

# Understanding and Responding to Students Who Self-Mutilate



STOCK PHOTO IMAGE

Principals can help preserve the physical and psychological welfare of students who self-mutilate by improving awareness about the causes and signs of the behavior and establishing appropriate procedures for response.

BY RICHARD LIEBERMAN

Students who self-mutilate present significant challenges to school administrators and crisis teams. Self-mutilation is one of the least understood behaviors of adolescence and appears to be increasing at a staggering rate. Today, for every 100,000 adolescents, it is estimated that between 750 and 1,800 will exhibit self-injurious behaviors (SIB) (Suyemoto & Kountz, 2000). This translates to 150,000 to 360,000 students nationwide, more than 70% of whom are female.

Often known as *cutters*, students who self-mutilate repetitively and intentionally inflict bodily harm on themselves. They typically engage in the behavior secretly and may do so at school in bathrooms, empty locker rooms, or other secluded areas. They also might come to school with recent wounds or injuries. When these injuries are initially identified and the student

is referred to the school nurse or mental health professional, the student typically appears to be at low risk for suicide but is very likely at risk of further physical harm. This can create a quandary for school crisis teams as they attempt to create the appropriate response and intervention.

It is particularly alarming that self-mutilation appears to have a “contagious” effect among peer groups, which has implications both for the prevalence of the behavior in any given school and for the approach to prevention and intervention. Although schools are not appropriate environments for treating self-mutilation, principals can help preserve students’ physical and psychological welfare by improving awareness about the causes and signs of the behavior and establishing appropriate procedures to respond to students who self-mutilate.

## What Is Self-Mutilation?

There are several classifications of pathological self-mutilation (Favazza, 1996), but the most common and concerning to middle and high school educators is Repetitive Self-Mutilation Syndrome (RSM). RSM is referred to by many terms, such as *self-injurious behavior*, *parasuicidal behavior*, and *deliberate self-harm*. Forms of RSM include cutting, scratching, burning, head banging, preventing wounds from healing, picking, poking, and hair pulling. Of these, cutting is by far the most common behavior. RSM behaviors differ from many culturally sanctioned behaviors—such as ritual tattooing and piercing—that typically are intended as ornamentation or for established cultural, spiritual, or social purposes.

Experts generally consider RSM to be an impulse disorder. This group of disorders includes alcohol and substance abuse, suicide attempts, shoplifting, and eating disorders. (Evidence suggests that more than half the girls displaying RSM have had an eating disorder concurrently

---

*Richard Lieberman is a school psychologist who leads the Los Angeles Unified School District's Suicide Prevention Unit and cochair of the National Emergency Assistance Team of the National Association of School Psychologists (NASP). This column was created in cooperation with NASP.*

or at some other time [Favazza & Conterio, 1989].) Impulsive behaviors have two factors in common: First, they occur episodically, meaning that a student will not harm herself everyday but intermittently and usually following some precipitating event. Second, there is some gratification achieved by the behavior, which is why it becomes addictive and repetitive. As the adolescent cuts or burns herself, the brain secretes endorphins that are natural antidepressants. This is one of the disconcerting aspects of the behavior that makes it difficult for the observer to understand. It is a natural instinct to ask, "Doesn't that hurt?" but the answer is usually no. A student who is actively self-mutilating often does not report feeling pain, but rather a sense of relief, release, calm, or satisfaction. They also often feel isolated and ashamed afterward.

### Is It a Suicide Attempt?

Self-mutilation is clearly a sign of a troubled individual. A common misperception, however, is that students who self-mutilate are cutting themselves in an active attempt to commit suicide. Actually, the opposite appears to be true: RSM is a recurrent failure to resist impulses to harm one's body physically without conscious suicidal intent. In fact, these students are self-mutilating so they do *not* kill themselves. Although the suicidal student seeks to end his or her life and painful feelings, the student who self-mutilates seeks to feel better and, usually, is crying out for help. The wounds are typically not life threatening—for example on the inner thighs, forearms, and torso—as opposed to fully slitting the wrists.

This does not mean that suicide is not a concern. Although the self-mutilator may not be driven by suicidal intention during the act, he or she may be actively traveling down a very self-destructive path. At some point, self-mutilators may have

considered suicide or tried to harm themselves more seriously—or may do so in the future. For many of these students, RSM behaviors surface at a time of crisis when their coping skills are poor. They are at a particularly dangerous turning point when their negative thoughts evolve into harmful behavior. And, although self-injury is characteristically associated with girls, boys who display RSM are considerably at risk as well, particularly if they become suicidal. Adolescent boys are six times more likely to succeed at committing suicide than girls (Lieberman & Davis, 2002). Educators must stay vigilant in identifying and referring students who display RSM behaviors to provide appropriate interventions and assess suicide risk.

### Who Self-Mutilates?

Self-mutilating behaviors typically have an onset in late childhood or early adolescence and can last up to 15 to 20 years. Rates are at their highest in adolescent populations. Experts observe that 60% of elementary students with RSM are female but this percentage increases to as much as 80% in middle level and high school populations (Favazza & Conterio, 1988). The onset of RSM can be triggered by a specific stressful situation or simply by the extremely tumultuous nature of early adolescence. Dramatic hormonal swings, intense social dynamics, and the stresses of seeking both self-definition and group connectedness can exacerbate or trigger self-injurious impulses. Self-mutilation also can be associated with such disorders as borderline personality disorder and post-traumatic stress disorder (PTSD), and often occurs with depression. (Lukomski & Folmer, in press.)

Students who self-mutilate have never learned to cope with strong emotions and have a very negative self-image and poor emotional resiliency. Most feel chronic anxiety

and tremendous rage (usually against themselves), are dissociated from reality (emotional numbness), and have a sense of depersonalization and powerlessness. Their families are often characterized by divorce, neglect, or deprivation of parental care. Adolescents in these circumstances can experience a deep sense of loss that is usually associated more with an emotional distancing and inconsistent or lack of parental warmth and connectedness than with physical loss (e.g., one parent moving out of the house or death). RSM is sometimes a re-enactment of an early traumatic event. Broad research indicates that there is a strong correlation between chronic RSM and a history of childhood physical or sexual abuse. Therefore, as a standard procedure, it is important to inquire about current or previous episodes of physical or sexual abuse when collecting background information in any RSM or suicide assessment protocol.

### FACTS ABOUT RSM

- Self-mutilation is a maladaptive mechanism by which trouble teens cope with extreme and painful emotions.
- Behaviors include cutting, burning, hitting, poking, hair pulling and head banging; the most common form is cutting.
- Self-mutilators are typically *not* attempting suicide. By expressing their inner pain through injury, they are keeping themselves from suicide.
- Self-mutilators can become suicidal or accidentally kill themselves.
- RSM is an Impulse Disorder, similar to eating disorders, shoplifting, and substance abuse.
- Between 150,000 and 360,000 adolescents in the United States self-mutilate.
- More than 70% of self-mutilators are girls, many of whom were abused.
- Self-mutilators have low-self esteem and difficulty regulating their emotions. Many come from families characterized by divorce, neglect, and poor parental connectedness.
- Self-mutilators can have underlying personality or mood disorders and depression.
- Self-mutilation appears to have a contagious affect among peer groups.

## Why Do Adolescents Injure Themselves?

RSM is a maladaptive coping behavior that fulfills a multitude of needs in a troubled adolescent's life. Adolescents with RSM are unable to regulate or control their emotions. Things happen, tensions build, and they are driven to find relief from the pressure. Self-mutilation can serve as a means to relieve intolerable emotional pain; a form of self-punishment; a way to reconnect or "stabilize" the body in response to a dissociative episode; and, almost always, a means of communicating a deep sense of anguish. Typically, students who self-mutilate are *not* trying to manipulate others around them; they are trying to express what they cannot put into words. The injury externalizes and releases the pain, thereby helping them feel more in control of their emotions and body.

Clearly, students who self-mutilate are not in control; the behavior is controlling them. It is never appropriate—or effective—to discourage a student from self-injury by demanding they just "stop doing that!" Most students who self-mutilate cannot stop on their own. They need professional help that addresses the behavior and its underlying cause.

## Treating RSM

Unfortunately, no single, definitive approach has been identified to treat RSM. The most promising treatments involve a combination of cognitive behavioral therapy with medications for underlying disorders. (Lukomski & Folmer, in press.) Treatment must be provided by a clinical mental health professional. This can involve hospitalization or intensive outpatient care, but ideally the self-mutilator can maintain as normal a routine as possible. The goal is to help them identify the underlying cause of their pain and help them develop alternative coping and

communication skills that will build their self-esteem and create a sense of connectedness.

The self-mutilating behavior may continue for some time even during active treatment. This means that a student in treatment could be attending school and still be self-mutilating. School mental health personnel should coordinate with a student's private clinician and parents on appropriate interventions and responses, depending on the course of treatment. Because of the potentially contagious nature of the behavior, students should always be interviewed or counseled on an individual basis, never in a group setting.

## Intervention Recommendations

The best role for schools is to identify students who self-mutilate; refer them to and coordinate with community mental health resources; and offer safe, caring, and nonjudgmental support. This takes commitment from school administrators to ensure that appropriate personnel are trained to work with self-mutilating students. The violent nature of this behavior can be very unnerving and frightening to many people. Most students who self-mutilate, however, are better off attending school and knowing that they have the option to leave the classroom if they become overwhelmed. The school psychologist's or counselor's office may be the only safe place that a student struggling with the impulse to self-mutilate can go during the school day. These students need to connect with someone who cares and understands their plight; who is comfortable letting them talk, cry, or rant without criticism; and who can help them employ alternative coping mechanisms. Specific recommendations for schools include:

***Incorporate RSM training into your crisis team responsibilities.***

Because RSM involves physical harm to a student and indicates a seriously troubled youth, responding to a student who self-mutilates should be done by members of your crisis team and handled initially as a suicide risk. The crisis team should include the school's psychologist, counselor, or social worker as well as the school nurse and the appropriate administrator. The crisis team should address medical needs, assess the suicide risk, determine appropriate support resources (e.g., parents, private mental health professional), notify parents (or, if necessary, child protective services), and coordinate with relevant community resources. Students should always be dealt with individually and supervised until deemed safe or put in the care of their parents.

***Provide information to all adults on how to recognize signs of RSM.*** Parents and certain school personnel, especially coaches and PE teachers, are often in the best position to detect the physical evidence of self-mutilation. Students who self-mutilated may wear long sleeves regardless of warm weather in an effort to conceal their injuries. They may also exhibit signs of aggression, repressed anger, emotional numbness, or emotional pain in class work or in interactions with teachers or peers.

***Train all staff members to respond appropriately.*** Staff members should not further alienate or isolate students who self-mutilate; therefore, it is important not to react with criticism or horror. These students already suffer from a sense of shame and self-loathing and they need to be reassured and supported (see figure 1). The responding staff member must let the student know that he or she is required to inform someone if the student's behavior is deemed to be harmful—not as a punishment, but to help the student. The roles and responsibilities

of crisis team personnel (risk assessment and ongoing support) and other school staff members (identification and initial intervention) should be clearly differentiated.

**Use caution when educating students.** Unlike when educating students on depression and suicide prevention, information about RSM should be very general and kept within the context of seeking help from a trusted adult. Students should also be encouraged to tell an adult if they think a friend is self-mutilating. Messages should focus on RSM as a mental health problem that can be treated, the signs of emotional stress and risk behaviors, alternative coping strategies, and adults within the school who are trained to help troubled students. Descriptions of why or how students hurt themselves should be avoided because of their potentially suggestive effect.

**Notify and involve parents.** When a student is at risk for harm through self-mutilation, the school is responsible for warning parents and providing resources to help the student. It is best to call parents while the student is present so everyone hears what is said. The principal or their designee should always collaborate with staff members to determine whether notifying the parents will place the student in any danger. If there is danger or a history of abuse in the family, the school's duty to warn parents is satisfied through contact with the local children's protective services agency.

**Collaborate with the student's parents and psychologist.** Treatment can take time and, as appropriate, should be supported and reinforced at school. The school mental health professional should coordinate with the student's private clinician and parents to reinforce alternative coping mechanisms and implement appropriate interventions. (Coping mechanisms may include building

## SIGNS OF RSM

Detecting students with RSM is difficult because of the secretive nature of the behavior. Adults can look for certain signs, however, that may also indicate other risk factors such as depression or abuse:

- Frequent or unexplained scars, cuts, bruises, and burns, (often on the arms, thighs, abdomen) and broken bones (fingers, hands, wrists, toes)
- Consistent, inappropriate use of clothing designed to cover scars
- Secretive behavior, spending unusual amounts of time in the bathroom or other isolated areas
- General signs of depression
- Social and emotional isolation and disconnectedness
- Substance abuse
- Possession of sharp implements (razor blades, thumb tacks)
- Indications of extreme anger, sadness, or pain or images of physical harm in class work, creative work, etc.
- Extreme risk taking behaviors that could result in injuries.

better communication skills and teaching coping strategies such as exercise programs, relaxation, meditation, imagery, and art therapy.) Students should know at least one adult in the building to whom they can go if they feel the impulse to hurt themselves. Usually this would be the school psychologist, nurse, social worker, or counselor. No-harm agreements can be also be helpful. In a no-harm agreement, the student agrees in writing not to hurt him- or herself and has specific agreed-to alternatives and designated adults to contact if he or she feels the impulse to self-mutilate. Likewise, the school should clearly communicate to parents and the student how the school is required to respond.

**Limit contagion.** Limit activities that detail or focus on self-mutilating behaviors when RSM is identified in a subgroup on your campus. The best approach is one that is low key and individually focused to prevent imitative behaviors. Refrain from assemblies or videos on the topic. To the extent possible, monitor movies (such as *Thirteen*) or television programs that address RSM, because these can also trigger self-mutilating behavior in at-risk students. PL

## References

- Favazza, A. (1996). *Bodies under siege* (2nd ed.) Baltimore, MD: Johns Hopkins University Press.
- Favazza, A. R. & Conterio, K. (1988). The plight of chronic self-mutilators. *Community Mental Health Journal*, 24, 22-30.
- Favazza, A. R., De Rosear, L., & Conterio, K. (1989). Self-mutilation and eating disorders. *Suicide and Life-Threatening Behavior*, 19(4), 352-361.
- Lieberman, R., & Davis, J. (2002). Suicide intervention. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), *Best practices in school crisis prevention and intervention*. Bethesda, MD: National Association of School Psychologists.
- Lukomski, J., & Folmer, T. (in press). Self-mutilation: Information and guidance for school personnel. In A. Canter, L. Paige, M. Roth, I., Romero, & S. A. Carroll (Eds.), *Helping children at home and school II: Handouts for families and educators*. Bethesda, MD: National Association of School Psychologists.
- Suyemoto, K. & Kountz (2000). Self-mutilation. *The Prevention Researcher* 7(4).
- U.S. Department of Health and Human Services. (2001). *National strategy for suicide prevention: Goals and objectives for action*. Rockville, MD: Author.