Helping Parents Cope with Adolescents Who Self-Injure: Strategies for School Counselors

Julia S. Chibbaro

ABSTRACT

Professional school counselors experience unique challenges as they struggle to provide information to parents about self-injurious behaviors and methods to cope with adolescents who self-injure. This paper explores self-injurious behaviors, discusses some of the reasons why adolescents practice self-injury and recommends six strategies that professional school counselors could use with parents whose adolescents self-injure.

I self-injure because it grounds me and it makes me feel whole. When I injure myself I feel a sense of relief and calmness. Sometimes I do it to punish myself. [Female, age 18, (began self-injurious behavior 10 years ago)] *–Martinson, D. (1998)*

Self-injury is used by approximately 1% to 4% of the United States general population as a way of dealing with overwhelming feelings while an estimated 13% of adolescents reported engaging in self-injurious behavior (Ross & Heath, 2002). Professional school counselors (PSCs) often become aware of self-injurious behaviors before parents, family members, and persons outside of the school setting (White Kress, Gibson, & Reynolds, 2004). School counselors may be the first professional seen by students who self-injure and actions taken by school counselors may determine if and when students receive additional professional help (Froeschle & Moyer, 2004). As self-injurious behaviors become more visible in the school setting, many PSCs need to know how best to help both students and parents (White Kress, Drouhard, & Costin, 2006). Adolescents who self-injure typically begin the behaviors in middle school and will often continue into their late twenties (Austin & Kortum, 2004; Ross & Heath).

I like the thought that it is ME causing the pain for once, not someone else. [Female, 14, 9th grade]
–Martinson, D. (1998)

Self-Injury Defined

Self-injury has been defined as an act of attempting to alter a mood state by inflicting physical harm serious enough to cause tissue damage to one's body without leading to a result of death. The forms of self-injury vary and can include scratching, branding, cutting, self-hitting and burning (Patterson & Kahan, 1983). Of the various forms of self-injury, cutting is the most prevalent method used (Gallop, 2002; Ross & Heath, 2002). Self-injury is usually performed on the arms, wrists and legs, but the breasts, thighs, stomach, and genitals may also serve as self-injurious sites (Conterio, Lader, & Bloom, 1998). In regard to gender, females are more likely to self-injure than males (Ross & Heath).

I am full of anger and hurt. I feel like nobody cares. I do it because it is easier for me to hurt myself and deal with my pain then it is to tell someone and hurt their feelings. I would rather be the one hurting. I never want to make someone feel the way people make me feel, so I don't say anything. I keep everything to myself and then it builds up. I explode and then start cutting. [Female, age 17, HS senior (began self-injurious behaviors 7 years ago)]
–Martinson, D. (1998)

Contact Information:
For correspondence regarding this article please email Julie at jchibbar@westga.edu

Reasons for Self-Injury

Those who self-injure have identified several reasons for the behavior including the following: (a) avoiding overwhelming emotions by focusing on physical pain; (b) reducing numbness and providing a sense of being real; (c) keeping traumatic memories out of the present; (d) releasing the emotions of anger, anxiety, despair; (e) receiving care and support from others; (f) gaining control of one's life; (g) enhancing self-esteem (Austin & Kortum, 2004, White Kress, et al., 2004). Adolescents who self-injure may feel a sense of relief following the act of self-injury, but also may feel hurt, anger, fear and hate. Most people who self-injure will hide their injuries by wearing long sleeves or pants, even on warm days and adolescents who self-injure usually go to great lengths to hide their wounds and scars due to a feeling of shame and fear of the consequences if discovered (Gallop, 2002).

I get depressed, I don't know why. If anything goes wrong, at school or at home, if I forget my homework and a teacher shouts at me, if someone doesn't ring me when they said they would, silly stuff really. But after I self-injure I feel disgusted at myself, I feel as if, no matter how hard I try, I can't do anything right. I first cut when I was 14 after being raped by my geography teacher. [Female, age 15]
–Martinson, D. (1998)

Several life experiences correlate with self-injurious behaviors in adolescents including parental loss, violence in the family, childhood illness, childhood sexual abuse or rape, and familial self-injury (Conterio et al., 1998; Deiter, Nicholls, & Pearlman, 2000; White Kress et al., 2006). Of these, the two best predictors of self-injurious behaviors are histories of sexual abuse and family violence (Deiter, et al.). Variables which are most commonly identified as triggers for self-injury among adolescents include recent loss or death, peer conflict, intimacy problems, impulse control disorder and alienation from others or a feeling of disconnection (Kehrberg, 1997). Self -injurious behaviors should not be considered suicidal. Adolescents who self-injure are striving to feel better and their wounds are typically not life threatening (Lieberman, 2004; Stone & Sias, 2003).

School Counselors Work with Self-Injurious Adolescents

Professional school counselors are ethically obligated to keep student reported information confidential unless disclosure is required to prevent clear and imminent danger to the student or others (American School Counseling Association, 2004). Although self-injurious behaviors are not considered suicidal, professional school counselors should consider the potential for serious consequences and liability issues that may occur as a result of withholding this information from parents. PSCs should consult with other PSCs either in their own school or schools other than their own with regard to ethical decision making. Also, consultation with both school administration and district's attorneys should be considered (White Kress et al., 2006). In addition, professional school counselors should conduct a thorough self-injury assessment to determine the onset of the injury, whether or not the student has made changes in self-injurious behaviors over time, any medical complications (stitches, infections etc.), current life stressors, recent life experiences, and whether or not the student's family is aware of the self-injurious behaviors (Kress, 2003; White Kress et al., 2004). Determining if the student's home environment is safe is imperative and if issues of abuse are part of the student's report, the PSC should follow school protocol in reporting suspected abuse. Intervention efforts made on the part of PSCs are essential to helping adolescents understand and recover from self-injurious behaviors.

Professional school counselors should also provide faculty and staff with signs and symptoms of self-injurious behaviors as well as what to do if they suspect or know someone practicing self-injurious behaviors (Cornell Research Program, n. d.). Advocating for students and educating school personnel regarding self-injury will facilitate awareness and the identification and monitoring of student self-injurious behaviors (White Kress et al., 2004).

School Counselor Interventions

Intervention endeavors by professional school counselors with students who self-injure begin with the creation of a safe environment. Since many students who self-injure have a history of physical and sexual abuse, developing trust in adults is extremely difficult (White Kress et al., 2006; Zila & Kiselica, 2001). PSCs should make sure that students realize it is alright to discuss self-injury. PSCs should work with students to develop a safety plan emphasizing students' responsibility for self-injurious behavior which includes the identification of self-injury triggers (White Kress et al., 2004; Walsh, 2006). In addition, PSCs should teach students how to identify and verbalize emotions (Nichols, 2000). Creating a feeling vocabulary list and helping students to find words by prompting them with such questions as "If your wounds could speak to you, what would they be saying?" are helpful (Alderman, 1997; Favazza, 1996; Levenkron, 1998). PSCs should work with students to explore and develop alternative, healthy coping

behaviors. Teaching students cognitive problem solving skills such as defining a problem, considering solutions, making a choice, forming a plan of action to solve the problem and following through with the plan can be very helpful to students. To facilitate student safety, PSCs should assess issues such as depression, suicidal ideation, and familial history of suicide, social supports and any recent events which may have been stressful (White Kress et al., 2004). If appropriate, and the student's home environment is determined to be safe, parents should be called to school and provided information about self-injurious behaviors, referral information, support, and possible coping skills.

Working with Parents and Caregivers

Professional school counselors should be prepared for negative reactions from parents and caregivers, resistance to the information and a possible increase in family crisis (Trepal, Wester, & MacDonald, 2006). As parents and caregivers struggle to accept negative information, professional school counselors should help them to understand differences between self-injury and suicide while attempting to minimize problematic communication and conflict (Yip, 2005). PSCs should also be aware of cultural implications, though there has not been a stereotypical reaction based upon race observed (Trepal, et al.). Factors such as recent immigration, beliefs about health care, spirituality, and the level of community involvement may have an effect on parent and caregiver responses (Sen, 2004; Turell & Armsworth, 2000).

Following notification of parents and caregivers, the professional school counselor should provide a list of referrals in the community for treatment. PSCs can make either a partial or complete referral (Baker, 2001). A complete referral would involve disassociation from the student's case, while a partial referral would involve continued involvement while the student works with mental health professionals outside of the school (Kress, et al., 2004). In addition, a referral for inpatient or outpatient treatment may be appropriate. Professional school counselors should know which facilities specifically address self-injury. If the student is placed in an inpatient treatment center, the PSC should provide educational information to the facility and continue to monitor the student's educational progress. Upon returning to school, the PSC would help the student transition back into the regular school environment by providing services to the student as dictated by both the student and parents.

Strategies to Help Parents and Caregivers

Once parents and caregivers are aware of the self-injurious behaviors and have been provided referral information, they may benefit from additional information and assistance from professional school counselors (Pehrson & Boylan, 2004). Parents and caregivers may respond with this information as in any crisis situation and PSCs should provide emotional support and seek to instill hope (Campbell, Cataldie, McIntosh, & Miller, 2004). Based upon these assumptions and a synthesis of the current literature, strategies professional school counselors could use to help parents and caregivers are discussed. The strategies are not sequential and are provided as recommendations when dealing with parents whose children practice self-injury. The six strategies are as follows:

1. Educating parents and caregivers about self-injury
2. Dispelling myths surrounding self-injury
3. Approaching the situation as "no fault"
4. Knowing and understanding limitations in regard to self-injury
5. Trying to remain patient with those who self-injure
6. Creating a safety plan to prevent future occurrences and assist in emergencies.

Educating Parents and Caregivers about Self-Injury

Prior to educating parents and caregivers with information, professional school counselors could ask parents and caregivers what they already know about self-injury. Depending upon the response, PSCs should guide their discussions and information. Parents and caregivers should understand that self-injurious behaviors typically begin around age 14 (females more prevalent than males) and that the behavior is used as a coping mechanism to relieve unwanted emotions (Gallop, 2002: Ross & Heath, 2002). One way to help parents understand how self-injury serves adolescents in relieving emotional pain is to imagine a child who is riding a bicycle following a disagreement with a sibling and falls off of the bike skinning a knee. The focus is now on the skinned knee and the emotional anger felt previously has disappeared (Austin & Kortum, 2004). Parents and caregivers should be made aware that the forms of self-injury vary and may include biting, scratching, branding, cutting, self-hitting, and burning (Patterson & Kahan, 1983). However, of the various forms of self-injury, cutting is the most prevalent method used (Gallop, 2002; Ross & Heath).

Dispelling myths surrounding self-injury. There are several myths surrounding those who self-injure and parents should be aware of some of the myths in order to further heighten their awareness. One of the myths is that students who self-injure are trying to manipulate others. Self-injurers go to great lengths to hide their scars and prefer to present themselves as normal adolescents (Froeschle & Moyer, 2004; McLane, 1996). A second myth is that self-injurious behavior is synonymous with suicide. Self-injurious behaviors are performed for various reasons, but are usually not suicidal in nature (Zila & Kiselica, 2001). Another myth surrounding self-injurers is that students who self-injure are dangerous and will hurt others. In fact, the opposite is true. Self-injurious behavior is not violent toward others as it is performed to release emotional pain (McLane, 1996). A final myth surrounding those who self-injure is that self-injurers want attention and perform their injurious behaviors for the purpose of gaining attention (Levenkron, 1998). Parents and caregivers need to know that there is not any truth in the myths surrounding self-injurious behaviors. They can use this information to help others outside of their own family as they continue to become knowledgeable about self-injury.

Approaching the situation as "no fault." Parents and caregivers need to know that self-injurious behaviors are not designed to make others feel guilty or shameful. Professional school counselors should emphasize to parents that there is no reason to feel any blame. Some parents may feel guilty not knowing sooner about the self-injurious behaviors (Trepal et al., 2006). PSCs should work with parents and caregivers to externalize the self-injurious behaviors and relieve themselves of any thoughts they might have caused self-injurious behaviors and any feelings of guilt (LeGrange, Lock, & Dymek, 2003).

Knowing and understanding limitations in regard to self-injury. It is important for parents and caregivers to know that a self-injurer cannot be forced to stop hurting him or herself. Ultimatums do not work with self-injurers and can cause more damage to the self-injurer if self-injurious behaviors are suppressed (Austin & Kortum, 2004). Any type of punishment a parent or caregiver chooses to use is not likely to help stop the self-injurious behaviors. Professional school counselors can share information and resources available at the website http://crystalpalace.net. This website contains helpful information and additional links to information about self-injury.

Trying to remain patient with those who self-injure. Adolescents who self-injure tend to have a defensive barrier separating themselves from others. Self-injurers use this to protect their privacy. One of the best ways to help diffuse this barrier is to express compassion and understanding (Austin & Kortum, 2004). Parents and caregivers can recognize the pain and suffering the self-injurer is experiencing and let them know of their understanding (Levenkron, 1998). Professional school counselors can offer support to parents and caregivers and encourage patience. Reminding parents and caregivers that a self-injurer has to develop ways of expressing his or her emotions in a healthy manner and this may take a long time is useful.

*Creating a safety plan to prevent future occurrences and assist in emergencies.*Parents and caregivers should help the self-injurer develop a detailed safety plan. The self-injurer should first accept responsibility for his or her behaviors and for making future decisions as safe as possible. The plan should include identifying self-injury triggers, physical cues the self-injurer may perceive as well as any reducers to self-injury. The plan should also detail specific safe places and people to go to if wanting to self-injure and deliberate avoidance of objects which may be used to self-injure (White Kress et al., 2004). In addition, parents and caregivers should have a detailed plan to follow in case of any emergency situations. Family members and others who are likely to be in the presence of the self-injurer should also be advised of emergency procedures. Encouraging the self-injurer to be with others when wanting to self-injure is extremely important as self-injury is rarely done when others are near (Dallam, 1997).

Discussion

Cessation of Self-Injurious Behaviors

Cessation of self-injurious behaviors may be related to two important factors. The first factor that leads to cessation is the ability to identify and express feelings verbally and the second factor is learning to use appropriate behavioral alternatives to self-injury (Dallam, 1997). As PSCs focus on cessation and provide opportunities for students to learn both verbalization of emotions and healthy behavioral alternatives, the number of self-injurious behaviors among adolescents should decrease.

Advocating for Adolescents who Self-Injure

Professional school counselors can serve as advocates for those who self-injure and face challenges in intervention and prevention of adolescent self-injurious behaviors (White Kress et al., 2004). Providing

education to teachers, parents and students as to signs and symptoms of self-injurious behaviors as well as what to do if they suspect or know someone practicing self-injurious behaviors is imperative (Cornell Research Program, n.d.). Advocating for students and educating school personnel regarding self-injury will facilitate awareness and the identification and monitoring of student self-injurious behaviors (White Kress et al., 2004). Once parents and caregivers are aware of the self-injurious behaviors and have been provided referral information, they may benefit from additional information and assistance from the PSC (Pehrson & Boylan, 2004).

Summary

This paper explores self-injurious behaviors, discusses some of the reason why adolescents practice self-injury and recommends six strategies that professional school counselors could use with parents whose adolescents self-injure. It is the hope of the author that information provided in this paper will be helpful to professional school counselors as they face various challenges involved with adolescents who self-injure.

References

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

American School Counselor Association. (2004). *ASCA ethical standards*.Alexandria, VA: Author.

Austin, L., & Kortum, J. (2004). Self-injury: The secret language of pain for teenagers. *Education, 124*, 517-527.

Baker, S. B. (2001). *School counseling for the twenty-first century* (3rd ed.).Upper Saddle River, NJ: Prentice Hall.

Campbell, F. R., Cataldie, L., McIntosh, J., & Miller, K. (2004). An active ostentation program. *Crisis, 25*, 30-32.

Conterio, K., Lader, W., & Bloom, J. K. (1998). *Bodily harm: The breakthrough healing program for self-injurers*. New York: Hyperion.

Cornell Research Program on Self-Injurious Behavior (n. d.). *What do we know about self-injury?* Retrieved April 30, 2007 from www.crpsib.com

Dallam, S. J. (1997). The identification and management of self-mutilating patients in primary care. *The Nurse Practitioner, 22*, 151-164.

Dieter P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self-capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*, 1173-1191.

Favazza, A. R. (1996). *Bodies under siege: Self-mutilation and body modification in culture and psychiatry* (2nd ed.). Baltimore: John Hopkins University Press.

Froeschle, J., & Moyer, M. (2004). Just cut it out: Legal and ethical challenges in counseling students who self-mutilate. *Professional school Counseling, 7,* 231-235.

Gallop, R. (2002). Failure of the capacity for self-soothing in women who have a history of self-abuse and self-harm. *Journal of the American Psychiatric Nurses Association, 8,* 20-26.

Kehrberg, C. K. (1997). Self-mutilating behavior. *Journal of Child and Adolescent Psychiatric Nursing, 10*, 35-40.

Kress, V. E. W. (2003). Self-injurious behaviors: Assessment and diagnosis. *Journal of Counseling and Development, 81*, 490-496.

LeGrange, D., Lock, J., & Dymek, M. (2003). Family-based therapy for adolescents with bulimia nervosa. *American Journal of Psychotherapy,* 57, 237-251.

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

Lieberman, R. (2004). Understanding and responding to students who self-mutilate. *Principal Leadership, 4*, 10-13.

Martinson, D. (1998). Why do you SI? How does it make you feel? Retrieved May 1, 2007 from http://www.palace.net.

McLane, J. (1996). The voice on the skin: Self-mutilation and Merleau-Ponty's theory of language. *Hypatia, 11*, 107-121.

Nichols, P. (2000). Bad body fever and deliberate self-injury. *Reclaiming children and youth, 9,* 141-156.

Patterson, E. M., & Kahan, J. (1983). The deliberate self-harm syndrome. *Journal of Psychiatry, 140*,867-872.

Pehrson, D. E., & Boylan, M. (2004). Counseling suicide survivors. In D. Capuzzi (Ed.), *Suicide across the lifespan: Implications for counselors* (pp. 305-324). Alexandria, VA: American Counseling Association.

Ross, S., & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence, 31*, 67-77.

Sen, B. (2004). Adolescent propensity for depressed mood and help seeking: Race and gender differences: *Journal of Mental Health Policy and Economics,* 7, 133-145.

Stone, J. A., & Sias, S .M. (2003). Self-injurious behavior: A bi-modal treatment approach to working with adolescent females. *Journal of Mental Health Counseling,* 25, 112-125.

Trepal, H. C., Wester, K. L., & MacDonald, C. A. (2006). Self-injury and postvention: Responding to the family in crisis. *The Family Journal, 14*, 342-348.

Turell, S., & Armsworth, M. W. (2000). Differentiating incest survivors who self-mutilate. *Child Abuse & Neglect, 24*, 237-249.

Walsh, B. W. (2006). *Treating self-injury: A practical guide.* New York: Guilford.

White Kress, V. E., Drouhard, N., & Costin, A. (2006). Students who self-injure: School counselor ethical and legal considerations. *Professional School Counseling, 10*, 203-209.

White Kress, V. E., Gibson, D. M., & Reynolds, C. A. (2004). Adolescents who self-injure: Implications and strategies for school counselors. *Professional School Counseling,* 3, 195-201.

Yip, K. (2005). A multi-dimensional perspective of adolescents' self-cutting. *Child and Adolescent Mental Health, 10*, 80-86.

Zila, L. M., & Kiselica, M. S. (2001). Understanding and counseling self-mutilation in female adolescents and young adults. *Journal of Counseling and Development,* 79, 46-52.