Self-Injurious Behavior: Characteristics and Innovative Treatment Strategies

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Abstract

Self-injurious behavior is the intentional harming of one's own body. Little attention has been given to SIB in the past, particularly in terms of innovative treatment approaches. Adolescents are at a particularly high-risk for developing this ineffectual coping mechanism. School counselors are in a unique position to aid in the identification of this potentially deadly behavior. The characteristics and etiology of self-injurious behavior are presented, and innovative treatment strategies are outlined.

Self-Injurious Behavior: Characteristics and Innovative Treatment Strategies

Self-injurious behavior (SIB) is the deliberate alteration or damage of one's own body or body part without suicidal intent (Muehlenkamp, 2005). Although the most common methods include burning and cutting the skin, self-injurers (SI) may also scratch, interfere with the healing of wounds, amputate digits, break bones, inject toxins, or ingest harmful substances. Some SI will plan "accidents," engage in genital mutilation, or even complete castration (Conterio, Lader, & Bloom, 1998; Eke, 2000). Clarke and Whittaker (1998) report that an estimated 75% of SI utilize more than one method of SIB.

Most SI initially only injure areas of the body that are easily hidden from others. As SIB progresses, many will begin to have difficulty controlling impulses and injure in more observable areas. SI may also progress to more severe methods over time in order to maintain the same level of relief as their pain tolerance increases. A few SI cut words into their skin as a way of portraying how they feel. While some develop a ritual for harming (Conterio et al., 1998), others act randomly when the impulse to harm is strongest. Clarke and Whittaker (1998) add that it is not uncommon for females to incorporate the harming ritual into their grooming procedure.

SIB has been found to exist in every culture in the form of rituals and rites of passage (Conterio et al., 1998). SIB occurs at a rate of 4% in the general adult population and 14%-39% in the general adolescent population. These rates rise to 21% and 40-61% respectively in clinical populations (Nock & Prinstein, 2005). Research has shown that the prevalence is increasing. For example, only 51 cases were documented between the years of 1900 and 1977. However, in 1996 alone 110 cases were identified

(Eke, 2000). This increasing prevalence in SIB makes it critical for school counselors to be familiar with the characteristics of SI. School counselors are in the position to aid in the identification of SIB, which leads to the possibility of earlier treatment.

An Overview of Self-Injurious Behavior

Although SIB is found in virtually all races and classes (Edwards, 1998), SI are typically middle to upper class female adolescents or young adults, who are generally single and intelligent (Zila & Kiselica, 2001). Various populations, such as minorities (Edwards), sexually abused boys (Zila & Kiselica), and those in the prison system are underrepresented because they are less likely to seek treatment. Stone and Sias (2003) found that chronic SIB is also widespread among those with various psychiatric problems and disabilities.

Risk Factors

Average age of onset for SIB is “late childhood to early adolescence” (Stone & Sias, 2003, p.116) with the disorder varying between acute and chronic levels. Zila and Kiselica (2001) also found a correlation between the onset of SIB and menses in girls. Some SI state that onset of SIB occurred after a sense of relief followed an accident. The SI then turned to SIB in order to recreate the feelings of relief (Conterio et al., 1998).

It is common for SI to have traumatic childhoods, which may include deficits in parenting, childhood illness, or the illness or disability of a family member (Conterio et al., 1998). SI often relate that their parents did not meet their needs emotionally. Their mothers were emotionally unavailable, while their fathers tended to be openly cruel. As a result, anger surfaces as a central issue for many SI (Faulconer & House, 2001).

Conterio et al. also found that many SI come from families that were rigid, hyper-religious, or military-style, thus often extremely critical and intrusive. The opportunity to express emotions and think independently was diminished, resulting in the development of unclear boundaries between self and others. Stone and Sias (2003) describe family anomie syndrome as a home "characterized by normlessness and powerlessness" (p. 119). Conflicting messages and rules lead to a loss of control that may lead to SIB (Stone & Sias).

Stone and Silas (2003) found that parental alcoholism and/or depression was common within the home. Edwards (1998) reported that over 50% of SI had a history of sexual abuse. Conterio et al. (1998) add that 61% of SI reported suffering from an eating disorder. Childhood experiences, such as early parental conflict or child abuse, can also lead to gender confusion. It is not uncommon for SI to attempt to make themselves unattractive in the hopes of deterring possible rape or incest. Often SI are disgusted by their own body parts, in particular their own genital areas. Conterio et al. describe this "body alienation" (p. 101), or viewing of the body as a separate inanimate object, as the best predictor of SIB in adolescents.

This arrestment of healthy sexual exploration leads to the inclination of many SI to classify themselves as being sexually ambiguous. It is common for SI to have "strong longings to be a member of the opposite sex. This does not mean that they are latent transsexuals; instead it reflects their visceral loathing of their bodies and dissatisfaction with their selves" (Conterio et al., 1998, p.16). This confusion often leads SI to decide they do not like either gender, which makes achievement of sexual satisfaction difficult (Conterio et al.).

Male SI may at times admit to feelings of homosexuality while at the same time expressing homophobia. For some, even open acts of homosexuality may not be an identity, but a means of self-protection. Among female SI, some find it easier to express their sexuality with other women, who seem less physically threatening (Conterio et al., 1998).

SI share difficulties in three prominent areas related to communication and regulation of affect: inability to tolerate experiencing a strong affect, inability to develop and maintain a close connection with others, and inability to develop and maintain a positive sense of self. SI are likely to utilize avoidance as a coping strategy and have difficulty with problem solving, which are both related to feelings of powerlessness. SI also exhibit alexithymia, or the inability to express or describe feelings due to a lack of emotional awareness (Martinson, 2002).

Conterio et al. (1998) found that SI are hypersensitive to emotions and physical stimuli such as odor, noise, sound, and sights. SI attempt to avoid their own emotions because they are too intense and distressing to experience. They view all inner arousal and other sensations as being out of control, damaging, and invasive. Other characteristics and risk factors for SIB include perfectionist thinking, distorted body image (Stone & Sias, 2003), impulse control problems, fear of change, and low self-esteem (Conterio et al.).

SI exhibit a strong need for acceptance and love from others, often accepting the caretaker role in relationships. They also possess the inability to adequately care for themselves, the inability to maintain secure relationships, poor social skills, and "rigid, all-or-nothing thinking" (Conterio et al., 1998, p.140). SI appear to be fixed in a childish

state that is classified by narcissistic behaviors and pursuit of immediate gratification (Conterio et al.).

Types of Self-Injurious Behavior and Related Diagnoses

There are two main types of SIB: delicate and course. Females typically perform delicate self-injury where the wounds are made carefully in order to avoid main arteries and veins. Conversely, males are more likely to engage in the more severe method of course self-injury from which more serious injuries are likely to result (Conterio et al., 1998).

The two types of SIB can also be further divided into the categories of stereotypic or moderate. Stereotypic SIB, which is less common, tends to have a fixed pattern, is rhythmic, and is not symbolic. It is typically found in institutions and in people suffering from mental retardation, Rett's disorder, DeLange Syndrome, autism, Tourette's Syndrome, and Lesch-Nyhan Syndrome. Stone and Sias (2003) report that 35-40% of these individuals will press on their eyeballs, bang their heads against the walls, and/or chew on their fingers.

Moderate SIB, also known as superficial SIB, is the most common form and has three subcategories: compulsive superficial, episodic, and repetitive. Individuals engaging in compulsive superficial SIB tend to self-injure in ritualistic and repetitive ways several times daily. Episodic SIB occurs occasionally. Finally, repetitive SIB occurs in clients who have been diagnosed with repetitive self-mutilation or deliberate self-harm syndrome, which are both categorized as impulse disorders (Stone & Sias, 2003).

Repetitive self-mutilation syndrome is similar to the episodic type of SIB, but the SI's identity is now dependent on the self-injury. SI may describe themselves as being addicted and feel that they cannot resist the urge to engage in SIB. The individual who engages in deliberate self-harm performs chronic self-mutilation of low lethality that becomes a lifestyle (Stone & Sias, 2003).

SIB is typically found within various diagnostic labels and psychological syndromes (Conterio et al., 1998). The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) lists self-injury as a symptom of multiple personality disorder, borderline personality disorder, and sexual masochism (American Psychiatric Association, 1994). The most common diagnosis for individuals engaging in SIB is borderline personality disorder, but other diagnoses include other personality disorders, major depression, obsessive-compulsive disorder, panic disorder, bipolar disorder, psychosis (Conterio et al.), alcohol and substance abuse, eating disorders, factitious disorder (Faulconer & House, 2001), and impulsive disorders (Clarke & Whittaker, 1998).

Due to the presence of dissociation and/or anxiety and flashbacks, dissociative identity disorder or post-traumatic stress disorder are diagnoses likely in SI who have a history of chronic abuse. Bipolar SI use self-injury as a way to regulate affect during periods of mania. Very few individuals with schizophrenia engage in SIB, although those with borderline personality disorder may be found to have periods of psychotic thinking (Conterio et al., 1998). Individuals engaging in genital SIB are typically linked with psychotic illness and gender identity disorders (Catalano & Carroll, 2002).

Risk for Suicide and Aggression toward Others

Almost all SI use SIB as a means to concentrate aggression on a specific area of their body in order to prevent suicide (Conterio et al., 1998; Zila & Kiselica, 2001). According to Solomon and Farrand (as cited in Martinson, 2002), “the assumption is that the alternative to self injury is ‘acting normally’ but on the contrary…the alternative to self-injury is total loss of control and possibly suicide. It becomes a forced choice from among limited options” (p.5).

Many SI state an awareness of the reactions of others due to the stigma of SIB. As a result, they may admit to a suicide attempt in order to conceal the truth and “to be treated with more humanity” (Zila & Kiselica, 2001, p.50). However, if they have not admitted to a suicide attempt, SI become offended when addressed as suicidal. Already feeling ignored, now they also feel misunderstood (Conterio et al., 1998). It appears that when social rejection is a result of revealing their involvement with SIB, individuals are at a higher risk for attempted suicide (Stone & Sias, 2003).

Crowe and Bunclark (2000) have estimated that the risk of completed suicide for SI is 3% annually. Sometimes the SI will go too far, resulting in unintentional suicide. These cases, however, usually also involve comorbid severe major depression. Even though many SI maintain suicidal ideations, few act on them (Conterio et al., 1998). There is also a risk of other physical complications, such as hemorrhaging, as a result of chronic or severe SIB (Eke, 2000).

Rather than taking out aggression on others, SI turn the aggression inward by committing SIB. Rather than hurting someone else, they believe that it is “safer” to hurt themselves. When aggression toward others does occur, it usually involves male SI. It

is for this reason that male SI are more likely to spend time in either a psychiatric facility or in prison (Conterio et al., 1998).

Substance Abuse and Addiction

Alcohol and other drug abuse are common and play a large role in SIB. Fifty-six percent of SI admit to an alcohol problem and 30% admit to past use of street drugs (Conterio et al., 1998). A “drug-induced state” (Zila & Kiselica, 2001, p. 49) can trigger SIB, largely due to reduced pain perception and impaired judgment. Amphetamines, in particular, have been found to be associated with chronic SIB. Documented cases have involved self-enucleation (removal of the eye), hand amputation, and genital mutilation. Although rare, amphetamine induced SIB is believed to be underreported. European American males, 20 to 49 years old, diagnosed with psychosis and/or alcohol abuse are the most likely SI to be involved with amphetamines (Israel & Lee, 2002).

Some see the addictive quality of SIB as being related to other addictions, such as chemical dependency (Crowe & Bunclark, 2000). It has been theorized that SIB is “an addictive solution to emotional stress” (Conterio et al., 1998). Self-injury is seen as addictive because SI seem to develop tolerance to relief gained through the act. As the disorder progresses, SI must engage in the act in larger quantities by using more severe methods. Most SI relate experiencing anesthesia during the actual act of SIB (Zila & Kiselica, 2001), even though they feel pain normally in other situations (Conterio et al.).

Etiology of Self-Injurious Behavior

There are professionals across the country currently working to find a chemical, gene, or biological cause for SIB. Research has shown the possibility of chemicals

"similar to addictive opiates" (Conterio et al., 1998, p.25) being released in the brain during SIB, which could explain the development of tolerance and the habit forming quality of SIB. There is also evidence of deficits in the serotonin system of the brain in SI (Martinson, 2002). Some experts believe this serotonin deficit "may predispose some people to self-mutilation by making them tend to be more aggressive and impulsive than most people" (Focus Adolescent Services, 2003, par. 9). Researchers also believe that the brain's natural painkillers, the endorphins, play a role (Focus Adolescent Services).

There are also researchers who believe that SIB is not a chemical disposition, innate to the person, but a choice of behavior. Conterio et al. (1998) describe the Pressure Cooker Theory.

> The self-injurer comes to rely on action - not thoughts, fantasies, or works to gain relief from any uncomfortable feelings or thoughts. Ironically, her goal is to put an end to the pain and suffering she feels in her head, even if it means her body bears the brunt of an attack. She feels like she will "explode" if she does not release the tension. (p.20)

The most common precipitating factors to SIB include situations where SI experience rejection, anger, helplessness, or guilt (Stone & Sias, 2003), although the list of potential causes of SIB is wide-ranging and can include: attention seeking, ritual and symbolism, retaliation, sex, frustration, regression, manipulation, depression, risk-taking, low self-esteem, and self-punishment (Zila & Kiselica, 2001). Other causes may be anger reduction, desire to feel grounded rather than depersonalization, diverting attention from too-painful issues, feelings of self-control, or euphoric feelings (Martinson, 2002).

Regardless of the initial cause of SIB, there are two main models of motivation for SI: affect regulation and communication (Conterio et al., 1998). Affect regulation is the individual's attempt to maintain an emotional equilibrium (Martinson, 2002). This includes feeling in control, feeling "cleansed," physical calming, and mood regulation. Communication serves to illustrate to others their emotions, wishes, desires, and needs. It is also used to communicate with themselves. SIB can characterize "an act of vengeance, reenactment of earlier abuse, or a desperate cry for help and compassion" (Conterio et al.). SI feel unable to verbally express themselves so they revert to SIB (Martinson).

Before SIB, an individual often describes feeling agitated or anxious which will then rapidly intensify into panic and the typical symptoms of a panic attack (Conterio et al., 1998). Others describe feeling overpowering frustration, depression, rejection, tension, restlessness, and later depersonalization. SI repeatedly report feeling confused about what is the self and what is not the self and needing a "reference point to help…distinguish between the two" (Zila & Kiselica, 2001).

During the act, SI often do not experience physical pain and may not even be aware the act is occurring. Most individuals describe feeling empty or numb during the act, which is a form of dissociation. Conterio et al. (1998) report that some SI experience dissociation to a degree that self-injury is used to "prove to their minds that they are human" (p. 56). It is the extreme pain after the act that makes them feel alive. Feelings of calmness and relaxation can last as long as 24 hours after SIB, although they may be paired with feelings of guilt (Crowe & Bunclark, 2000).

Although SIB is an effective coping strategy for many SI (Clarke & Whittaker, 1998), other SI enjoy the pain involved in the act. For these individuals, SIB is a form of punishment. Most SI view themselves as being innately dirty or bad, a concept many learned from abusive parents. These individuals use SIB to "atone for their inherently sinful selves" (Conterio et al., 1998, p. 66). Milia (1996) believes that SIB is used as purification in order to reinstate the SI into good standing with another person or with authority in general.

In the case of previous abuse, SI feel they have little control over their own lives or bodies. SI often state that they would rather hurt themselves as opposed to some other person hurting them, because it gives them control over the course of the pain (Conterio et al., 1998). Some women with a history of abuse experience "Trauma Reenactment Syndrome," where the woman reenacts the previous abuse on herself. These women commonly demonstrate extreme secrecy and tend to repeatedly become involved in dangerous or abusive situations (Stone & Sias, 2003).

The majority of individuals who engage in SIB grew up feeling neglected and misunderstood. They began to feel that using words was not effective in getting their needs met. For some SI, the act demonstrated to others the intensity of their pain. It is common for SI to begin to enjoy the attention that they receive from others finding their wounds, which helps to keep them engaging in the act. For others, SIB may make them feel unique in that they think they appear to be tougher than those who do not self-injure. Another message may be one of vengeance, in which SI use SIB to gain revenge on the people who have inflicted pain on them. Some SI hold the belief that those who truly care for them will keep them from SIB. SI reinforce their view of the world being

unsafe and full of uncaring people when those close to them respond to SIB in an uncaring way. At this point, the act of self-injury itself will begin to replace actual relationships (Conterio et al., 1998).

SI who are also severely depressed or who have psychotic features are more likely to give explanations that are sexual or religious in nature (Crowe & Bunclark, 2000). For those who engage in genital SIB that is associated with religious delusions, the term Klingsor Syndrome is used (Eke, 2000). Some SI experience SIB as having the ability to aid in coping with sexual maturation or even sexuality itself (Faulconer & House, 2001). The pain of SIB may function to end feelings that sexual arousal is immoral or places one in danger (Milia, 1996).

Therapeutic Recommendations

Medication

Medications prescribed to SI are aimed primarily at treating associated symptoms that are likely to hinder the progress of counseling. Antidepressants are widely used for the treatment of depression, mood swings, and decreasing the amount of obsessive thoughts (Crowe & Bunclark, 2000; Conterio et al., 1998). For SI diagnosed with schizophrenia or for those who exhibit psychotic thinking, antipsychotics are recommended to weaken the ability to self-injure and decrease anxiety (Conterio et al.). The urge for genital SIB can sometimes be reduced by antiandrogen medication (Catalano et al., 2002). Anti-anxiety agents are prescribed for those suffering from anxiety or post-traumatic stress disorder. It is important to note, however, that there is a risk of abuse and dependence due to the desire of SI to deaden their feelings (Conterio et al.).

Counseling

Although medication alone is not a cure for SIB, it can be an integral part to the primary treatment of counseling. According to Conterio et al. (1998), founders of SAFE (Self Abuse Finally Ends):

> Self-mutilation is a learned behavior that can be unlearned. Self-mutilation is a behavior people rely on to relieve or distract themselves from difficult feelings, or to communicate emotions that they seem unable to speak. Once people learn to express themselves in other ways - verbally or in writing - the impulse subsides. (p.27)

Adolescence is the most advantageous time to begin recovery, which is typically a long-term endeavor, as short-term treatment has not proven effective. Various therapeutic schools have proven effective, including psychoanalytic, humanistic, and cognitive behavioral (Conterio et al., 1998). It is crucial for SI to identify and sort out the cause of self-injury in order to learn new behaviors (Stone & Sias, 2003). Zila and Kiselica (2001) favor a multifaceted approach to counseling that focuses on assertiveness, modeling, and reinforcing positive expression of feelings.

In order for clients to truly begin to choose not to self-injure, they must own their problem and know that the choice of SIB remains open (Crowe & Bunclark, 2000). However, the most essential limit that must be set early is that the client is not allowed to self-injure during any counseling session (Conterio et al., 1998). The primary treatment objective is for the client to begin to tolerate time between the initial impulse to self-injure and the implementation of SIB, which is referred to as the window of opportunity. During this time, it is important for the client to recognize and tolerate the

emotion and to focus on making a choice to self-injure or not. As clients learn to do this successfully, the window of opportunity should be increased. As clients become comfortable with this time, alternatives to self-injury should be explored, such as postponement tactics and other means of expression (Crowe & Bunclark, 2000). The goal is for the client to use the growing window of opportunity to identify feelings and thoughts and to utilize alternative coping skills (Conterio et al.).

Since relationships are often a problem area, the counselor must communicate to clients that he or she understands that SIB is a coping strategy. It may be common for the client to self-injure before a counseling session. If a client shows wounds, the counselor should assess the physical condition of the client immediately and seek medical attention if necessary. If the counselor is contacted by the client directly after self-injury, the counselor should limit the contact to an emergency assessment for medical need. It is recommended that the reasons behind SIB not be explored until next session, due to the client connecting SIB to “the feeling of being comforted” (Conterio et al, 1998., p. 187). Conterio et al. recommend in SAFE Alternatives that each client utilize a “toolbox” (p. 247) containing a no-harm contract, five alternatives, impulse control log, and writing assignments, which should all be used simultaneously.

No-Harm Contract

The client should participate in developing a no-harm contract that should state the responsibilities and expectations for both the client and counselor. This ensures that clients understand not only their own role and the counselor’s role, but also what to expect from treatment. Goals and a recovery plan should also be organized within the contract. When clients experience the impulse to self-injure, the contract should state

the steps to be followed to avoid engaging in SIB. It is crucial that the consequences outlined in the contract be upheld. Periodically, the contract should be reevaluated to determine if it is current with the client's progress (Conterio et al., 1998).

Many contracts contain a no-harm clause stating that clients will not self-injure during specific time spans. Many counselors require their clients not to self-injure not only during the sessions, but on days sessions are scheduled. The reasoning is that if clients have already soothed their anxiety, it will be more difficult to explore these feelings during the session. Conterio et al. (1998) explain that the contract is "designed to send a strong message from the beginning that self-control is possible" (p.214) and also that clients must find and utilize alternative coping skills. When clients violate one or more terms of the contract, Conterio et al. state:

> …we ask her to answer this set of written probation questions: (1) What precipitated the behavior? (2) What was the feeling? (3) Why did you choose destructive behavior? (4) What could you have done differently? (5) What can you do differently in the future? (6) Do you want to continue with a recovery program? Why? (p. 252)

Safe Alternatives/Coping Skills

Conterio et al. (1998) believe a minimum of five "safe alternatives" (p. 256), or alternative coping skills, should be in place before assigning the impulse control log. Clients should make a list of activities that comfort them or that distract from self-injury. It is important that several of the alternatives be ones that can be done at any location or at any time so clients are always equipped. It is also vital that clients choose alternatives that they can use in moderation, since compulsive urges are usually part of

the problem. Examples of alternatives include progressive muscle relaxation, writing in a journal, or deep breathing. Clients should understand that use of alternatives will not give them the quick relief that they have grown accustomed to, but will allow them time to work through the underlying problems (Conterio et al.).

Impulse Control Log

The impulse control log is another tool recommended for SI. Its goal is to create awareness by asking the client to “try to describe the impulse, to analyze it, and to postulate what it might be communicating” (Conterio et al., 1998, p. 253). The client should write about each feeling and thought associated with every desire to engage in SIB, regardless of if the act is carried out. The goal of the impulse control log is twofold: to be a substitute for SIB and to allow SI to understand the relationship between thoughts, feelings, and actions. The impulse control log allows the counselor to communicate to clients that the urge to self-injure is not a feeling, but a thought about a feeling. The urge to self-injure is present when clients experience what they see as a negative feeling. The counselor aids clients in identifying patterns, such as when they are most likely to self-injure and ways to avoid the behavior (Conterio et al.).

Writing Assignments

Writing assignments are used to aid clients in identifying, tolerating, and expressing conflicted feelings. Clients work to organize thoughts and to focus energy in safe ways. SAFE Alternatives recommends 15 specific writing assignments that are given sequentially. Assignments concentrate on identifying feelings, self-awareness, issues regarding gender or the body, and issues surrounding family and relationships. Each assignment becomes more challenging and strengthens analytical skills. Clients

choose the length of their writings, but thoughtful responses are typically 2-3 pages in length (Conterio et al., 1998). The following are some of the most used assignments:

Assignment 1 consists of clients writing their autobiography, which helps them put life events into perspective. Of the assignments, Assignment 1 is usually the longest and serves as a foundation for the others that follow. Assignment 2 asks clients to identify their strengths or weaknesses. While processing this activity, it is important to discuss how personality traits listed may either help or obstruct the therapeutic process. This assignment may also be utilized in group sessions so that feedback can be given regarding the accuracy of the clients' perceptions of the self. Assignments 3 and 4 ask clients to write about a female and a male that are the most influential to them. The counselor processes this exercise by discussing ways in which clients can use these relationships to conquer SIB. If the relationship is the type that undermines the clients' recovery, the counselor should aid clients in finding ways to cope with the relationship (Conterio et al., 1998).

Emotions are explored through Assignment 5, in order to improve clients' awareness of the role of emotion in SIB. Clients should explore fantasies and feelings before, during, and after self-injuring. Clients should answer the following questions: "What feelings do you want to create in others through this?" and "What feelings do you elicit in others, even if you don't intend to?" (Conterio et al., 1998, p. 263). Similarly, Assignment 6 asks clients to explore their anger in order to better manage and tolerate it. Clients should determine what types of circumstances most induce anger and also address three specific questions: "What kinds of thoughts arise once you're angry?,"

“What do you need to learn about handling your anger?,” and “Are you afraid of others seeing you angry?” (Conterio et al., p. 263-264).

Because conflicted relationships play a role in SIB, Assignment 7 asks clients to write about “what I can’t stand about the people in my life” (Conterio et al., 1998, p. 264). In processing this assignment, clients should explore ways to face their feelings about those relationships in a constructive manner. They should answer: “When do you feel more satisfied with these people?” and “What are some possible strategies for improving these relationships or dealing with the conflict?” (Conterio et al., p. 264).

In Assignment 8, clients identify hurt and victimization that may be fostering self-injury and develop mechanisms to help empower themselves. First, clients should identify specific ways they have been hurt and in what way, if any, this pain has been acknowledged by other people. Clients imagine what type of compensation, including punishment or revenge, would rectify the pain. Then clients identify what actual compensation is available and discuss the differences between the two. Assignment 9 is then focused on clients nurturing themselves, which diverts self-injury while developing self-esteem. Clients describe ways they can care for themselves and answer “Is there anything that keeps you from nurturing yourself more often?” (Conterio et al., 1998, p. 264-265).

Assignment 12 asks clients to explore negative thoughts about gender identity. Experiencing positive thoughts about one’s gender enables clients to begin cultivating their self-esteem. Clients should analyze negative preconceptions, myths, and thoughts held about their gender, so the counselor can aid clients in replacing those misconceptions with more accurate models. Several questions should be addressed

such as: “What feelings and ideas do you have about being a woman/man?,” “About body size?,” “What aspects do you find discouraging?,” “Positive or rewarding?,” and “Do you attribute greater ability, competence, or adequacy to men or women?” (Conterio et al., 1998, p. 267).

Assignment 13 requires clients to “say goodbye” to SIB (Conterio et al., 1998, p. 268). By this point in treatment, clients realize that self-injury is a negative way in which they define the self. Formally “saying goodbye” allows clients to look at other, positive definitions of the self. Client should write about how they imagine life without self-injury. Specifically, clients should identify things they will miss, in order to be prepared to experience some of the feelings that will arise (Conterio et al.).

Clients identify things they have learned about themselves in Assignment 14. This is an opportunity to explore clients’ internal motivations and ways in which they can make better decisions in the future. Clients should be able to state the most important, the most unpleasant, and the most surprising things they have learned through the process of completing the writing assignments. Lastly, clients make plans for the future in Assignment 15. Clients should have specific and concrete goals and objectives to help reach those goals. Enough goals should be set so that clients can complete them on a monthly basis for the next 6 months. Clients should also write about where they see themselves in 5 years (Conterio et al., 1998).

Conterio et al. (1998) note that some clients may find it beneficial to maintain a journal of experiences, thoughts, and feelings. Journaling as well as writing assignments in addition to those already mentioned can be incorporated into

counseling. It is crucial that clients not be allowed to write in a self-destructive manner. Clients should not use the journal or writing as a negative substitute for self-injury.

Conclusion

The increasing prevalence of SIB makes it critical for school counselors to be familiar with the characteristics and behaviors related to self-injury. Muehlenkamp (2005) even argues for the inclusion of a self-injury syndrome into the DSM. Although all SI are unique, knowing the commonalities among those engaging in SIB enables school counselors to have an initial frame of reference to begin working with the client. By understanding common family backgrounds and problems encountered by SI, school counselors are better prepared to piece together the story of the client in front of them.

We understand that school counselors may not be able to provide the in depth counseling needed by SI, however they still benefit from understanding the process SI are undertaking to overcome SIB. For effective treatment, it is crucial for counselors to understand the client and the reason SIB has become a coping mechanism. Medication might be an avenue to pursue, but it should only play a secondary role to counseling. Conterio et al. (1998) have set forth concrete steps for the counselor to follow to help SI realize the place self-injury holds in their lives. The writing assignments detailed by Conterio et al. are a clear-cut method for clients to work through identifying and expressing the feelings they have been keeping inside. The goal of counseling is for clients to find avenues other than self-injury to express themselves and cope with life’s hardships.

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