Self-Injury: A School-Wide Response to a Growing Problem

A Research Paper

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for

the Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

By:

Emily Ann Kramer

May 2011
Abstract

Adolescent self-injury is a phenomenon that has exploded in our schools in the last decade. With the topic gaining recognition in movies, television, and the internet, more and more students are exposed to and trying self-injury as an emotion-regulatory tool. To address this important issue, implementation of a comprehensive prevention and intervention program can enable all staff, administration, parents, and students to recognize and help those students who may need it. This thesis explores how to build a school-wide program that will effectively create a school climate that is ready to handle these crisis situations through the use of a comprehensive toolkit.
Self-Injury: A School-Wide Response to a Growing Problem

Self-injury has developed into one of the most prevalent problems for adolescents in middle schools and high schools in the United States and all around the world (D’Onofrio, 2007). Perceived in the past as only an issue with severe clinical psychiatric patients, the phenomena is sweeping our schools. Rates of self injury have become so prevalent that the upcoming 2013 DSM-V will include it as a disorder (Prinstein, 2011; Rettner, 2010).

In a 2007 survey of 443 school counselors nationwide, Roberts-Dobie and Donatelle found 81% of the counselors surveyed had worked with an adolescent who self-injured at some point in his/her career. Students who self-injure continue to overload school support personnel (Galley, 2003). With the increasing prevalence of self-injury, school counselors can nearly guarantee they will encounter the behavior at some point in their careers (Klonsky, 2007). Because of this, school counselors need to have a better understanding and knowledge of self-injurious behaviors in order to appropriately intervene and best help those who are struggling with this behavior (White Kress, Drouhard & Costin, 2006).

Overview of Self-Injury

Self-injury, also known as non-suicidal self-injury, deliberate self-injury, deliberate self-harm, self-mutilation, and auto-aggression (Klonsky, 2007; Mikolajczak, Petrides, & Hurry, 2009), is often defined as “a broad class of behaviors defined by direct, deliberate, and socially unacceptable damage to one’s body tissue without suicidal intent” (Guerry & Prinstein, 2010, p. 77). These “broad class of behaviors” include cutting, burning, scratching, interfering with wound healing, carving words or symbols into the skin, banging body parts, breaking bones, and needle sticking (Kelly, Jorm, Kitchener, & Langlands, 2008; Klonsky, 2007), with cutting being the most used method of self-injury in the non-hospitalized population. The areas of the body
most typically injured include the arms and wrists, legs, abdomen, head, chest, and genitals, in that order (White Kress, Gibson, & Reynolds, 2004; White Kress et al., 2006).

**Percentage of Population**

Much of the current research on self-injury has been done with the clinical population. Very little has been done with college age students, and even less with adolescents. However, one trend is evident in all studies—the rising rates of self-injury in the United States and around the world (D’Onofrio, 2007). Non-hospitalized adolescent prevalence rates range from 15-20% with some studies reporting rates as high as 39% (Heath, Ross, Toste, Charlebois, & Nedecheva, 2009; Muehlenkamp, Hoff, Licht, Azure, & Hasenzahl, 2008). Most experts agree that the age range falls in the high teens to low twenties (Rettner, 2010).

**Age of Onset**

Self-injury usually begins in early to mid adolescence between the ages of eleven to fifteen with the average age of onset being around thirteen to fourteen years of age, or the freshman year of high school (Klonsky & Muehlenkamp, 2007; Moyer & Nelson, 2007; Rettner, 2010). Many researchers and clinicians see adolescence as the “perfect storm for self-injury” due to the developmental processes of the brain at this time in one’s life. The amygdala, the part of the brain involved in emotion, and the cortex, the part of the brain involved in higher thinking, are not yet fully developed and therefore do not communicate very well to each other. Janis Whitlock, a researcher at Cornell University states, “It is very common for adolescents, particularly early adolescents, to feel high levels of emotion and really not have many skills to deal with the emotion” (Rettner, 2010). Many adolescents have not yet learned mature coping skills to manage this range of strong emotions coupled with the interpersonal challenges of
adolescence (Dyl, 2008). During this time, the adolescent may turn to unhealthy coping mechanisms, such as self-injury.

**Life-time prevalence.** Most people who self-injure engage in the behavior very infrequently. Only a minority continue to chronically self-injure (Klonsky & Muehlenkamp, 2007; Laye-Gindhu & Schonert-Reichl, 2004). Of those who become chronic, 80% stop injuring themselves within 5 years of starting. This may be because as adolescents’ brains become more fully developed, they learn other more positive coping methods (Rettner, 2010).

**Gender Differences**

In the past, clinicians typically considered self-injury only a “female issue”. This may be due to the fact that very few research studies on self-injury included males in their samples (Laye-Gindhu & Schonert-Reichl, 2004). Recent large-scale studies have found little information regarding gender differences (Guerry & Prinstein, 2010; Klonsky & Muehlenkamp, 2007; Prinstein, 2008).

Even today, when the average person thinks of self-injury, often an image of an adolescent girl cutting herself comes into mind. This may be because the genders differ in how and why they self-injure. Boys tend to “act out” in their self-injury (externalizing and interpersonal) while girls are more likely to turn inward on themselves (internalizing and intrapersonal). In their self-injury, boys often engage in risky behaviors such as dangerous driving or daredevil feats, punching things, or hitting themselves—making them better able to hide their injuries as accidents or sports injuries. Boys more likely self-injure out of boredom and with a group as a “test of will” or as a peer game (Hogg, 2010; Laye-Gindhu & Schonert-Reichl, 2004). School counselors need to be aware of the gender differences in self-injury so they do not miss very important signs in adolescent boys.
Ethnicity

Research has provided little data to reach conclusions regarding ethnic differences in self-injury (Prinstein, 2008). Studies vary in their findings of self-injury rates in Caucasians versus non-Caucasians, although no study to date has found lower rates in Caucasians than non-Caucasians (Klonsky & Muehlenkamp, 2007).

The Myths

Four myths believed by those unfamiliar with self-injurious behavior exist. These myths include: (a) self-injury serves as a manipulative behavior, (b) adolescents who self-injure just want attention, (c) those who self-injure will probably harm others, and (d) self-injury equals suicide.

Self-Injury Serves as a Manipulative Behavior

Adults often see self-injury as a behavior used to manipulate others into doing, acting or behaving in a certain manner (Laye-Gindhu & Schonert-Reichl, 2004); however, this is not true. Adolescents use self-injury as a coping mechanism to help replace intense emotional pain. Most people who self-injure go to great lengths to hide their physical scars and injuries and rarely seek to manipulate people through the behaviors (Froeschle & Moyer, 2004).

Adolescents Who Self-injure Just Want Attention

While some adolescents may eventually begin to use their self-injury to gain attention from others, this never initially causes the behavior. Most who self-injure keep their behaviors very private and do not show their scars and injuries out of embarrassment (Kibler, 2009).

Those Who Self-Injure Will Probably Harm Others

Self-injury does not denote craziness. Instead, it acts as a means of trying to help one’s self. The violence is not against others, but against one’s self release emotional pain (Froeschle
& Moyer, 2004; White Kress et al., 2004). In their book *Bodily Harm: The Breakthrough Treatment Program for Self-Injurers*, Conterio, Lader, and Kingson Bloom (1998) state, “Aggression is one of the most difficult emotions for self-injurers to face directly, which is why they disguise it and work it out through acts of self-harm” (p. 29).

**Self-Injury Equals Suicide**

When most adults see an adolescent with self-inflicted injuries, they immediately think he or she tried to commit suicide. A study conducted by Nock, Prinstein, & Sterba (2010) found that an adolescent’s thoughts of self-injury were rarely accompanied by suicidal thoughts. In fact, many adolescents engage in self-injury to prevent themselves from thinking about suicide. Self-injury acts as a “life preserver” for adolescents. It allows them to cope with stress and relieve difficult inexpressible feelings in order to stave off suicidal thoughts (Conterio et al., 1998).

In their article *Self-Injury: A Research Review for the Practitioner*, the authors Klonsky & Muehlenkamp (2007) state, “It is well established that suicidal behaviors are different from self-injury in their phenomenology, characteristics, and intent, although they share some psychosocial risk factors” (p. 1049). Self-injury masks emotional pain through a painful repetitive act. Adolescents who self-injure do not try to end their life; they try to cope with life (Froeschle & Moyer, 2004; Rettner, 2010). An assumption of a direct correlation between self-injury and suicide can lead to unnecessary and invasive interventions by school counselors, teachers and administrators (Hoffman & Kress, 2010; White Kress et al., 2004).

**Characteristics**

According to Steven Levenkron’s book *Cutting: Understanding and Overcoming Self-Mutilation* (1998), the clinical diagnostic criteria of self-injury include:
recurrent cutting or burning of one’s skin, a sense of tension present immediately before the act is committed, relaxation, gratification, pleasant feelings, and numbness experienced concomitant with the physical pain, a sense of shame and fear of social stigma, causing the individual to attempt to hide scars, blood, or other evidence of the acts of self-harm (p. 25).

These diagnostic criteria explain the cyclical experience of self-injury, but fail to look deeper into the reasons adolescents choose to self-injure.

**Why**

Many people who self-injure arrive at adolescence in an already vulnerable state, and find the usually ordinary tasks of this developmental stage very painful and traumatic (Conterio et al., 1998). Adolescents are more likely to self-injure when feeling rejected, angry toward oneself or another, self-hatred, and numbness, than when feeling sad or worthless (Nock, Prinstein, & Sterba, 2010). For these adolescents, the highly maladaptive emotion regulation strategy of self-injury provides a “quick fix”—a fast and relatively easily accessible coping method (Mikolajczak et al., 2009; Nock, 2009).

After studying the motivations behind self-injury, researchers have found four functions for this maladaptive behavior. These functions include: (a) intrapersonal negative reinforcement, (b) intrapersonal positive reinforcement, (c) interpersonal positive reinforcement, and (d) interpersonal negative reinforcement (Nock, 2009; Nock, Teper & Hollander, 2007). The functions of self-injury do not exist exclusively. They can and often do co-occur in individuals who self-injure (Klonsky & Muehlenkamp, 2007).

**Intrapersonal negative reinforcement.** Adolescents often perform self-injury to temporarily relieve negative emotions that frequently and intensely build up within themselves
(Guerry & Prinstein, 2010; Klonsky, 2007). The use of self-injury for affect regulation appears to be the most prevalent reason for self-injury (Heath et al., 2009; Nock et al., 2010; Polk & Liss, 2009). Studies have shown adolescents who self-injure experience more frequent and intense negative emotions than those who do not self-injure. In fact, they score highly on measures of negative temperament, emotion dysregulation, depression, and anxiety (Klonsky & Muehlenkamp, 2007). Self-injury may be a desperate attempt to down-regulate negative feelings intensified by the adolescent’s ineffective emotional coping strategies (Mikolajczak et al., 2009).

Adolescents who self-injure often have a psychological pain so unspeakable they need to speak their pain through their acts of self-harm (D’Onofrio, 2007). They resort to a damaging physical conversation with oneself. According to Levenkron (1998), “It is the experience of physical pain—for its calming effect on her more painful psychological state—that is being sought” (p. 24). Adolescents may engage in self-injury to suppress negative emotion or self-threatening thoughts associated with the negative emotions (Prinstein, 2008).

Many adolescents who self-injure blur anger and violence into one category by believing when someone gets angry, someone has to get hurt. They feel uncomfortable or unable to express this violence to those who make them angry so they turn the violence on themselves. They feel as if they have to “get the feelings out” and instead of hurting others, they hurt themselves, rather than realizing bad feelings can be dealt with in a nonphysical manner (Conterio et al., 1998). In a 2007 qualitative study conducted by Moyer & Nelson, an adolescent female described her self-injury in this way: “Things got so hectic and I couldn’t control any of it… [Self-injury] is a way of relieving stress and then there’s anger like when I want to yell at people I know I can’t; it’s a way to like get it out” (p. 44).
As a person self-injures, it releases endorphins which relieve pain and can produce euphoria—similar to taking morphine (Dyl, 2008; Galley, 2003; Levenkron, 1998; Rettner, 2010; White Kress et al., 2004). Emotions such as anger, anxiety, and frustration tend to build up intensely with feelings of relief and calm following the act of self-injury (Klonsky & Muehlenkamp, 2007). However this relief lasts only a short time. When accompanied with a sense of euphoria, it can become addicting. Self-injury has then become the adolescent’s “drug of choice” (Levenkron, 1998).

Self-punishment and self-directed anger represent another aspect of intrapersonal negative reinforcement, and adolescents often cite these reasons for their self-injurious behavior (Klonsky & Muehlenkamp, 2007). Polk & Liss (2009) cited self-punishment as the fourth most frequent reason people self-injured. Some theorize adolescents use self-injury to self-punish because the behavior may be a learned response to repeated abuse and criticism from others (Nock, 2009).

**Intrapersonal positive reinforcement.** To interrupt episodes of antidissociation, the feeling of being unreal or not feeling anything at all, adolescents injure themselves to feel alive and regain a sense of self (Klonsky & Muehlenkamp, 2007; Prinstein, 2008). When they feel the pain on their bodies and see the blood flowing down their skin, they once again come to feel, even if that feeling is pain. Polk & Liss’ study (2009) found “feeling generation” to be the second most frequent reason people self-injure.

The act of self-injury may also be used to generate a sense of excitement through activities similar to skydiving or bungee jumping. Adolescents who self-injure for excitement often do so around friends or peers. The sensation seeking motivation may also be more prevalent in boys than in girls (Klonsky & Muehlenkamp, 2007).
**Interpersonal negative reinforcement.** The two functions of interpersonal negative reinforcement include: to establish interpersonal boundaries and to escape. Self-injury can be used to affirm boundaries of the self—giving a sense of control to those who self-injure when they often feel out of control (Klonsky & Muehlenkamp, 2007). Polk & Liss’ study (2009) found this to be the third most frequent reason people self-injure. Self injury can also be used by adolescents to escape undesirable situations. The self-injury can suppress unwanted social stimulus—such as reducing or getting away from conflict (Prinstein, 2008).

**Interpersonal positive reinforcement.** This function of self-injury elicits affection, reinforces responses from authority figures, or provides a way to bond with self-injuring friends (Klonsky & Muehlenkamp, 2007). Adolescents may escalate to using self-injury to gain the attention of others when they feel talking or yelling does not work (Heath et al., 2009; Nock, 2009). Because of the interpersonal demands and stressors of this age, adolescents who self-injure more likely have a social function to their behavior than adults who self-injure (Prinstein, 2008).

Self-injury may provide a way to communicate, influence, or connect with other people when being performed out of emotional needs (Heath et al., 2009). A response from others might not be the primary goal of adolescents’ self-injury, but it may serve as reinforcement for the behavior, or a secondary gain. They begin to like the attention it brings even though this was not initially the cause of the behavior. Often a paradoxical connection results because many adults who could be seen as a “helper” (parents, teachers) often express disgust over the behavior. The adolescent may have discovered negative attention is better than none (Kibler, 2009; Levenkron, 1998).
Risk Factors

Many people assume adolescents self-injure because of sexual abuse, but most research has only found a modest relationship between the two. Those who engage in self-injury more likely come from difficult family environments and have high exposure to trauma (D’Onofrio, 2007; Klonsky & Muehlenkamp, 2007). These childhood traumas include: emotional, physical or sexual abuse, and neglect, marital violence, family history of self-injury, critical parenting, peer victimization, childhood illness, loss of parent or guardian, and/or the breakdown in the structure of family roles where the adolescent has often had to play the parent role (Conterio et al., 1998; D’Onofrio, 2007; Froeschle & Moyer, 2004; Heath et al., 2009; Prinstein, 2008; White Kress et al., 2006; White Kress et al., 2004).

Critical parenting. Of all the childhood traumas, critical parenting may actually be the most harmful because adults are less aware of the impact it has on children. Critical parenting dangerously leads to the child developing a schema, suggesting interpersonal relationships lack adequate care or support during times of stress. Some studies have suggested a significant association between critical parenting and adolescents reporting alienation from their parents (Prinstein, 2008).

Critical parenting fosters an invalidating environment for the growth and development of a child—a central factor to developing self-injurious behaviors. The child grows up in a poor emotional environment where the carer does not listen to or attend to the child’s emotional needs (Hogg, 2010). In their book, Conterio et al. (1998) state, “One reoccurring theme in the very early lives of most [self-injuring] patients is a sense of something profoundly missing in the bond between themselves and their early caregivers” (p. 74). The child learns safety does not exist in intimate relationships (Trepal, 2010; White Kress et al., 2004). Critical parenting also fosters an
environment where difficulty tolerating the expression of emotions exists, thus beginning the cycle of learning maladaptive ways to regulate emotions (Dyl, 2008).

**Co-Morbidity**

Self-injurious behaviors often indicate additional mental health problems the adolescent may be experiencing. Studies have shown high co-morbidity between self-injury and Borderline Personality Disorder, Substance Disorders, Eating Disorders, Posttraumatic Stress Disorder, Obsessive Compulsive Disorder, Major Depression, Anxiety, and Suicidality (Hoffman & Kress, 2010; Klonsky, 2007; Levenkron, 1998). In opposition to popular opinion, Klonsky & Muehlenkamp (2007) found anxiety may be more strongly correlated to self-injury than depression because anxiety closely relates to the emotional pressure that often triggers self-injury. In addition, adolescents who self-injure more likely report suicidal ideations, plans, and attempts than those who do not self-injure (Nock et al., 2010).

**Rates on the Rise**


Like other disorders that have emerged out of a particular time and place, reflecting the cultural condition of that time, self-injury has materialized as a new pathology of this particular time, specifically reflecting the cultural situation in which we currently find ourselves (p. 30).

Our culture increasingly emphasizes the “quick fix”—immediate gratification and resolution of problems. Society no longer tolerates being uncomfortable. Humanity is becoming increasingly disenfranchised and disconnected from its extended community and family. This causes
increasing isolation and gives children fewer adults with whom to make meaningful connections as confidants (Conterio et al., 1998; D’Onofrio, 2007).

Social Learning Theory

With fewer adults in their lives, adolescents often turn to those around them. Behaviors of others often influence adolescents harming themselves. Many report having heard about self-injury from a friend, family, or the media (Nock, 2009). Muehlenkamp et al. (2008) hypothesize Albert Bandura’s social learning theory plays a key role in the sudden increase in adolescent self-injury. Bandura’s social learning theory posits “behaviors such as [self-injury] can be learned through direct and indirect experiences within the social environment via social modeling” (p. 234). In a study conducted by Heath et al. (2009), 43.6% of participants reported their self-injury was learned socially, either through knowing someone else who engaged in the behavior or by reading about it or seeing it through the media.

Media. Self-injury in the media has bombarded adolescents in the last decade. Celebrities, such as Angelia Jolie, Johnny Depp, and Drew Barrymore, have begun talking about their self-injurious behaviors. Movies, such as Thirteen and Manic, and Pink’s newest music video for Perfect portray adolescents who self-injure. As media and the internet increase awareness of self-injury, the behavior may be viewed as a normative and acceptable behavior (Heath et al., 2009). In recent years, internet chat forums have quickly gained popularity as a place where adolescents can obtain information on self-injury techniques and give each other support and encouragement for the behaviors (Kibler, 2009).

Personal connection. In a qualitative study done by Moyer & Nelson (2007), many of the students interviewed learned about self-injury as a “helpful” technique from a friend. One student stated, “A couple of my friends were doing it at school and they told me about it…I
couldn’t imagine how people could inflict pain on themselves. And after I did it, instead of hurting, it actually felt, like better, instead of pain” (p. 45). Preadolescents who had a best friend who engaged in self-injury were more likely than others to pick up self-injury within one year. In the article Introduction to the Special Section on Suicide and Nonsuicidal Self-Injury: A Review of Unique Challenges and Important Directions for Self-Injury Science, Prinstein (2011) states, “Research suggests that the most consistent and powerful predictor of adolescents’ decisions to engage in a risky behavior is their belief that their peers engage in a similar behavior” (n.p.). Whether used to achieve attention, support, or a sense of belonging, this shared experience helps normalize the behavior (Heath et al., 2009). Self-injury creates a powerful bond because of the belief that only others who self-injure can truly understand how they feel. This bolsters and fortifies group cohesiveness (D’Onofrio, 2007).

“Cutting clubs”. Adolescents have recently begun turning their self-injury into a group activity, causing a new phenomenon of “cutting clubs”. These cutting clubs can be found in schools or in on-line chat rooms where adolescents who self-injure trade tips about cutting and hiding their scars, and act to help normalize the self-injurious behavior. This very dangerous phenomenon can turn the act of self-injury into “one-upmanship” where adolescents try to prove they can handle more pain than their peers by making their cuts longer, deeper, and on more sensitive areas of the body (Booth, 2004).

**Role of the School Counselor in Individual Crisis Response**

The American School Counseling Association (2005) recommends delivering services to students through four components: school guidance curriculum, individual student planning, responsive services, and system support. Often due to overwhelming case loads, individual crisis response becomes the most pressing issue for school counselors to manage. This becomes
particularly true when a student presents with self-injurious behaviors. During these situations, literature recommends acting as a frontline responder and as a student advocate.

**Frontline Responder**

Because self-injury often begins and ends in adolescence, school counselors are in a unique position to intervene as a frontline responder. In fact, a school counselor may become aware of students’ self-injurious behaviors before their families and others outside the school setting (Froeschle & Moyer, 2004; White Kress et al., 2004). The frontline responder’s responsibility does not lie in curing the adolescent of self-injury. This is a long-term, multidimensional process the majority of school counselors do not have time to afford, and it does not fit within the scope of a school counselor (D’Onofrio, 2007; Roberts-Dobie & Donatelle, 2007).

As frontline responders, school counselors play a crucial role in the pathway to treatment. In a 2004 qualitative study of those who self-injured, the ones who eventually decided to seek professional help for their behavior first reported their self-injuring behavior to a school mental health professional (D’Onofrio, 2007). As frontline responders, school counselors need to recognize the warning signs of an adolescent who self-injures, approach the adolescent in a calm and caring manner, assess the adolescent’s current situation, and open the adolescent to pathways of help.

**Warning signs.** School counselors need to be aware of the defining behaviors and risk factors associated with self-injury in order to recognize the students who may be in need of help (White Kress et al., 2006). Adolescents who self-injure may be very difficult to distinguish from their peers because they hide the outward manifestation of their behavior. They appear as an intelligent, helpful, sensitive, caring adolescent on the exterior, but deep down they feel invisible
and have a hard time making their needs known to others (Galley, 2003, n.p.). With the numerous students on a school counselor’s case load, the importance lies with the ability to quickly evaluate a student beyond the outward appearance.

Key characteristics of adolescents who self-injure include negative affect and obvious deficits in emotion regulation. Many who self-injure describe themselves as feeling nothing or unreal. They often tend to be alexithymic (difficulty understanding and identifying emotions), and have extreme difficulty expressing their emotions to others (Klonsky & Muehlenkamp, 2007). Adolescents who self-injure often do not form close attachments with others (Levenkron, 1998). They have very low self-esteem and often exhibit self-hate and self-criticism (Klonsky & Muehlenkamp, 2007). Contrary to popular belief, adolescents typically self-injure when feeling rejected, angry toward themselves or another, self-hatred, and numbness, rather than when feeling sad or worthless (Nock et al., 2010).

Adolescents who self-injure have higher levels of reactivity in response to stress and lower levels of stress toleration. They tend to make internal, stable, and global attributions to life events rather than external, transient, and specific attributions demonstrated by the general population (Guerry & Prinstein, 2010). Many studies have described adolescents who self-injure as very impulsive and as having a negative body image (Froeschle & Moyer, 2004; Rettner, 2010; White Kress et al., 2004). Adolescents who self-injure also more likely participate in additional “risky” behaviors such as unprotected sex, sex with strangers, dangerous driving, and substance use and abuse (Hoffman & Kress, 2010; Laye-Gindhu & Schonert-Reichl, 2004).

Self-injury often begins with a triggering event in an adolescent’s life. These events range from experiencing grief and loss, feeling pressure, remembering a bad memory from childhood, or rejection from family or peers (White Kress et al., 2004). Many preadolescent girls ages 10-14
report peer victimization experiences concurrently with the beginnings of their self-injury (Prinstein, 2008).

**Approaching a student.** When asking an adolescent about self-injury, one needs to be mentally and calmly prepared to hear the answer. In a Delphi study conducted by Kelly, Jorm, Kitchener, and Langlands (2008), adolescents endorsed not asking a person about self-injury until prepared to react calmly to the answer. Talking about the injuries must not frighten and overwhelm the counselor, or the adolescent may dismiss the counselor as not being able to help—alienating a student further and causing a rift in a developing counselor/student alliance (Levenkron, 1998; White Kress et al., 2004). An effective helper needs to be confident, empathetic, knowledgeable, understanding, nurturing, and optimistic, and should convey these qualities to the adolescent (Levenkron, 1998). School counselors also need to manage their reactions to a student’s self-injury or they may pursue their own treatment agendas, rather than focus on the needs of the student (Hoffman & Kress, 2010).

**Assessment.** When conducting an assessment with an adolescent who self-injures, the assessment needs to be comprehensive, but it should be done in a casual conversational style to make the student feel at ease. Formal assessment tools can provide valuable information, but make it difficult to establish trust and rapport with the student (D’Onofrio, 2007). The four key issues a school counselor needs to assess include: suicidality, level of risk, co-occurring conditions, and functionality of the self-injury.

**Suicidality.** While self-injury does not usually equate suicidality, adolescents who engage in self-injurious behaviors have a significantly increased risk for suicidal thoughts and attempts (Nock et al., 2010). As self-injury becomes more chronic and enduring, it may no longer work and suicide becomes a more likely option (Laye-Gindhu & Schonert-Reichl, 2004). Because of
this, adolescents who self-injure should be routinely assessed for the intent and motivation of their injuries. A suicide attempt can often occur if an adolescent reports “being repulsed by life, having greater amounts of apathy, self-criticality, fewer connections to family members and less fear about suicide” (Klonsky & Muehlenkamp, 2007, p. 1049). However, while it important to assess for suicidality, to overemphasize it in the assessment process may actually be counterproductive because the student may feel once again misunderstood (D’Onofrio, 2007).

**Level of risk and co-occurring conditions.** Adolescents who self-injure should also be assessed for the level of risk to themselves. Some important factors to consider include: severity of physical injury and need for medical attention, tools used to self-injure and whether or not the adolescent shares these tools with others, appropriate care of wounds, age of onset, frequency of the behavior, and co-morbidity with other mental health issues (Hoffman & Kress, 2010; White Kress et al., 2006).

**Function of the behavior.** It is essential to understand the function of the self-injury from the adolescent’s perspective (Klonsky & Muehlenkamp, 2007; Trepal, 2010). Understanding emotional states and triggers for the self-injuring behavior; whether or not family and friends know about the adolescent’s behavior; and the adolescent’s recent life experiences, past traumas and current life stressors helps the school counselor fully understand the student’s behavior. Once understood, the adolescent’s level of risk becomes more evident and the counselor can determine the next steps to treatment (White Kress et al., 2006). If the adolescent is found to be at high risk, he or she should be immediately referred to emergency services. If low risk, the school counselor should continue to monitor the adolescent on a regular basis because risk level can change suddenly (Hoffman & Kress, 2010).
**Student Advocate**

After first having learned of an adolescent’s self-injuring behavior and once the initial crisis period has passed, the school counselor acts as an advocate on the adolescent’s behalf. White Kress, Gibson, and Reynolds (2004) state: “Counselors can serve as powerful advocates to students who self-injure through challenging a culture that may contribute to adolescents’ challenges and by hearing the adolescent’s stories, validating their experiences, and providing a safe refuge” (p. 200). The two key roles in advocacy for a student who self-injures include: being a helping adult who will listen with an open mind and working within the limits of the position as a school counselor.

**Listen with an open mind.** A primary goal of working with students who self-injure should be to help them create a safe environment, and show them no fear of getting close to their anger, hurt and despair (Levenkron, 1998). The school counselor can fulfill the important role of a compassionate witness to the adolescent’s struggles by recognizing the person behind the behavior and by developing a trusting relationship and fostering a strong alliance with the student (D’Onofrio, 2007; White Kress et al., 2004).

Studies have shown help for adolescents who self-injure can be as simple as a safe and trusting relationship where true communication and care occurs (Rissanen, Kylm, & Laukkanen, 2009). School counselors must reserve judgment and convey understanding and a sense of hope (Conterio et al., 1998). The adolescent needs to make an authentic connection with another person where the exchanges of emotions occur in a healthy manner. School counselors can serve this important function (Trepal, 2010).

While helping an adolescent who self-injures, school counselors should not try to prevent the act of self-injury. This can actually do more damage than good. Research shows trying to
preventing people from self-injuring can actually increase the frequency and severity of the self-injurious behavior (Hogg, 2010; White Kress et al., 2004). In a qualitative study conducted by Moyer and Nelson (2007), some adolescents reported they had family members yell at them to stop their behavior, but it only made them feel worse so they cut even more. Instead, the school counselor should focus on the underlying feelings and function of the behavior not on the physical effects (Dyl, 2008). Focusing on the wounds and the lurid details of the self-injuring behavior can actually glorify the behavior in the eyes of the adolescents who self-injure. It may also serve as a technique to distract from really focusing on the underlying issues (Conterio et al., 1998).

Work within the limits of a school counselor’s practice. Individual therapy falls outside the scope of practice of school counseling, but the school counselor can work in conjunction with an outside therapist to help support the adolescent within the school setting. The supports a school counselor can provide include: (a) teaching students healthy coping strategies and assertiveness training, (b) developing a safety plan and a safe kit to use while in school, (c) increase the adolescent’s sense of belonging and contributing to the school community, and (d) create a 504 plan if necessary.

Healthy coping strategies and assertiveness training. School counselors can play a key role in an adolescent’s journey to healing by teaching healthy coping mechanisms in response to stress (Kibler, 2009). Helping the adolescent begin to make connections between behavior, thoughts, and feelings, and finding which coping strategies work provides an effective method for the work of a school counselor (D’Onofrio, 2007). A study conducted by Nock, Prinstein, and Sterba (2010) showed actively engaging activities, such as walking, talking to a friend, or doing a hobby work better as replacement coping strategies than passively engaging activities
such as watching television or sleeping. Prescribing substitute behaviors like snapping a rubber band or writing on oneself with marker is not a valuable alternative. They only focus on releasing tension through behaviors rather than through communicating the underlying emotions. Also, one should not recommend to an adolescent who self-injures to hit or throw soft objects. This just reinforces the connection between anger and violence (Conterio et al., 1998).

Assertiveness training also teaches the adolescent very valuable skills. Many adolescents who self-injure have difficulty standing up for themselves and their feelings. Assertiveness training helps instill methods of empowerment while supporting the adolescent’s dignity by learning how to stand up for personal rights. The adolescent learns the appropriateness of disagreeing with others. This can be practiced through role playing with the school counselor (Froeschle & Moyer, 2004; Levenkron, 1998).

**Safety plan and safe kit.** A safety plan provides structure to help stabilize the student until professional mental health support can begin. It should include “identifying triggers, physical cues, and reducers related to self-injury; exploring safe people and safe places to go when wanting to self-injure; and the deliberate avoidance to objects which could be used to self-injure” (White Kress et al., 2004, p. 197). A safety plan should also state the student will not engage in self-injurious behavior while in school or on the school premises and that he or she will not discuss their behavior with other students at school in order to avoid contagion (Kibler, 2009). Included in the safety plan could be the development of a safe kit for the student to use while in school. The safe kit includes a journal and comfort items school counselors can use to assist the students in working toward an alternative to self-injury in a nonthreatening and meaningful way (Moyer, 2008).
Belonging and contributing. According to the book *Maintaining Sanity in the Classroom* by Dreikurs, Grunwald, and Pepper (1998), the desire to belong is one of the greatest needs of any child. Many adolescents who self-injure see themselves as worthless, inadequate, and unloved—they do not value their place in their social and family group. Once adolescents can begin to see they play an intricate and important role within their community, they begin to feel valuable. A school counselor can help increase a student’s sense of belonging and contributing by emphasizing and encouraging the student’s strengths and by finding an outlet for his or her talents within the school community. For example, if the student enjoys art, perhaps he or she can do a mural for a bland hallway in the school building. Or if the student has leadership qualities, he or she can organize the school community to create change in an area of need. The school counselor needs to emphasize wholeness and integrity and the strengths of students, not their weaknesses. Students are often over-aware of their weaknesses (Yip, 2006).

504 plan. Students who need special support during the school day but do not qualify for special education services may be eligible for a 504 plan, and in many school districts the school counselor coordinates these services for students. Adolescents who self-injure may need a 504 plan if they need to leave class for counseling sessions, medical care, or as a self-induced time-out to calm down and practice self-soothing techniques. The 504 plan helps make teachers aware of special circumstances in the student’s life and provides teachers with special accommodations for the student in the classroom (Froeschle & Moyer, 2004; White Kress et al., 2004).

School-Wide Response for Prevention and Intervention

While school counselors’ scope of practice does not include the diagnosis and treatment of mental and emotional disorders, their scope of practice does include the prevention and intervention of them (White Kress et al., 2004). Prevention and intervention of self-injury
requires school counselors to act as coordinators of education for school staff, parents, and students and as a liaison by linking systems and coordinating care by serving as a conduit for treatment (D’Onofrio, 2007; Roberts-Dobie & Donatelle, 2007).

School Counselor as Coordinator and Educator

**Education of self.** In order create an effective prevention and intervention program, school counselors must first educate themselves. As school counselors begin to increase their knowledge base of the beginning characteristics of self-injury, they can build effective support programs and begin to develop and implement preventative intervention strategies in their schools (Moyer & Nelson, 2007). School counselors should also use professional development days to visit treatment centers to gain quality referral sources and to better aid families in the decision making process of finding treatment (White Kress et al., 2004).

**Education of staff.** Many students see teachers as playing an important role in their lives; therefore, teachers can be principle helpers with students who self-injure (Rissanen et al., 2009). School staff needs to know how to recognize the warning signs of self-injury, how to manage student self-disclosure, and how to report suspected cases (Kibler, 2009; Roberts-Dobie & Donatelle, 2007; White Kress et al., 2004). One study revealed 64% of teachers reporting not having enough information about self-injury, but wanting more information about it (Rissanen et al., 2009). The school counselor needs to advocate for professional development workshops and even provide these workshops for the school staff. Through these workshops, school staff can begin to understand the needs of students who self-injure so they can assist those students more effectively and with less judgment (Moyer & Nelson, 2007).

**Develop protocols with administration.** As part of educating school staff, counselors and administrators need to create a school-wide protocol for working with students who self-injure.
Many schools have a crisis response plan that includes how to respond to students in crisis, but these plans often focus on suicidality and threats of harm to other students. Few crisis response plans have procedures for how to help a student suspected of self-injuring (Kibler, 2009; White Kress et al., 2006). All students with a mental health crisis should not be lumped into the same category and responded to in the same manner. In order to avoid this, the school should develop a response plan specific to students who self-injure before the crisis occurs. If teachers, administrators, and school counselors have an effective system in place which fosters communication and encourages a unified plan of action, the whole system can work as an informed and effective team committed to the same game plan (D’Onofrio, 2007).

**Education of students.** As a school counselor’s primary responsibility, the entire student body needs to be taken into consideration when a student goes “public” with self-injury. Contagion has been noted in high school students where an outbreak of self-injury followed an initial public incident (Heath et al., 2009). For these reasons a school counselor needs to attend to other vulnerable students in the school community particularly after the publicity of a case of another student’s self-injury. To help minimize risk of contagion, students need to be encouraged to limit their communication of self-injury with their peers, to not show their wounds and scars to other students, and to be helped individually by their school counselor (D’Onofrio, 2007).

**Self-injury groups.** While studies have shown self-injury groups to be an effective form of treatment, all of these groups were conducted in a clinical mental health setting with psychiatrists and nurses. Schools do not have the resources, nor do school counselors have the time, to dedicate to such an intensive form of treatment in order to carry it out effectively (Kibler, 2009). The close, intimate space of a group creates the perfect breeding ground for competition between those who self-injure—for attention and nurturance, for who can take the
most pain, and for the top status in the group. It can easily become a place for them to share “war stories” and gain tips and techniques for continuing the self-injuring behavior rather than stopping the behavior—turning the group into a “cutter club” (D’Onofrio, 2007; Kibler, 2009).

_Emotional intelligence classroom guidance lessons._ Adolescents who self-injure have shifted their complex psychological problems to the body because they have difficulty understanding and labeling what they feel. Alexithymia—having no words for feelings—is a deficiency in emotional intelligence. According to a recent study, while childhood maltreatment was the highest correlate with self-injury, “emotional inexpressivity” was the most highly correlated variable with maintenance of self-injury over time (D’Onofrio, 2007). In a study conducted by Mikolajczak, Petrides, & Hurry (2009), data showed students with high trait emotional intelligence scores, indicative of high emotion regulation skills, were less likely to self-injure. This data suggests it would be useful to incorporate programs targeting adolescents’ emotional competencies into school intervention programs. “Emotional intelligence aims to capture the individual differences in the extent to which people experience, attend to, identify, understand, regulate, and utilize their emotions and those of others” (p. 182).

Preventative guidance lessons could include topics on healthy coping skills, appropriate ways to express emotions, and establishing strong emotional support systems. Focusing on these skills in the classroom would help to provide an environment that encourages self-expression and the use of positive coping skills. While it would be most beneficial to focus on these topics in elementary school before self-injuring behaviors develop, students of any age could benefit from lessons focusing on these skills (Moyer & Nelson, 2007, White Kress et al., 2004).

_Education of family._ According to Roberts-Dobie and Donatelle (2007), parents should be educated for three reasons.
First, it makes parents more likely to notice self-injurious behaviors in their children.

Second, it informs them of what to do when they notice these behaviors. Third it informs them that the school has a plan for this behavior and can be of assistance (p. 263).

Family members need to be educated about the differing levels and severity of self-injurious behavior, how these behaviors differ from suicide, and how to help their child when the behavior reaches a crisis point (D’Onofrio, 2007).

In a qualitative study exploring parental views on how to help adolescents who self-injure, one parent stated, “If parents could get information about self-mutilation and if it was discussed at school, parents would not believe when seeing marks on their children’s hands that they were caused by a cat. As I did” (Rissanen et al., 2009, p. 1715). School counselors should not be afraid to discuss the negative feelings and emotions surrounding the adolescent’s self-injury with the family. As a service to affected families, school counselors could partner those just beginning on the journey of healing from self-injury with families who are further along in the process, or arrange for a peer group of parents to meet who all have adolescents who are struggling with this issue (Rissanen et al., 2009).

**School Counselor as Liaison**

**Conduit to therapy.** For mental health concerns, such as self injury, school counselors provide the key function of being a conduit to professional therapy. Parents need to be made aware of the distinction between the school counselor’s role of providing academic support versus the professional therapist’s role of providing mental health services (Roberts-Dobie & Donatelle, 2007). While school counselors can be supplementary to an outside therapist’s treatment, they cannot be the only source of mental health services for these students (Kibler, 2009).
In order to be an effective conduit to therapy, school counselors should proactively establish appropriate referral sources and community based resources to which they and the student and their families can turn to for support (Moyer & Nelson, 2007). This can be done by asking colleagues about successful experiences and calling therapists to ask about their experience with issues such as self-injury. A school counselor should also ensure the therapist’s availability and willingness to accept a client before referring the student (D’Onofrio, 2007; Roberts-Dobie & Donatelle, 2007).

A small amount of research has been done to determine evidence-based therapies effective in working with adolescents who self-injure. Cognitive behavioral therapies have received the most research attention as evidence-based treatment for reducing self-injury (Klonsky & Muehlenkamp, 2007). Dialectical behavior therapy (DBT), typically used with those who have borderline personality disorder, has also proven very effective because it works to improve emotion regulatory skills (Klonsky, 2007). In particular, an outpatient adolescent version of DBT shows promise with this population (Nock et al., 2007). Psychodynamic therapies have also begun to show empirical evidence in reducing self-injury. This may be due to the therapeutic elements of processing past relationships, building new positive relationships, increasing awareness of and expressing emotions, and developing the client’s self-image (Klonsky & Muehlenkamp, 2007). Other techniques gaining popularity, although there have been no official studies examining their effectiveness, include emotional regulation group therapy, art and writing therapy, and relational cultural models of therapy (Hogg, 2010; Inckle, 2010; Trepal, 2010).

Students who self-injure may also need to be referred to a physician if the severity of the behaviors warrants it because chronic self-injury runs a higher risk of infection (White Kress,
Gibson, & Reynolds, 2004). Therefore an effective school counselor should establish a list of physicians and pediatricians who feel comfortable helping an adolescent who self-injures.

**Linking the systems.** Finally the school counselor plays the liaison role of linking all of the systems together—the school system, the family system, and the outside community system. When accomplished successfully, the system provides a safer, more understanding school environment where students feel comfortable seeking help and self-injurious behavior is recognized early (Roberts-Dobie & Donatelle, 2007).

**Ethical Considerations**

In order to be effective advocates for students, school counselors must know the legal implications of working with minors as well as the ethics of privacy, confidentiality, privileged communication, and informed consent (White Kress et al., 2006). While the ethical debates relating to self-injury are too extensive to fully cover here, the school counselor needs to keep a couple of key issues in mind—parental rights and professional competence.

**Parental Rights**

Parents ultimately have the right to information about their child’s well-being. In fact, judicial decisions most often protect the rights of the parent to have access to information about their children, but school counselors have an ethical duty to balance this with the confidentiality rights of the student (Hoffman & Kress, 2010; White Kress et al., 2004). The American School Counseling Association ethical codes state, “Provide parents/guardians with accurate, comprehensive and relevant information in an objective and caring manner, as is appropriate and consistent with ethical responsibilities to the student” (B. 2d). The school counselor should seek legal counsel with the school district attorney when unsure over the decision to break
confidentiality, but the school counselor must always consider the serious consequences and liability that may occur by withholding information from the parents (White Kress et al., 2006).

Although parents may have the legal right to know of a student’s self-injury, the school counselor has an ethical responsibility to try to get the minor’s permission before sharing anything. An ideal situation would be the counselor and the student drafting a plan for disclosure together, and then the student discloses to the parents in person in the presence of the counselor. This removes the ethical and legal burden from the counselor and gives the student more control over a situation which may feel out of their control (D’Onofrio, 2007; Froeschle & Moyer, 2004; Hoffman & Kress, 2010).

**Professional Competence**

The ASCA ethical code states a school counselor must “function within the boundaries of individual professional competence” (standard E. 1a). This means that school counselors should only practice within the boundaries of their education, training and experience and regularly seek supervision and consultation when encountering issues with less familiarity (Froeschle & Moyer, 2004; White Kress et al., 2006). Because self-injury has developed into such a prevalent issue for today’s adolescents, school counselors have the ethical and legal obligation to educate themselves about self-injury and implement appropriate plans of action (Froeschle & Moyer, 2004).

**The Need**

In a survey of 443 school counselors, only 6% identified themselves as “highly knowledgeable in working with self-injurers.” Almost all (92%) of respondents reported an interest in learning more about self-injury (Roberts-Dobie & Donatelle, 2007, p. 260). With the
sweeping epidemic of adolescents self-injuring, school counselors need to understand, recognize, and already have an action plan in place.

One can find a large amount of literature describing a school counselor’s work helping students with mental health issues such as suicidality or eating disorders, but a very small amount of literature exists which aids the school counselor in working with the increasing self-injuring adolescent population (D’Onofrio, 2007). In one national questionnaire study, school counselors requested pre-packaged materials for training teachers, staff and parents, and for teaching classes and facilitating groups, as well as knowledge of good resources for information (Roberts-Dobie & Donatelle, 2007). The current available resources do not provide school counselors with everything they need to create a school-wide prevention and intervention program within their schools.

Self-injury is a dangerous, futile symptom of deeper psychological pain that ultimately diverts an adolescent’s energy from focusing on relationships, career, and creativity (Conterio et al., 1998). The appropriate student response system and school-wide prevention and intervention program can ultimately help thousands of adolescents to not struggle in silence and get the beneficial help they need to cope with their pain.
References


