury in some individuals (Nichols, 2000). Schools can help with these issues by addressing these concerns in health or physical education classes. School personnel should be aware of these concerns and know the appropriate individuals to contact in case this situation presents itself.

Another form that may present itself within the school is suicidal ideation. Although most self-injurers are not attempting to end their lives, it can happen. They may decide that they can no longer cope with their current situation or they cut too deeply and end up committing suicide (Nichols). School staff needs to be aware of the limits of confidentiality and contact the parents. Staff members who are aware of the situation should keep a record of these incidents in case the student does commit suicide (Nichols).

The last form of self-injurer is one who needs to feel in control of something in her life and resorts to injuring to be the one thing that she can control (Nichols, 2000). The school can reinforce the message that the individual is in control of whether or not she chooses to self-injure. School personnel can help these students gain the skills to take control of their lives and actions (Nichols).

## CHAPTER THREE

### Summary, Critical Analysis, and Recommendations

This chapter will summarize research findings from the previous chapter, as well as provide a critical analysis of information on self-injury. This chapter will conclude with recommendations to improve research and provide implications or ideas for future research.

#### Summary

Self-injurious behavior is very complex and is exhibited in many forms. There are several factors that may be attributed to why individuals self-injure. Some of these reasons include: sexual, physical, and/or mental abuse, substance abuse, eating disorders, and psychological disorders. Overall, one of the main contributing factors is abuse. All areas of abuse can affect how an individual copes with reality. In some instances, those who have been abused are at a higher risk of self-injuring than others because the parents of the self-injurer may not have obtained the needed skills to be an effective parent. The lack of guidance and nurturing can leave a person feeling very vulnerable and unable to cope in an appropriate way, leading them to cope in a different way, such as self-injury.

Many psychological disorders occur co-morbidly with self-injury. Eating disorders, substance abuse, and body image disorders are examples of some co-morbid diagnoses. Self-injury can occur with these disorders or in some cases one form of self-injury will replace another. For example, an individual may receive treatment for an eating disorder. The individual does well with regards to eating, but replaces the control she once had over eating by controlling the self-injury.

Medications can be used with individuals who self-injure. Medications are often used when there is a co-morbid diagnosis, such as depression or an anxiety disorder. There are some medications that should be used with caution because an individual may become addicted to the feeling the medication produces (Conterio & Lader, 1998). Some medications can be used to reduce the amount of self-injuring because the medication lowers the pain tolerance, allowing individuals to sense the pain as they cut. In many cases, these individuals will stop taking medication so they can regain the experience they received from cutting (Conterio & Lader).

One of the residential programs discussed in chapter two is located in a separate wing of a hospital in London, England. This inpatient program is automatically scheduled for a six month time period. Patients in this program are required to take responsibility for their actions, such as bandaging their own wounds, if the wound is not too serious. Patients also need to be willing to change and be willing to try different types of treatment options. The treatment program is based on a psychosocial model and attempts to address all parts of the individual: emotionally, socially, and cognitively. The staff members act as neutral parents because they are instructed not to overreact or under-react to a situation. An important concept from this program is that staff and patients learn from each other (Crowe & Bunclark, 2000).

The S.A.F.E. Alternatives® Program is an inpatient and outpatient facility located in Oak Park, Illinois and takes a very different approach to treating self-injury than others (Conterio & Lader, 1998). The main premise of the S.A.F.E. Alternatives® Program is that patients need to have a true desire to stop self-injuring and that the patients have the

choice to self-injure. Taking away sharp objects and placing them in four-point restraints is not the answer and will often provoke more self-injury after being released.

Admission to the program is not based on a crisis situation; it is predetermined (Conterio & Lader, 1998). The program is scheduled to last thirty days, but the patient can discharge herself at any point during this time. This program has several steps and utilizes different “tools” to help the self-injurer. One of these tools is a No-Harm contract, which is often written by the therapist and patient, so each person knows what is expected as a part of the therapeutic relationship (Conterio & Lader). A second tool in the toolbox is the impulse control log, which helps the individual track her feelings, thoughts, responses, etc. related to self-injuring. The goal of the log is to connect and become aware of thoughts, feelings, and actions that are related to self-injury. The third tool in the toolbox is identifying five non-harming alternatives to self-injury, such as taking a walk or writing in a journal (Conterio & Lader). The fourth item in the toolbox is the writing assignments which are given in a sequential order that helps the patient identify several areas about herself, such as an autobiography, whom she admires most and why, and what are her future plans (Conterio & Lader).

The S.A.F.E. Alternatives® Program has a caring staff that takes a stance of neither accepting or disapproving of an individual if she chooses to self-injure. The staff is there to support the patients (Conterio & Lader, 1998). At times, individuals may be discharged from the program if the No-Harm contract is violated too many times. As the patient nears the end of the programming, there is an outpatient group that is available to her after discharge (Conterio & Lader).

Nichols (2000) offered several recommendations for school personnel to work with individuals who self-injure. There are several reasons for self-injury and different ways to work with each individual based on the reasons. An example is a self-injurer who injures as a result of poor coping skills. One response from school personnel is to help teach emotional control through techniques such as relaxation training and identifying self-help strategies to replace the coping skills.

### **Critical Analysis**

Research on self-injury can be somewhat confusing because there are so many variables as to why an individual may self-injure. One confusing issue involves abuse. Favazza and Conterio (cited in Zila & Kiselica, 2001) stated that 62% of their study participants reported having been abused while growing up. In most instances, physical and sexual abuses are the most common forms of reported abuse in those who self-injure, yet some individuals reported emotional abuse and neglect. Conterio and Lader (1998) discussed a link between self-injury and abuse. Conterio and Lader believed that a bond was never established between the parent and the child. The parent(s) does not have appropriate ways to solve problems. These problems influence the child as she grows up and the child attempts to cope with problems in any way he or she can devise. Not every individual who self-injures has been abused and not every individual who has been abused self-injures. Needless to say, abuse is not a guarantee that an individual will self-injure.

There are so many different reasons, situations, or more than one reason why an individual may turn to self-injury. There are several reasons and situations that can lead a

person to self-injure; it would be impossible to devise a single research study to focus on every situation.

Co-morbid diagnoses have the same issues as abuse. Not everyone who has a specific disorder self-injures and not every self-injurer has a co-morbid diagnosis. It would be interesting to see more research on how many people suffer from co-morbid diagnoses and if self-injury is classified as a part of that specific diagnosis.

The inpatient program at Bethlem and Maudsley Hospital in London has some good components. One of the most interesting aspects of this program is that staff and patients are on the same level, where the medical professionals are not considered superior (Crowe & Bunclark, 2000). This is interesting because it takes into account the knowledge and experiences of the person who self-injures. Staff members are also instructed to take a neutral approach to situations in which people could overreact. For example, if individuals cut themselves, they are to bandage their own wounds. The staff member is to react in a neutral manner, neither approving nor disapproving of the injury (Crowe & Bunclark). The length of stay is a bit bothersome. Crowe and Bunclark stated that individuals are admitted for a set time of six months, yet later in the research it stated that the average stay was under five months. Six months seems like a lengthy time for an initial placement. In some cases it may be warranted, but the stay could start at three months and a longer stay can be granted if needed. Crowe and Bunclark (2000) also addressed the importance of the program to be as similar as possible to the outside world. This better prepares these individuals to cope with experiences they may be exposed to when they are discharged. Another beneficial component of this program is that individuals who have been discharged are allowed to attend groups at the facility up to

three months after their discharge date. This is important because these individuals need support after they have been released; plus they are able to provide insights to individuals still in placement. Crowe and Bunclark did not state what these individuals do for ongoing support after the three months. Crowe and Bunclark discussed some results of their study, but future studies should address more recent findings and discuss the results in more detail.

The S.A.F.E. Alternatives® Program offers self-injurers a different type of treatment that the self-injurer may have most likely never come across before. One of the most important aspects of this program is that the self-injurer takes responsibility of their actions because they are the only ones who can control them (Conterio & Lader, 1998). Another important aspect of the program is the helpful role of the staff. They are trained and understand the various reasons for self-injury. Plus, they are not appalled when individuals state that they self-injure. This program is against showing off scars, which serves as a reenactment of the original situation (Conterio & Lader). The S.A.F.E. Alternatives® Program also uses several “tools” to help their patients. One of the most important tools is the impulse control log, which helps self-injurers connect their thoughts with their actions and reactions. This helps them become aware of their thoughts and feelings that precede the thoughts of self-injuring (Conterio & Lader). Overall, this program is very comprehensive and appears to have a good record of successful discharges. It would be interesting to see data and follow-up data of individuals who have successfully completed the S.A.F.E. Alternatives® Program. It would also be interesting to find out how many insurance companies allow patients to stay in the program for the

entire thirty days or if there is other funding available for individuals who cannot afford the program.

Another interesting aspect to Conterio and Lader's (1998) book is that they offer ways for therapists to utilize the techniques used in their program. In their book, they included copies of the No-Harm contract and impulse control log, which indicates how much they are willing to help therapists, as well as those who self-injure.

### **Recommendations**

A recommendation for future research would be to assess the possibility of getting a self-injury category placed in an upcoming version of the *Diagnostic and statistical manual of mental disorders*. Before this can be done, more research needs to be completed on other factors related to self-injury. One possibility is that self-injury may fall under a new term labeled Obsessive-Compulsive Spectrum Disorder. As of now, there has not been a great deal of research done on this form of spectrum disorder. It is also a possibility that self-injury may not be classified under that category because self-injury is done for so many different reasons.

Another recommendation for future research would be to classify each self-injurious episode of a group of self-injurious individuals. Then, take these episodes and classify them according to type of intent, like manipulative intent or tension release.

A third recommendation for further research is to focus on reactions of individuals involved with self-injurers. A survey could be done on the reaction of parents, teachers, school counselors, staff, principals, mental health care workers, or other individuals who work with self-injurers. Depending on specific reactions from individuals, self-injurers may not confide in them about their problem with self-injury.

Training could be made available to individuals who are not sensitive or knowledgeable about self-injury. Post-tests could be administered to assess the effectiveness of self-injury sensitivity training.

There are several different prospects for future research that correspond with current literature or diverge from current literature, such as testing the perceptions of school personnel. Either way, more research is needed to clarify many aspects of self-injury, such as other possible influences that may lead a person to self-injure. Overall, self-injury is a very misunderstood concept. Hopefully more research will clarify self-injury and this knowledge can be dispersed to individuals who self-injure and to people who work or live with those who self-injure.

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