72

Self-Mutilation

Richard Lieberman

Los Angeles Unified School District

Scott Poland

NOVA Southeastern University

School-based professionals are often called on to consult with school staff and parents when students exhibit self-injurious behaviors. The alarming numbers of adolescent students engaging in self-mutilation (SM) pose a challenge to all school mental health personnel. Complicating matters for the educator is that these behaviors can appear contagious, often running through schools, peer groups, or grade levels. SM behaviors such as cutting and burning have recently been the focus of the media, popularized by current movies and personalities who have publicly admitted to SM. The effect of such exposure on youth has not been adequately measured.

For some students, these harmful behaviors seem superficial, occurring in response to certain precipitating events that are typical in the life of the adolescent. For other students, these behaviors are clearly more habitual, repetitive, dangerous, and self-destructive. Most school psychologists and other school-based mental health service providers are skilled in assessing suicide risk, but they may have limited knowledge of intervening with students exhibiting SM, many of whom will assess at low risk of suicide. This chapter provides suggestions on ways school mental health professionals can respond to the unique individual and community needs that surround self-injurious students, but it is essential that the reader begin by gaining a better understanding of this puzzling, disturbing, and often misunderstood behavior.

BACKGROUND AND DEVELOPMENT

Classifications

SM has been referred to in the literature by a variety of terms, including self-harm, self-abuse, self-inflicted violence, and self-injurious behavior. It is important to distinguish SM behaviors from other culturally sanctioned behaviors such as ritualistic tattooing, piercing, and branding. Those behaviors, as traced by Favazza (1996), have been linked to such issues as salvation, social orderliness, spirituality, and healing and are distinct from the SM behaviors that are the focus of this chapter.

Favazza and Rosenthal (1993) proposed three classifications of pathological SM. *Major SM* is an infrequent act that occurs suddenly with a great deal of tissue damage. It is most commonly associated with individuals who are psychotic or acutely intoxicated. It rarely occurs at school. *Stereotypic SM* includes behaviors such as head banging, wrist and lip biting, and complex tics most associated with those who have developmental disabilities, autism, or Tourette's syndrome. *Moderate/superficial SM*, which is the focus of this chapter, includes cutting, burning, pinching, puncturing, scratching, nail-biting, and interference with wound healing. The arms, wrists, inner thighs, and abdomen are the areas most typically injured (Zila & Kiselica, 2001; Conterio & Lader, 1998). These areas are strategic in that they can be easily concealed by clothing. Cutting is one of the most common forms of self-injury found in the non-hospitalized population (Ross & Heath, 2002; Briere & Gil, 1998).

SM has been associated with a wide variety of disorders, including psychotic, antisocial, and borderline personality, mood, and anxiety disorders (Zila & Kiselica, 2001). To many clinicians SM is synonymous with borderline personality disorder, which is diagnosed more often in females and characterized by significant fears of abandonment (Favazza, 1996; Linehan, 1993). Although individuals with borderline personality disorder often

engage in SM behaviors, this diagnosis is not appropriate for the majority of students engaging in SM. A history of physical and sexual abuse (Boudewyn & Liem, 1995; Turell & Armsworth, 2000), family violence (Conterio & Lader, 1998), and post-traumatic stress disorder (Favazza & Rosenthal, 1993; Kehrberg, 1997; Langbehn & Pfohl, 1993) have been identified as significant risk factors in SM. As a symptom of post-traumatic stress disorder, cutting may be seen as a reenactment of childhood trauma (Levenkron, 1998) in an effort to gain some control over what happened. All of these correlates can be useful in identifying at-risk adolescents for the purposes of intervention and prevention (Kress, Gibson, & Reynolds, 2004; Walsh & Rosen, 1988).

Clearly, SM is a complex behavior that may have compulsive or impulsive characteristics. Consequently, Favazza (1996) further broke down the classification of moderate/superficial SM into three types: compulsive, episodic, and repetitive. *Compulsive self-injury* includes such behaviors as hair pulling (trichotillomania), skin picking, and the binging and purging of eating disorders. These behaviors are responses to obsessive thoughts from which the child seeks relief. There is ample evidence of a relationship between SM and eating disorders, with as many as one half to two thirds of youth that exhibit SM experiencing concurrent or previous eating disorders (Favazza, 1996; Favazza & Conterio, 1988). Common to these disorders are the issues of regaining control and achieving a rapid respite from distressing, overwhelming emotions. *Episodic SM* and *repetitive SM* (RSM) are characteristic of impulse disorder and behaviors. They differ only in the degree and frequency of the act. Episodic impulse disorders include parasuicidal behaviors, alcohol and substance abuse, and shoplifting. All these behaviors have two factors in common: they are episodic and gratifying. *Episodic* implies the behaviors are occasional and in response to certain precipitating events. They are gratifying because of the complex endorphins, natural antidepressants released by the brain when an adolescent engages in SM (Favazza). This may be why so many teens do not report pain in response to SM but a sense of relief or release. This neurological, addictive component of impulse disorder may play a critical role in the behavior escalating from episodic SM to RSM (Pies & Popli, 1995).

We support Favazza's (1996) proposal of a new Axis 1 diagnostic category in the DSM, Repetitive Self-Mutilation Syndrome (RSM), which is defined as a "recurrent failure to resist impulses to harm one's body physically without suicidal intent" (p. 253). Because this category does not exist in the current DSM, Favazza urges clinicians to consider the diagnosis of Impulse Control Disorder, Not Otherwise Specified for individuals engaging in this kind of repetitive self-injury.

Incidence

Approximately 3 million Americans engage in some form of self-injury, and 90% of them began in adolescence (Bowman & Randall, 2004). However, it is difficult to determine the actual incidence of SM in the adolescent population. Rough estimates range from 750 to 1,400 per 100,000 (Favazza, 1996). It has been estimated that 13% of adolescents and 12% of college-age youth have engaged in some form of SM (Ross & Heath, 2002; Favazza, DeRosear, & Conterio, 1989). The incidence increases significantly to 40% to 60% in adolescent inpatient settings (Darche, 1990).

Developmental, Cultural, and Gender Issues

SM typically has an onset in late childhood to early adolescence and appears more common in females (e.g., Simeon & Hollander, 2001; Zila & Kiselica, 2001). A wider variety of self-injurious behaviors appear in the elementary school–age population, with a greater representation of males. Common harmful impulsive behaviors that school staff may observe can range from cutting, puncturing, poking, hair pulling, head banging, scratching, or burning with the use of erasers (Poland & Lieberman, 2002). SM is prevalent in all cultures and races and cuts across all socioeconomic boundaries.

Suicidality

A common misconception is that adolescents who cut themselves do so with suicidal intent. SM is performed for different reasons than suicide, and it is distinguished from parasuicide (suicide attempts) in that "a person who truly attempts suicide seeks to end all feelings whereas a person who self-mutilates seeks to feel better" (Favazza, 1998, p. 262). Essentially, adolescents engaging in SM might harm themselves superficially in an effort to *not* attempt suicide.

Although most students exhibiting SM behaviors do not harm themselves with suicidal intention, many have extensive mental health histories that include parasuicidal behaviors. A well-intentioned adult may try to help by commanding the adolescent to stop these behaviors immediately. However, without identifying other coping

skills and replacement behaviors to fall back on, the adolescent may, in desperation, attempt suicide (Favazza, 1989). Assessing a student for risk of suicide and obtaining a complete mental health history is always prudent and best practice when a student is referred for SM (see chapter 17, "Suicidal Ideation and Behaviors").

PROBLEMS AND IMPLICATIONS

Functions of SM

Evidence demonstrates that SM can fulfill a multitude of needs in the lives of troubled adolescents. Reasons that adolescents engage in self-harm include (a) feeling concrete pain when psychic pain is too overwhelming; (b) reducing numbness and promoting a sense of being real; (c) keeping traumatic memories from intruding; (d) modulating affect; (e) receiving support and caring for others; (f) discharging anger, anxiety, despair, or disappointment; (g) self-punishing; and (h) gaining a sense of control (Kress, Gibson, & Reynolds, 2004). In general, SM appears to function as a means to regulate and control emotions (Suyemoto & MacDonald, 1995).

Precipitating Events

In today's complex society, situational crises challenge adolescents' coping capacities on a daily basis. However, a number of stressful, potentially traumatic life events have been identified as precipitants to episodes of SM. They include losing a parent, being sexually abused, having a sibling who engages in SM, and witnessing family violence (Walsh & Rosen, 1988). Some events more typically observed by school support personnel can include peer conflicts, intimacy problems, breakup of a romance, or rejection of human interconnection (Kehrberg, 1997; Zila & Kiselica, 2001). In addition, mood disorders and alcohol and substance abuse are substantial risk factors for both SM and suicide (Moscicki, 1995). The Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance data (Grunbaum et al., 2003) revealed that almost 30% of youth reported feeling a prolonged sense of hopelessness during the previous year. These are youth who are at risk for SM and suicidal behavior.

Isolation

Many adolescents choose to self-injure in isolation and attempt to avoid attention and embarrassment by wearing clothes that conceal their injuries very well (Alderman, 1997). Shrouded in shame and secrecy, they may go to great lengths to present themselves as uninjured and normal. Isolation from peers and the mental health community and feelings of being disconnected at school have been found to raise risk in youth to engage in SM. Girls were particularly vulnerable to SM if they abused alcohol and had friends who were not friends with each other (Bearman & Moody, 2004).

Contagion

Contagion, or the imitation of behaviors by others in the environment, is a phenomenon associated with adolescent SM. Having a sibling, friend, or other acquaintance who engages in SM raises risk in youth to imitate the behavior (Walsh & Rosen, 1988). School administrators have observed self-injurious behaviors spread through peer groups, grade levels, and campus clubs. SM may serve as an occasional "rite of togetherness," used to cement certain friendships and romances (Froeschle & Moyer, 2004). Sometimes an adolescent will pick up the behavior from older siblings or peer group leaders and seek acceptance and inclusion through SM. Although every student referred for SM should be assessed for suicide risk and have parents contacted, mental health professionals should expect that many students will inevitably assess as low risk and not demonstrate any overt psychopathology or emotional disturbance. Studies have demonstrated repeatedly that with appropriate interventions, the majority of students develop better coping skills, and SM behaviors diminish (see Alternative Actions sections below).

As clinicians, we have observed that, within certain peer groups displaying similar SM behaviors (such as a group of fourth graders who were referred for having eraser burns on their arms), there is often one individual, "the alpha male/female," whose behaviors and emotional lability have set off other peers, who imitate the SM. That student, however, may in fact be in the early stages of a more serious borderline or antisocial personality disorder or be a victim of severe abuse or family violence. These students, once identified, require referral to appropriate community agencies that address such serious disorders. In the majority of cases, students who exhibit episodic SM need intensive monitoring and follow-up to ensure that better coping strategies have replaced poor ones and that episodic SM has not progressed to repetitive SM.

ALTERNATIVE ACTIONS FOR PREVENTION

There is growing awareness of the importance of mental health services, especially primary prevention programs, in helping students succeed academically. The World Health Organization (2000) outlined a number of protective factors associated with children's mental health: good relationships with other youth, the ability to seek adult help when it is needed, access to mental health care, religiosity or a spiritual life, stable family environment, possession of coping and problem-solving skills, a connectedness to school, and involvement in extracurricular activities. The importance of supportive environments has also been demonstrated, specifically with respect to SM. Adolescents were less likely to harm themselves through SM or to engage in suicidal behavior if they attended schools where they felt safe, had a higher density of friendship ties, and had a more tightly knit school community (Bearman & Moody, 2004). Thus, prevention of SM is inextricably linked to the general promotion of children's mental health in schools and to districts' safety planning. Specifically, safety planning should include crisis preparation, training for staff, and implementation of primary prevention programs that reduce risk in youth (National Institute of Mental Health [NIMH], 2002).

Crisis Preparation

Well-developed crisis preparation plans allow for sensitive and rapid response to a wide variety of problems, including SM. For example, the strong association between sexual and physical abuse and cutting behaviors makes it critical for schools to collaborate with child and family protective services in the community and to require all personnel to attend annual professional development events to learn the warning signs and procedures when referring students who are potential victims (see also chapter 60, "Psychological and Physical Abuse," and 61, "Sexual Abuse").

School crisis teams provide not only an opportunity for collaboration between the school's administration and school mental health and medical staff (e.g., psychologists, counselors, nurses, and social workers) but also a critical link to the mental health resources in their communities (Poland & McCormick, 1999; see Alternative Actions for Intervention, below). School mental health professionals play an important role in the referral of students to qualified professionals in their communities, and they are urged to update their lists of mental health resources annually. They need to be knowledgeable of the practitioners and treatment centers that have specific training in the management of self-injury, as well as those resources that provide culturally sensitive services (e.g., interpreters and therapists who reflect the ethnicities present in the school community). If possible, school-based professionals might use an inservice day to visit local treatment facilities and determine the steps a student would go through in seeking help and receiving treatment. When school professionals are aware of what the treatment process is like, they can better help students and their families make decisions and develop intervention plans (Kress, Gibson, & Reynolds, 2004). Brock, Lazarus, and Jimerson (2002) provide more detail on developing school-based crisis preparation teams.

Training

The Surgeon General (U.S. Department of Health and Human Services, 2001) has identified two promising strategies for suicide prevention that have particular relevance in any discussion of SM prevention: gatekeeper training and screening programs (discussed in the following section). Gatekeeper training takes into account the fact that the self-mutilating, potentially suicidal student does not generally self-refer. The goals of this effective strategy are to raise awareness of the risk factors and warning signs of SM and suicide (see Table 1) and to provide clear, succinct intervention procedures to all adults, including school staff and parents. It also is helpful for all staff to be aware of the myths versus the facts regarding SM (see Table 2).

The National Association of Secondary School Principals provides these additional recommendations to administrators: incorporate SM training into your crisis team responsibilities, provide information to all adults on campus on how to recognize the risk factors and warning signs of SM and suicide, and train all staff to respond appropriately and refer students to crisis team personnel (Lieberman, 2004).

Primary Prevention Programs

A myriad of evidence-based primary prevention programs exist that address and reduce health risks of adolescents, such as depression, alcohol and substance abuse, bullying, and suicide. Promoting appropriate, trusting

Table 1 *Signs of Self-Injury*

- Frequent or unexplained bruises, scars, cuts, or burns.
- Consistent, inappropriate use of clothing designed to conceal wounds (often found on the arms, thighs, or abdomen).
- Secretive behaviors, such as spending unusual amounts of time in the student bathroom or isolated areas on campus.
- General signs of depression, social–emotional isolation, and disconnectedness.
- Substance abuse.
- Possession of sharp implements (razor blades, shards of glass, thumb tacks, or paper clips).
- Evidence of self-injury in work samples, journals, art projects.
- Risk-taking behaviors such as playing with guns, acting out sexually, jumping from high places, or running into traffic.

Note. From "Understanding and Responding to Students Who Self-Mutilate," by R. Lieberman, 2004, *National Association of Secondary School Principals: Principal Leadership, 4*(7), pp. 10–13. Adapted with permission.

adult–child relationships and creating caring environments where students feel welcomed, respected, and trusted are related benefits of any primary prevention program (Webster & Browning, 2002), and these programs should be beneficial in preventing SM as well.

For example, the SOS (Signs of Suicide) program has documented evidence of reducing adolescent suicide attempts (Aseltine & DeMartino, 2004). The goals of this program are to identify depressed youth at risk for self-injurious behaviors and increase their help-seeking skills. Presumably, improved help-seeking skills should also reduce students' risk for SM; however, the screening instruments used in the SOS program (and similar programs) do not specifically address SM.

ALTERNATIVE ACTIONS FOR INTERVENTION

The following are just a few of the challenges that face school mental health professionals when they respond to referrals of students exhibiting SM behaviors:

> "Over the past few months I have had 12th, 7th, and now 2nd graders referred to my counselors for hurting themselves. Should I talk to my staff and parents about this, and if so, what should I say?"
> —*K–12 Principal*

> "I have eight hysterical seventh-grade girls in my office and they are all cutting themselves and talking about suicide. I need your help!"
> —*Middle School Assistant Principal*

> "I have a first-grade boy who keeps poking himself with thumb tacks in the classroom. I've assessed him and he is low risk for suicide. Now what do I do?"
> —*Elementary School Nurse*

> "I have identified six middle school students who are engaging in self-mutilation. I don't have a lot of time; can I work with them in a group?"
> —*Middle School Counselor*

> "I just discovered a bunch of cuts on my daughter's arm and she tells me all her friends are doing it. I have forbidden her to ever do this again and I've told her never to see those friends again. Was this OK?"
> —*Concerned Parent*

School personnel and parents are facing increasingly complex situations involving SM, and they often consult school-based practitioners for assistance. Responding to these requests requires knowledge and skills to educate the adults of the school community, provide guidance on treatments, and, in some cases, provide individual and group interventions in the school setting.

Adult Education

School districts should take a proactive approach to educating faculty and school staff, particularly coaches, physical education instructors, health educators, resource officers, bus drivers, and nurses, on ways to recognize SM and to correct misunderstandings about the nature of this behavior. In addition, all staff members must know how to manage student self-disclosure of SM. All adults on the school campus should be aware of the referral procedures and should identify students who have injured themselves in any way. Such adult education could contribute to students feeling less shame, more optimism, greater trust of adults, and increased willingness to seek help.

Response to Student Disclosures

School mental health professionals may lack the time, space, or diagnostic expertise to respond to the therapeutic needs of students referred for exhibiting SM behaviors. Their primary role, once the student has been

Table 2 *Myths Versus Facts in Self-Mutilation*

Myth 1: Self-mutilators use this behavior to manipulate other people.
Fact: Physical pain is inflicted in an attempt to replace emotional rage. The victim's attempts to conform to expectations of normal behavior lead to silence about the event. Victims go to great lengths to present themselves as uninjured and normal and rarely seek to manipulate others through SM (McLane, 1996).
Myth 2: Self-mutilation is synonymous with suicide.
Fact: SM is a ritual performed for reasons other than suicide. The self-mutilator uses pain to mask emotional pain but does not intend to destroy the entire body (Zila & Kiselica, 2001; Levenkron, 1998).
Myth 3: Self-mutilators are dangerous and will probably harm others.
Fact: SM is generally secretive and most often performed in isolation. The behavior is not performed in an attempt to harm but rather to vanquish emotional pain. Violence is not directed toward others (McLane, 1996).
Myth 4: Self-mutilators just want attention.
Fact: Most self-mutilators perform their ritual and symbolic acts in private. They are often humiliated about their scars and keep them private (Levenkron, 1998).

Note. Information from "Just Cut It Out: Legal and Ethical Challenges in Counseling Students Who Self-Mutilate," by J. Froeschle and M. Moyer, 2004, *Professional School Counseling, 7*, pp. 231–236. Adapted with permission.

identified, is to assess the student for immediate risk, communicate with parents, and direct the family to the appropriate district and community mental health resources (see chapter 17, "Suicidal Ideation and Behaviors," for detailed information on assessment of suicide risk). Then, by obtaining the appropriate authorization for release of information, they can focus on "tightening the circle of care" around the student by facilitating communication among the adolescent, school, home, and community mental health agencies. School nurses are vital crisis team members who should be consulted on all cases of students referred for SM. The school nurse has medical expertise to address immediate wound treatment and the risk for possible secondary infections. The nurse also is familiar with medical and mental health resources in the community.

Personal reactions. In general, students engaging in RSM are very difficult to work with, and it is not uncommon for practitioners to have strong emotional reactions to the self-injury. These feelings can include intense horror and repulsion, and reactions to the adolescent can range from helplessness, anger, guilt, and sadness to utter frustration (Kress, Gibson, & Reynolds, 2004). Mental health professionals must continually monitor and manage their personal reactions and recognize their limitations—the ratio of support staff to students and other work demands that are placed on them. Practitioners should work with only a few RSM students at one time, identify and refer to experts in the community, share regularly with colleagues, and routinely seek collaborative support and guidance from supervisors.

Legal and Ethical Issues

Practitioners often must weigh legal and ethical responsibilities when responding to a student engaging in SM. Froeschle and Moyer (2004) provided succinct recommendations to assist in responding to these issues:

- Clarify the limits of confidentiality with both students and parents. When students are at risk for self-harm (as in the case of SM), counselors have a duty to warn parents and may be in legal jeopardy for nondisclosure if a student who reports SM behavior to the counselor is later seriously injured or dies.
- Practitioners should teach the student the importance of communication with parents and role-play such interactions.
- Practitioners should recognize the limits of their abilities; maintain accurate and objective records; familiarize themselves with state law, statutes, district policies, and procedures; collaborate and confer with colleagues regularly to make decisions in the best interests

of their students; and maintain liability insurance coverage.

Finally, child sexual abuse and family violence are distinct risk factors for RSM. If at any time the practitioner has a suspicion of abuse, neglect, or maltreatment or feels that parent notification would place a child in more danger, local child protective services should be notified immediately.

Warning parents. Contacting parents about their child's depression and SM behaviors must be done with patience, tolerance, and cultural sensitivity. Inevitably, parents can provide critical information that will assist in assessing the appropriate level of risk of their child's behavior that will help guide interventions. Table 3 summarizes the information to be gleaned during parent notification interviews. Table 4 provides some suggestions for parents whose child is engaging in SM. Family counseling can be critical to resolving communication and attachment issues that often may be at the root of SM (Kehrberg, 1997).

Using no-harm agreements. No-harm agreements, also known in the literature as no-suicide contracts or individual safety plans, may assist an adolescent in taking control over harmful impulses by identifying trusted adults, alternative behaviors, help-seeking and communication skills, grief resolution activities, and links with community and district resources. These agreements should be part of a comprehensive plan to control SM and never be used as a sole intervention. In cases in which no-harm agreements are used, students who refuse to sign and cannot guarantee their own safety should be considered high risk and should be supervised and released to a parent or emergency personnel only.

School-Based Interventions

In addition to intervention steps already discussed, recent treatment approaches that have applications for school-based personnel and have been effective in decreasing self-injury include building communication skills and learning to use behavioral alternatives (Dallam, 1997). These approaches can easily be incorporated into a student's no-harm agreement.

Communication skill building. SM may serve as a means for an adolescent to communicate intense feelings of anguish to the world (Levenkron, 1998).

Table 3 *Information to Gather Through Parent Interview*

1. Is the parent available?
2. Is the parent cooperative?
3. What is the child's previous mental health history?
4. Has the child ever tried to harm himself or herself before?
5. Has the child suffered recent losses?
6. Has the child ever been traumatized or victimized?
7. Does the family possess mental health insurance?

Note. From "Suicide Intervention," by S. Poland and R. Lieberman, 2002, in A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology IV* (pp. 1151–1167). Copyright by National Association of School Psychologists. Reprinted with permission.

Communication skill building is essential in helping a teen learn and develop healthier coping strategies when the stresses of life seem overwhelming. Adolescents should be encouraged to identify and talk with trusted adults at home or at school about self-injurious impulses. However, when adults are unavailable, the school practitioner can help the teen vent his or her emotions using written journals or art projects. One example of journaling is a "trigger log," which can be included in the student's no-harm agreement. Students record each time they engage in SM and identify the precipitating events. They can also compare their experiences to days they did not self-injure. Use of age-appropriate techniques such as play and clay and art work also is recommended to aid communication, particularly when working with younger, elementary school–age children.

Tension release and alternative behaviors. Stress management and tension release exercises and substitute behaviors empower adolescents with alternatives to self-injury. The stress response is just that, *a response*, and students can realize that they have some control over their responses. Techniques such as diaphragmatic breathing, meditation, and visualization can be effective exercises to reduce tension. One of the best prescriptions for the treatment of depression that also provides tension release is physical exercise. Exercise lends itself well to no-harm agreements because goals can be short term ("Let's exercise today") and then gradually extended. Adolescents who can manage to exercise every day or every other day for 3 weeks will not only feel better (physically and about themselves); they will also sleep and eat better. Other physical exercises include flattening recycling cans; hitting a punching bag or bean bag; playing tennis,

Table 4 *Suggestions for Parents Whose Child Is Engaging in SM Behaviors*

DO:

- Accept your child even though you do not accept his or her behavior.
- Let your child know you love him or her.
- Understand that this is your child's way of coping.
- Make your home a safe place by removing anything that could be used as a tool for self-injury.
- Encourage participation in extracurricular activities and outreach in the community (e.g., volunteering to work with animals, in nursing homes, tutoring, or mentoring).
- Reach out to the school and tighten the circle of care.

DON'T:

- Discourage self-injury, threaten hospitalization, use punishment or negative consequences.
- Overreact or say or do anything to cause guilt or shame, and never publicly humiliate your child.
- Forbid your child to see friends, but monitor whom he or she does see. Contact other parents.
- Overprotect or blame yourself for your child's behavior.

Note. Information from *See My Pain! Creative Strategies for Helping Young People Who Self-Injure*, by S. Bowman and K. Randall, 2004, Chapin, SC: Youthlight, Inc.

handball, or karate; walking or running; or ripping phone books.

Substitute behaviors have been discussed in the media but have not yet been found to be effective treatments for SM in the literature. Clinicians have reported anecdotally some success with patients who have been encouraged to substitute ice for a cutting implement or to snap a rubber band around the wrist when the impulse to self-injure overwhelms them. Holding books at arm's length or standing on tip toes until exhausted are other common suggestions. School mental health personnel are urged to fully discuss alternatives with parents and obtain their permission before incorporating any of these substitute activities in a no-harm agreement.

School interventions to limit contagion. Because contagion may play a role in SM, it is prudent to disseminate materials carefully when responding to an outbreak of SM in the school population. Educators must refrain from school-wide communications in the form of general assemblies or intercom announcements. Health educators should reconsider the classroom presentation of certain popular movies and music videos that glamorize such behaviors and instead seek appropriate messages in the music and movies of artists who are popular with students. When students within a particular peer group are referred together, it is appropriate to divide the group up among different support staff and respond to each adolescent individually. When numerous members of one peer group are referred, a leader, the alpha female or male, may be identified whose behavior may be setting others off. As a rule, school mental health professionals should refrain from running specific groups that focus on cutting; however, groups that focus on empowerment, exercise and tension release, or grief resolution are worthwhile alternatives.

Community-Based Treatments

No single, correct therapeutic approach to SM has been identified in the literature. Although prevention appears to be the best form of treatment for SM, biological, psychosocial, and behavioral therapies have been used with some success (Favazza, 1996).

Biological. Biological explanations for SM have focused on neurotransmitters in the brain and lowered functioning of serotonin. Prozac (fluoxetine), Paxil (paroxetine), and Zoloft (sertraline) are classified as SSRIs (selective serotonin reuptake inhibitors) and are the most frequently prescribed medications for adolescent depression and anxiety despite a growing concern of side reactions. Although published studies of the efficacy of SSRIs in the treatment of SM are few, they are consistently positive. SSRIs do not selectively treat SM but rather affect impulsivity and compulsivity. There are reports of their effectiveness in treating SM, nail biting, skin picking, scratching, and hair pulling (Hawton et al, 1998; Coccaro, Kavoussi, & Hauger, 1997).

Psychosocial. Much has been published to outline the general principles of treatment of SM from a psychosocial perspective. Tantam and Whitaker (1992, cited in Favazza, 1996) reviewed the literature and suggested several treatment principles. First, the counselor should focus on forming and maintaining a working relationship with the client that includes clear limits. Second, the counselor should focus on helping the client stop the behavior, which is defined as a habit. Third, the counselor should assist the client in developing alternative, more effective means of expressing emotion and resolving conflicts.

Behavioral. Cognitive–behavioral therapy (CBT) and dialectical behavioral therapy (DBT) have received empirical support in the treatment of SM. CBT seeks to connect thoughts, feelings, and behaviors in patients exhibiting SM. The process can be facilitated by redirecting the adolescents' attention away from environmental conflicts and toward their own controllable thoughts. Patients are guided to cope with overwhelming emotions by speaking about them, not acting on impulses to self-injure. They are trained to replace negative perceptions with a focus on their positive qualities and on aspects of their world in which they do have some control. CBT seeks to help the student make sense of self-injury.

Recent findings from the Treatment for Adolescents with Depression Study are consistent with work suggesting that CBT has a specific beneficial effect on self-injurious behaviors and, more importantly, that CBT combined with Prozac may confer a protective effect not only against suicidal ideation but also on SM and other harm-related behaviors (March et al., 2004).

Linehan (1993) pioneered DBT in her work with patients diagnosed with borderline personality disorder. DBT involves a structured combination of skills training and group and individual psychotherapy and addresses a hierarchical structure of treatment goals with clients. The focus is on first reducing high-risk behaviors, followed by learning to cope with post-traumatic stress responses, enhancing self-respect, and developing alternative coping skills. In weekly psychotherapy sessions, a particular problematic behavior or event from the past week is explored in detail, beginning with the chain of events leading up to it, going through alternative solutions that might have been used, and examining what kept the client from using more adaptive solutions to the problem. Both between and during sessions, the therapist actively teaches and reinforces adaptive behaviors, especially as they occur within the therapeutic relationship. The emphasis is on teaching clients how to manage emotional trauma rather than reducing or taking them out of crises. Telephone contact between the client and the therapist between sessions is part of DBT procedures. Linehan has documented success in reducing patients' parasuicidal, life-threatening, and self-injurious behaviors as well as reducing behaviors that interfere with the treatment process. School mental health personnel must become aware of the expertise that exists in their communities, especially for identifying therapists trained in CBT and DBT when responding to some of the most severe cases of students exhibiting RSM.

SUMMARY

SM is a puzzling, disturbing, and poorly understood behavior. The overwhelming number of students engaging in some form of SM presents a significant challenge to school-based mental health personnel. With an onset in early adolescence, and with higher rates among females, SM has been associated with many disorders. SM is a complex behavior, with both compulsive and impulsive characteristics, that appears to fulfill a multitude of needs for the self-injurer. The family environments of SM students can be chaotic, abusive, and dysfunctional, and a history of being sexually abused and witnessing family violence have been identified as significant risk factors in SM. One widely accepted theory views these students as being unable to tolerate or express emotions, and as, at times, seeking a rapid respite from distressing thoughts, feelings, and tensions by engaging in repetitive SM. SM can have both organic and behavioral components that foster repetition. Cutting and burning are the most common forms of self-injury found in non-hospitalized populations. SM appears to be episodic, and is often performed ritualistically in isolation and culminates in pervasive feelings of shame and guilt. The typical SM adolescent female conceals her wounds well and takes great pains to appear normal and uninjured to others at school.

School mental health practitioners must be prepared to identify these students, effectively communicate with parents, and refer them to the appropriate, culturally responsive community mental health agency. In addition, school professionals can implement a myriad of school-based interventions that focus on teaching appropriate communication skills and tension release and coping skills. Professionals aim to "tighten the circle of care" that surrounds the student by educating school staff and parents and by facilitating communication among the adolescent, the school, the home, and the community mental health agency. In addition to identifying, advocating for, and referring the students, school professionals must be knowledgeable and skilled in developing and coordinating primary prevention programs, educating adults in the school community, assessing for suicidal tendencies, understanding the complex legal and ethical issues related to SM, establishing no-harm agreements, and providing guidance to school mental health staff on treatments and individual and group interventions. Finally, continued research is needed on interventions for adolescents with depression and impulse disorders, including SM, parasuicidal behaviors, and alcohol and substance abuse.

RECOMMENDED RESOURCES

Books and Other Printed Material

Alderman, T. (1997). *The scarred soul: Understanding and ending self-inflicted violence.* Oakland, CA: New Harbinger Press.

This book was one of the first written for victims of self-inflicted violence that sought to teach them what they could do to stop hurting themselves.

Favazza, A. (1996). *Bodies under siege* (2nd ed.). Baltimore, MD: Johns Hopkins University Press.

The American Medical Association has referred to this text as the most comprehensive historical, anthropological, ethnological, and clinical account of self-mutilation.

Levenkron, S. (1998). *Cutting: Understanding and overcoming self-mutilation.* New York: W.W. Norton.

With many examples from his practice, Levenkron provides clear and comprehensive information on the causes and effective treatments of self-mutilation.

Websites and Other Contacts

http://www.selfinjury.org

ASHIC—the American Self-Harm Information Clearinghouse—strives to increase public awareness of the phenomenon of self-inflicted violence and the unique challenges faced by self-injurers and the people who care about them. This website provides assistance, outreach, and public education about self-harm.

http://www.palace.net/llama/selfinjury/

This page, maintained by Deb Martinson, provides comprehensive outreach, resources, and information on self-injury. Interactive pages include web boards, self-assessment questionnaires, and links to off- and online resources and downloads.

Crisis Hotline Numbers: These numbers provide callers with immediate crisis response, information, and resources.
(800)-SUICIDE and (800)-DONTCUT

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