




Expressing Yourself: Working with Self-Injurers

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“If I’m suicidal I want to die, I have lost hope. When I’m self-injuring, I want to relieve emotional pain and keep on living. Suicide is a permanent exit. Self-injury helps me get through the moment.” (p. 32)

- ★ Strong, Marilee (1998). *Self-mutilation and the Language of Pain*. New York: Viking.





Learning Objectives

- Knowledge of statistics available on the prevalence of self-injury among adolescents
 - Understand differences between suicide and self-injury
 - Understand current treatment models available for self-injurers
 - Knowledge of interventions for working with student's who self-injure
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What is Self-Injury?

- Also known as self-harm, self-mutilation, self-abuse or self-inflicted violence
- It is the deliberate harming or alteration of one's body tissue without the conscious intent to commit suicide
- Damage is rarely life threatening
- Location of the wound in done is a spot that can be hidden (wrists, thighs, abdomen)
- Not yet officially recognized as a disorder in the DSM
- Can be a coping mechanism to relieve stress, pain, fear, anxiety





Classifications


- **Major Self-Mutilation:**

- Most extreme form of self-mutilation
- Most uncommon form
- Examples include castration, amputation
- Most often associated with psychotic or acute intoxicated states

- **Stereotypic Self-Mutilation:**

- Fixed rhythmic patterns such as head banging, finger or arm biting
- Most common in people who are institutionalized, autistic, and/or psychotic

- **Superficial or Moderate Self-Mutilation:**

- Most frequently performed act of self mutilation
 - Most common methods are cutting, burning, skin picking, hair pulling, bone breaking, hitting, scab picking
 - Favazza further divided this category into three sub-types compulsive, episodic and repetitive
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The DSM and Self-Injury

- Self-injury does not stand alone in the DSM
- Self-injury as part of the diagnostic criteria for Borderline Personality Disorder
- Self-injury could be considered for inclusion under Impulse Control Disorder
- Proposed research criteria for self-injury for inclusion in the DSM

• Turner, V.J. (2002).





Prevalence of Self-Injury


- **It is hard to get a clear cut picture of the prevalence of self-injurious behavior as like disorders such as bulimia it is a “hidden” problem**
- **However, what we do know...**
 - **Walsh and Rosen (1998) estimated that 1400-1600 out of every 100,000 people in the general population have engaged in some form of self-injury**
 - **Briere and Gil (1998) found that 4 percent of the general population and 21 percent of the clinical population reported self-injurious behaviors**
 - **Favazza (1998) reported that superficial/moderate self-injury occurred at a rate of at least 1,000 per 100,000**
 - **Favazza, DeRosear, and Conterio (1989), found that 14 percent of college students admitted to at least one episode of self-injury**
 - **The landmark case by Favazza and Conterio (1989) found that of 240 female self-injurers, 62 percent had suffered from child abuse**



Prevalence of Self-Injury (cont.)

- **Fenning, Carlson, and Fenning (1995) stated that self-injury in educational settings is probably more frequent than reported**
 - Turner, V.J. (2002).
- **Ross and Heath (2002) studied a sample of 440 youth from Canada and found that 61 percent reported having self-injured**
 - **Of those who reported having self-injured higher levels of depression and anxiety were found through the BDI**
 - **The behavior breakdown in this study looked like: self-hitting (32.8%), pinching (6.5%), biting (5%), and burning (3.3%)**
 - **13.1 % said they self-injured at least 1 time per day**
 - **59% reported beginning in 7th or 8th grade and 11.5% in 9th grade**
 - **24.6% stated that the began in the 6th grade or earlier**

Walsh, B (2005).







Self Injury vs. Suicide

- **Self-Injury**

- Individuals who self-mutilate do not want to end their lives
- Others react to the behavior with hostility and disgust, and the frequency does not diminish
- Self-mutilators continue the behavior even if a change occurs in the stressful situation
- Self-mutilation is considered low lethality
- A sense of relief is felt after the episode of self-mutilation
- Self-mutilation does not bring about persistent thoughts of death and dying

- **Suicide**

- Suicidal people want to end their lives
 - Suicide attempts elicit an active response from members of the person's environment, serving to diminish possible future attempts
 - Suicidal clients often improve when removed from the stressful situation
 - Suicide is high lethality
 - Suicide attempts do not offer relief
 - Suicidal behavior brings about persistent thoughts of death and dying
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“Hurting myself provided the perfect way of expressing my frustration and pain.”

★ Sian Davies, said in an article for the BBC News “I Cut Myself with Knives”





Who Engages in Self-Injury?

- These behaviors are not limited by gender, race, education, age, sexual orientation, socio economic status or religion
 - Occurs most commonly among adolescent females
 - Many have a history of physical, emotional or sexual abuse
 - Many have co-existing problems with substance abuse, obsessive compulsive disorders, eating disorders, or borderline personality disorder
 - Often raised in families that discouraged expression of anger, and have a lacking sense of expressing emotions
 - Often lack a good social support network
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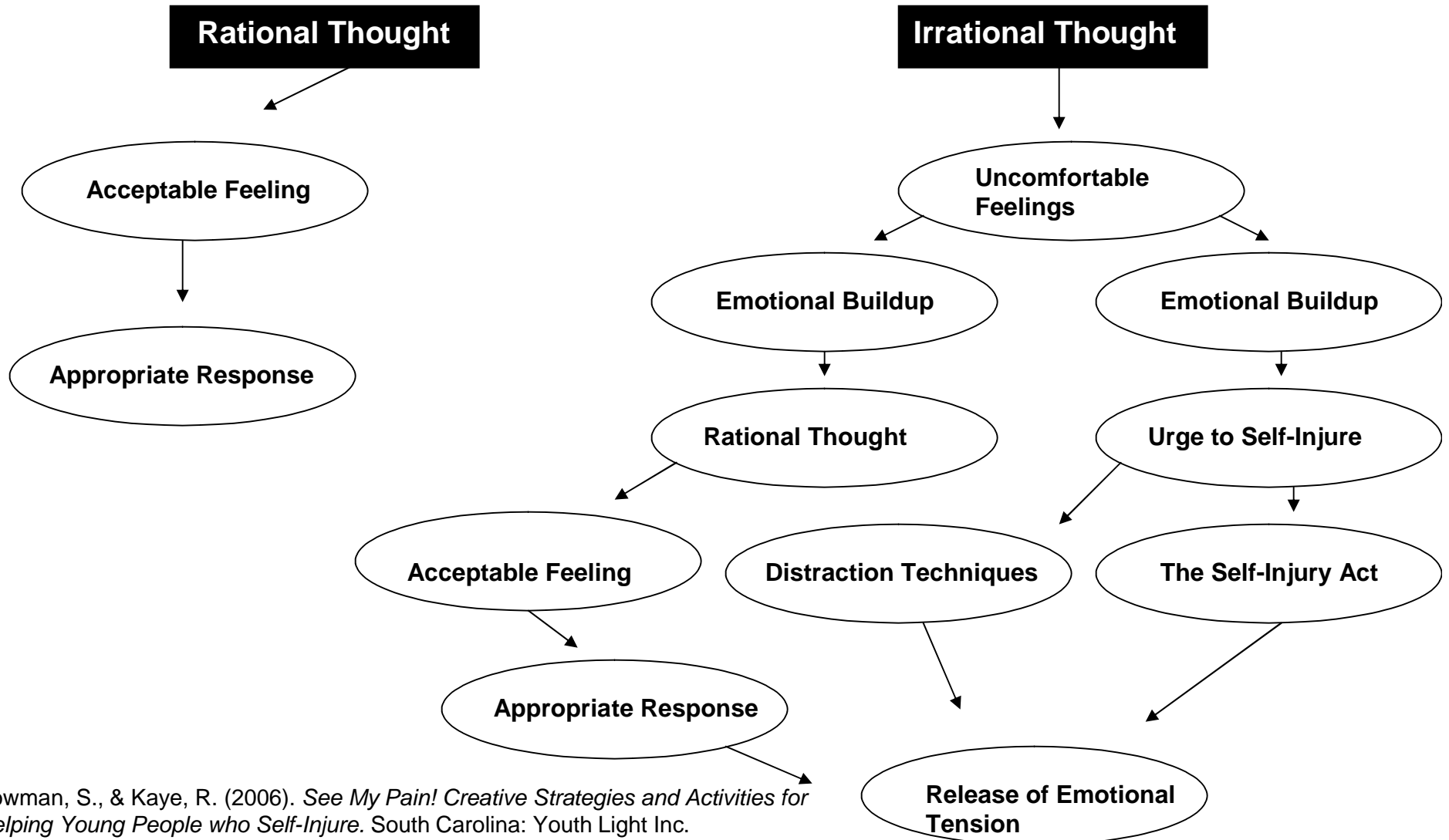
Psychological Characteristics

- Dislike/invalidate themselves
- Hypersensitive to rejection
- Chronically angry
- Tend to suppress anger
- High levels of aggressive feelings, which they disapprove of
- More impulsive and lacking impulse control
- Tend to act in accordance with their mood in the moment
- Tend not to plan for the future
- Depressed and self-destructive
- Chronic anxiety
- Tend toward irritability
- Do not see themselves as having skills in coping
- Do not have a flexible repertoire of coping skills
- Tend to be avoidant
- Do not see themselves as empowered



Cycle of Self-Injury

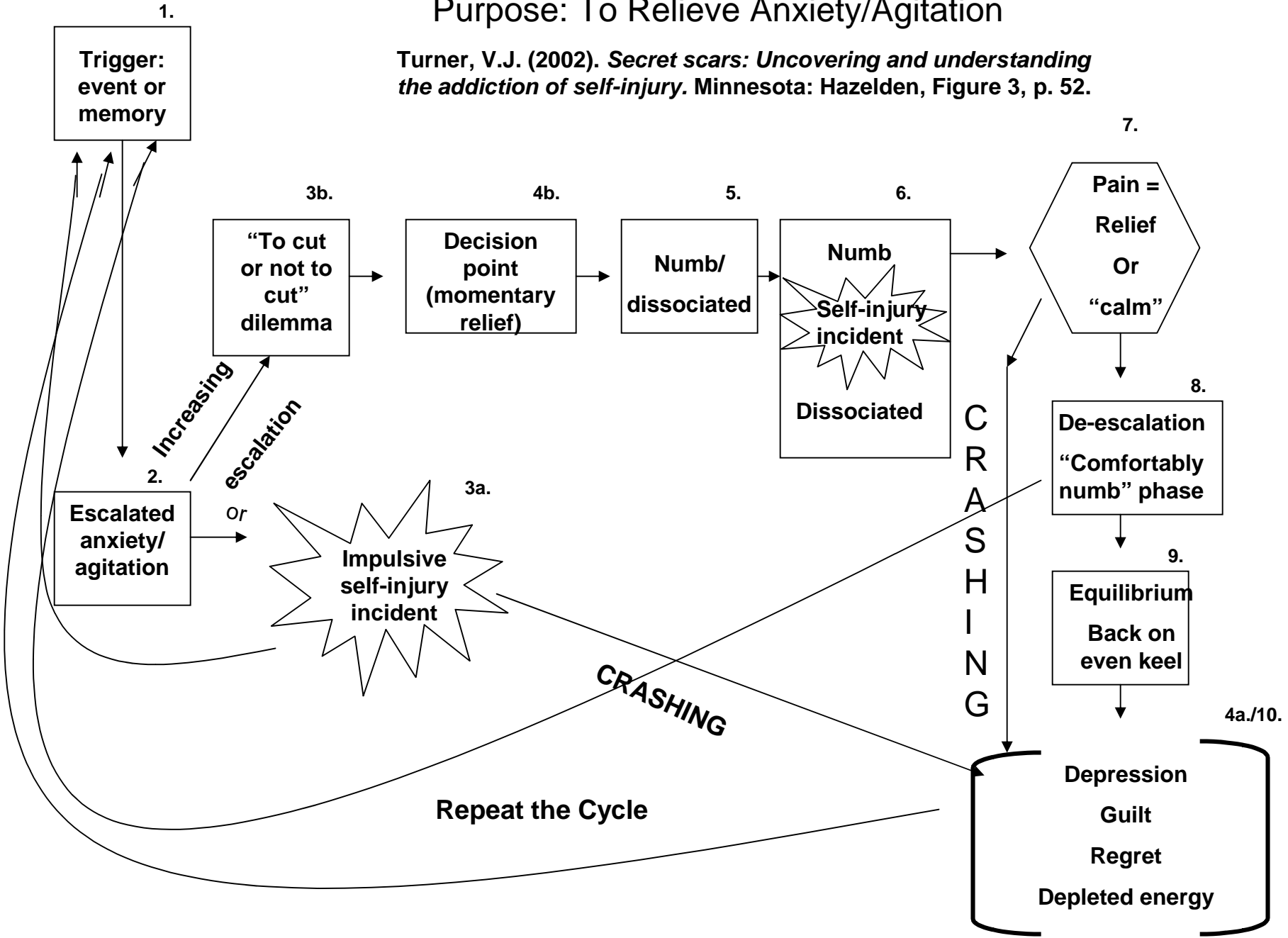
Activating Event



Bowman, S., & Kaye, R. (2006). *See My Pain! Creative Strategies and Activities for Helping Young People who Self-Injure*. South Carolina: Youth Light Inc.

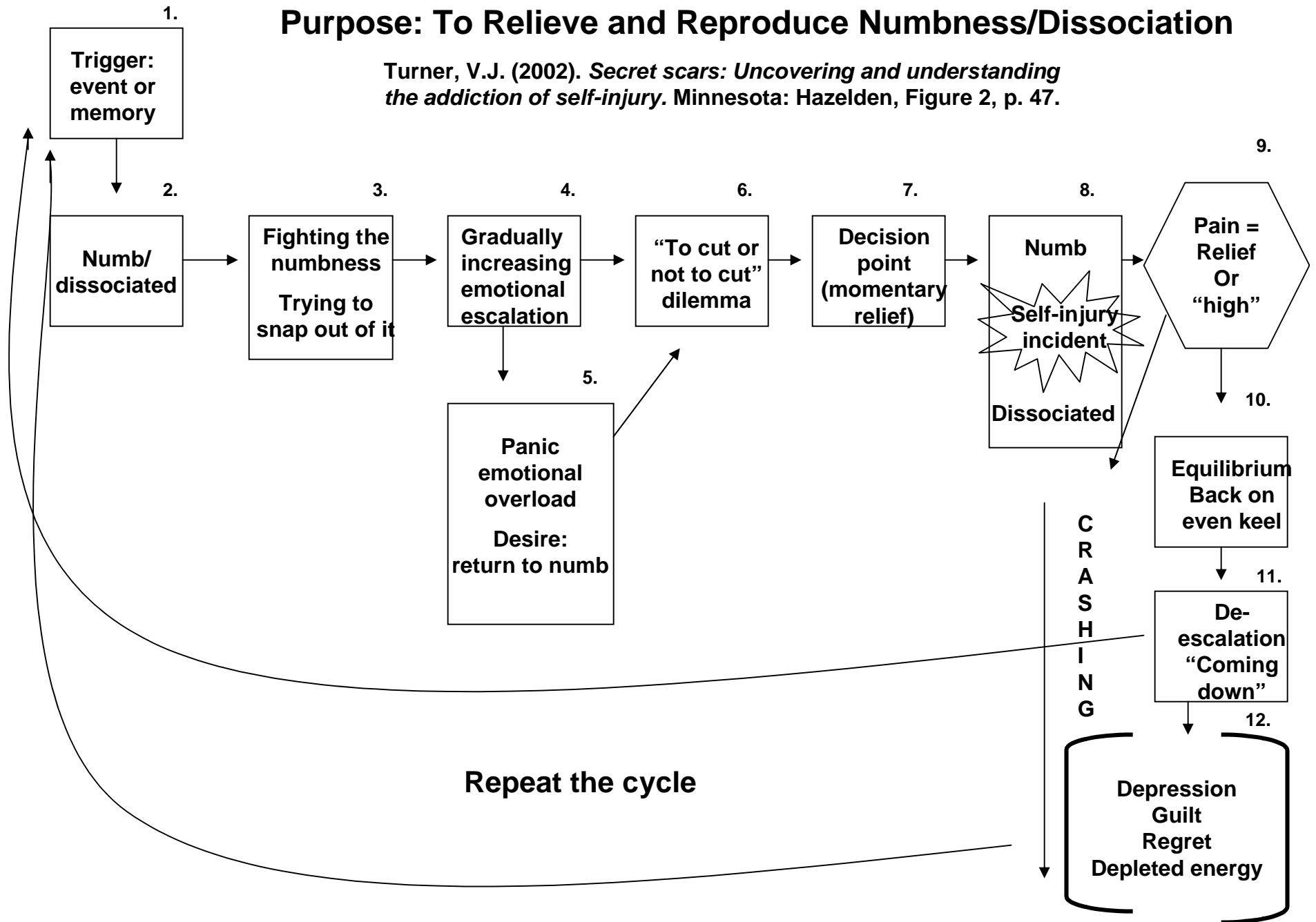
Purpose: To Relieve Anxiety/Agitation


Turner, V.J. (2002). *Secret scars: Uncovering and understanding the addiction of self-injury*. Minnesota: Hazelden, Figure 3, p. 52.



Purpose: To Relieve and Reproduce Numbness/Dissociation

Turner, V.J. (2002). *Secret scars: Uncovering and understanding the addiction of self-injury*. Minnesota: Hazelden, Figure 2, p. 47.





“Despite the prevalence of self-mutilation, attempts to understand it have been hampered by negative social attitudes...”

- ★ Armando Favazza stated in *Hospital and Community Psychiatry* as quoted in Conterio, K., & Randall, W.L. (1998). *Bodily Harm: The Breakthrough Treatment Program for Self-Injurers*. New York: Hyperion, p. 98.





One's Initial Therapeutic Response

- Avoid the use of terminology associated with suicide
- Try to use the same descriptive language that the client uses
- Gently challenge client's language that is minimizing
- Demonstrate respectful curiosity
- Try to be nonjudgmental and compassionate





Responding to Students Who Self-Injure

- Unhelpful responses
- Biological responses
- Psychological responses
- Social-environmental responses





Do's and Don'ts for Counselors


- **Do –**
- Show unconditional acceptance
- Accept the person regardless of the behavior
- Have a goal to understand the underlying causes of the behavior
- Communicate it is okay to talk about self-injury
- Suggest a list of coping techniques
- Show that you care about the injuries
- Acknowledge the efforts to deal with difficult emotions
- **Don't –**
- Make eliminating the behavior the primary goal
- Tell the adolescent to stop the behavior
- Use contracting as a system of reward and punishment
- Make the adolescent feel guilty or ashamed of their behavior
- Be the only source of support for the adolescent





- Asking clients to stop their self-injurious behavior before learning new ways to cope with their emotions is asking the near impossible of the client
- When one observes cues that a self-injurer is becoming flooded with emotion, it would be important once she has learned replacement skills to point out that you recognize that she is becoming flooded with emotion and recommend that she practice one of her new skills





“Can’t you see how much I hurt? Can’t you see how badly I need you?”

★ quoted in Conterio, K., & Randall, W.L. (1998). *Bodily Harm: The Breakthrough Treatment Program for Self-Injurers*. New York: Hyperion, p. 68.



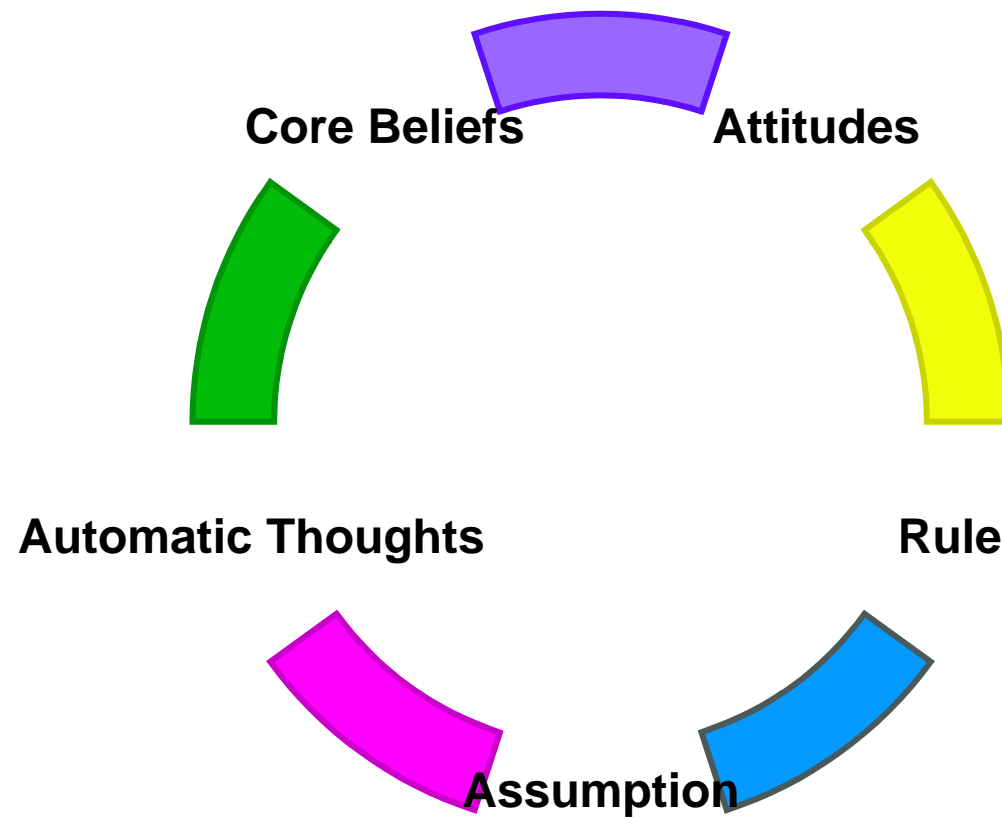


Assessment of Self-Injury

- Have client's keep a log of self-injurious behavior between sessions
- Items that could be included on a log are:
 - Frequency
 - Episodes
 - Extent of physical damage
 - Body area
 - Pattern of wounds
 - Use of a tool
 - Room or place of the self-injury
 - Social context

Cognitive Therapy

- Cycle of automatic thoughts





Replacement Skills Training

- Replacement skills have to be at least as effective as the self-injurious behavior has been for the person
- Nine types of replacement skills:
 - Negative replacement skills
 - Mindful breathing skills
 - Visualization techniques
 - Physical exercise
 - Writing
 - Artistic expression
 - Playing or listening to music
 - Communicating with others
 - Diversion techniques





“You have so much pain inside yourself, you try and hurt yourself on the outside because you need help”

★ Princess Diana as told to the British Broadcasting Company





S.A.F.E. Program

- Self Abuse Finally Ends
 - Only inpatient treatment center solely dedicated to self-injurers
 - Established in 1985
 - Located in Illinois
 - 99% of the patients are women
- A NO HARM contract is signed by patients stating that they will not harm themselves while at the treatment center
 - For those who do relapse, instead of punishment, steps are taken to keep the individual safe






S.A.F.E. Toolbox

- Tools developed by the S.A.F.E. Alternative program for interventions to help self-injurers modify their behavior:
 - Tool 1: No Harm Contract
 - Tool 2: Impulse Control Long
 - Tool 3: Five Alternatives
 - Tool 4: Writing Assignments





No Harm Contract


- A contract between the counselor and client which outlines expectations and responsibilities, and how behaviors that threaten counseling will be dealt with
 - The client should participate in the development of the contract
 - The treatment agreement is a collaboration
 - Overtones that make the contract an avenue of control and punishment by the counselor could hurt the effects it has on the success of the counseling
 - It can be short-term agreements done day by day or week by week depending on the severity and frequency of the self-injurious behaviors
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Impulse Control Log


- The log is a way for client's to monitor their behavior when they have an urge to self-injure:

Acting Out/Self-Injury Thoughts	Time and Date	Location	Situation	Feeling	What would be the result of the self-injury	What would you be trying to communicate	Action taken	Outcome





Five Alternatives

- Alternatives are comforting activities or temporary distractions that take the focus of the person away from the thoughts of self-injury
 - Some of alternatives could be such things as:
 - Use of impulse control log
 - Writing in a journal
 - Talking to a trusted person
 - Taking a walk
 - Listening to music
 - Working on an arts and crafts project
 - Playing an instrument
 - Cooking
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Writing Assignments

- The S.A.F.E. program advertises 14 different writing assignments that can be useful in treating a self-injurer:
 - Autobiography
 - How do I see myself
 - The female most influential to me
 - The male most influential to me
 - Emotions surrounding self-injury
 - Anger inside of me
 - What I cannot stand about people in my life
 - Compensation for life's injuries
 - Nurturing myself
 - A time I was comfortable in the presence of someone else
 - Person I want to be
 - How I feel about being a woman
 - Saying good-bye to self-injury
 - What I have learned about myself
 - Future plans



“The knife runs deep, deep enough to finally draw blood, reality comes back, the colors and sensations in the room all get very bright and very strong, then finally the welcome pain, the scream, the relief, and it’s over...for now.”

- ★ Excerpt from a passage in Turner, V.J. (2002). *Secret scars: Uncovering and understanding the addiction of self-injury*.





Activities

- Several activities specified for self-injurers are outlined in *See My Pain: Creative Strategies and Activities for Helping Young People Who Self-Injure* by Susan Bowman and Kaye Randall (2006):
 - My Personal Timeline
 - Body Breathing
 - Mind Escape
 - Remember When...
 - My Sand Tray World
 - Motivational Metaphors
 - Musical Collage
 - Comfort Kit






“I need to practice opening up instead of closing in and self-injuring. I need to work on reminding myself that pain is not her forever, and that I need to challenge my thoughts before acting out in dangerous ways. I need to apply a new definition to myself – I am not a self-injurer anymore.”

- ★ Passage from Conterio, K., & Randall, W.L. (1998). *Bodily Harm: The Breakthrough Treatment Program for Self-Injurers*. New York: Hyperion, p. 98.





Managing Self-Injury in the School Setting

1. Learn the full-range of self-destructive behaviors
 2. Training those like school counselors who are often the first line of intervention to do a basic assessment of an identified student's needs
 3. Training in differentiating self-injury from suicide
 4. Understanding the types of self-injury that require immediate assessment by a psychiatric emergency service
 5. Being aware that body modification such as tattooing, and piercing is not the same thing as self-injury
 6. Learning how to respond to a student who self-injures
 7. Learning that self-injury is a complex problem with biological, environmental, and psychological factors
 8. Learning that stating students can only return to school when they have extinguished their self-injurious behavior is unrealistic
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Intervening with a Self-Injuring Student

- A point person should be designated (school counselor, social worker, psychologist, nurse)
- If a student presents with certain behaviors this point person should be contacted
- The point person should then contact the student discretely and confidentially to investigate
 - It may be beneficial to not reveal the source of the referral if possible
- After speaking with the student, the point person can do 1 of 3 things:
 1. If the incident is minor or already resolved no action needs to be taken beyond the first meeting but the student should be encouraged to come back if she/he becomes distressed again





Intervening with a Self-Injuring Student (cont.)

2. If the incident is deemed to need further intervention, the parent or guardian will need to be contacted and the student should be advised whenever possible that this is going to happen
 - The purpose of the call is to ensure that the student has adequate support, protection and assistance
 - Good idea to try and make this phone call with the student present
- Several possible options to be pursued to help the student:
 - Initiating outpatient counseling for the child/family
 - Seeking psychotropic medication
 - Agreeing to have the child receive enhanced academic/counseling supports within the school
- The point person should make sure that releases of information are in place so that that person can communicate with outside agents helping the student





Intervening with a Self-Injuring Student (cont.)

3. If the incident is deemed an emergency or crisis situation the point person should be able to arrange an immediate screening at an emergency psychiatric service and/or police intervention
 - These instances can include a student who discloses a specific plan to overdose, a student who threatens to shoot him- or her- self, or plans on jumping from a dangerous height on that day

