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Self-Harm and Self-Injurious Behaviors in Female Adolescents: A Silent Epidemic, A Review in Literature

Abstract

Self-harm and self-injurious behavior is a widespread problem among female adolescents. Self-injurious behaviors are a dangerous coping strategy used by many female adolescents who lack in the primary needs for managing feelings and coping mechanisms. Although several of these adolescents share an association with diagnoses of traumatic childhood experiences, major depression, alcohol/drug use/abuse, and/or other recognized mental illnesses, the act of self-harm or self-injurious behaviors is not recognized as an isolated mental disorder by the 4th Edition of the Diagnostic and Statistical Manual of Mental Disorders. Thus, self-harm or self-injurious behaviors continue to remain a problem that is often a silent, and sometimes, deadly behavior among today's female adolescents. The research conducted surrounded the belief that female adolescents either go undiagnosed with regard to self-harm or self-injurious behaviors or are wrongly diagnosed and that the behavior of self-harm is often combined into categories of Emotional Disturbance. Self-injurious behaviors are not socially acceptable behaviors and therefore, many preconceived notions compromise the treatment of the adolescents. In a review of literature, and surveys of young female adolescents who engage in this behavior, the researcher will conclude that these identified behaviors in females must be acknowledged both by educators, families, and society.

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Self-Harm and Self-Injurious Behaviors in Female Adolescents: A Silent Epidemic

A Review in Literature

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April 15, 2009
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The research conducted surrounded the belief that female adolescents either go undiagnosed with regard to self-harm or self-injurious behaviors or are wrongly diagnosed and that the behavior of self-harm is often combined into categories of Emotional Disturbance. Self-injurious behaviors are not socially acceptable behaviors and therefore, many preconceived notions compromise the treatment of the adolescents. In a review of literature, and surveys of young female adolescents who engage in this behavior, the researcher will conclude that these identified behaviors in females must be acknowledged both by educators, families, and society.

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Self-Harm and Self-Injurious Behaviors in Female Adolescents: A silent epidemic
A Review in Literature

In today's society, individuals have become hardened by reality-based television shows and media portrayals of explorations into undefined territories that are designed to shock viewers. The status quo of information provided by the media forums no longer exists. However, when it comes to the admittance of an individual suffering from distinct signs of emotional or mental pain, our society neglects the severity of the situation. This lack of acknowledgement suggests that the recent escalation within this issue will only continue to intensify in problematic behavior for adolescent females. This literature review consists of whether the recognition of self-harm or self-injurious behaviors as an isolated mental disorder would prove a promising approach to further research within this area of study, and thus, solving this silent epidemic among female adolescents. This review analyzes and responds to the following areas of concern:

- The history of self-harm and self-injurious behaviors
- The various definitions of self-harm and self-injurious behaviors
- Understanding who exhibits self-harm or self-injurious behaviors
- Understanding the various forms of self-harm and self-injurious behaviors
- Treatment, education, and support for individuals who have been affected by self harm and self-injurious behaviors

Understanding the current trajectory of this crisis highlights the complexity of the self-harm and self-injurious behaviors demonstrated by many female adolescents, as well as what our nation needs to do to facilitate effective assistance and support for these females.

History of Self-Harm and Self-Injurious Behaviors

Instances of deliberate self injurious behaviors such as skin-cutting are recorded as far back as the old and New Testaments of the Bible. In fact, researcher Armando R. Favazza (1996) states “blood customs are amongst the oldest known to mankind” (p. 7). In her book, *A Bright Red Scream: self-mutilation and the language of pain*, author Marilee Strong (1998) states:

Blood is the most symbolic of all body substances, Favazza points out, and it seems likely that self-injurers are drawn to it as much for its symbolic powers of healing and transformation as for the concrete relief it provides. Blood, pumped through the body by the beating heart, is the essence of the life force. The spilling of blood both gives life, during birth, and takes it away, at death. Throughout time, blood has been used in religious ritual to demonstrate suffering and salvation, piety and enlightenment: from blood sacrifice to crucifixion, mortification of the flesh to the martyrdom of saints, from ecstatic stigmata representing the wounds of Jesus to the drinking of wine representing Christ’s blood at Holy Communion. Bleeding has always signified healing, from the bloodletting of early medicine to the psychological release of ill will known metaphorically as “getting rid of bad blood” (p. 34).

Furthermore, there are numerous accounts throughout history that include religious self-flagellation as a means of penance. Historically, these individuals took it upon themselves to judge their own behaviors and alleviate the corruption they felt to be too overwhelming. Similar to these individuals’ feelings of emotional torment in the face of guilt and divine judgment, many of today’s female adolescents carry a fear of their own self and thus, turn to

the act of self-harm or self-injurious behaviors to expel these feelings and have tangible evidence of self-healing.

What is Self-Harm and Self-Injurious Behavior?

Self-harm and self-injurious behaviors are conscious actions which are in need of consideration as an isolated mental disorder. Although it is not a simple task to define self-harm or self-injurious behaviors, there does tend to be broad signs and symptoms which can summarize prevalent characteristics of those individuals who self-harm. Strong (1998) states, “The most frequent diagnosis assigned to cutters is borderline personality disorder” (p. 60). Yet, this labeling has been under scrutiny from researchers in the field for some time. Strong reports, “Psychologist David Frankel says the problem lies with the way the *Diagnostic and Statistical Manual* focuses on the symptoms, not underlying causes. ‘The borderline label is so overused they should almost throw out the word’”(p. 61). Researcher Michelle Onacki (2005) defines self-injurious behavior as “deliberate, repetitive, impulsive, and nonlethal harming of one’s body. It includes cutting, scratching, reopening wounds, burning, inserting objects into body openings, and breaking bones” (p. 400). Researchers Karen L. Suyemoto and Marian L. MacDonald (1995) state that “the most inclusive definition is offered by Yaryura-Tonias et al. (1995): ‘Self-mutilation is a volitional act to harm one’s own body without intention to cause death’ (p. 33). This explication is broad enough to capture the essence of self-mutilation and its many possible categories. Also helpful is Alderman’s (1997) summary of characteristics of self-mutilation as an act that is done to oneself, performed by oneself, physically violent, not suicidal, and intentional and purposeful” (p. 47). The overall damage caused by individuals who self harm or participate in self-injurious behaviors is usually not life-threatening, though not always. Because the individual will

usually harm the skin, the major or long-term damage caused to the individual is most often scarring. However, many of the consequences caused by this type of behavior have a hidden damage that is still profoundly complex and largely misunderstood. Strong (1998) states, “The fields of research that are adding most rapidly to our understanding – developmental psychology, neurochemistry, posttraumatic stress disorder research, and the psychology of abused children – are either relatively new or currently in a state of very rapid change (p. 62). However defined, self-harm and self-mutilation is a desperate act which is accompanied by lasting physical, emotional, and mental results.

Understanding the various forms of self-harm and self-injurious behaviors

Individuals who self-harm or exhibit self-injurious behaviors have many different reasons for their actions. According to researchers Suyemoto and MacDonald (1995), an examination of literature suggested eight differentiable theoretical models addressing why adolescents might engage in self-mutilation: behavioral, systematic, avoidance of suicide, sexual, expression of affect, control of affect, ending depersonalization, and creating boundaries” (p. 162). Suyemoto and Macdonald cited the earlier work done by the renowned Armando Favazza, an American author and psychiatrist who is best known for his studies of cultural psychiatry and deliberate self-harm. Favazza’s work is quite detailed in how he defines the various motivations that associate with self-harm and self-injurious behaviors. Favazza has isolated eight different models in which he proposes as concepts to explain the motivation that lies behind individuals who self-harm. These eight models are distinguished as: behavioral, systemic, suicidal, expression, control, boundaries, and depersonalization (Suyemoto & MacDonald, 1995, p. 163).

The behavioral model is based on the idea that environmental factors may cause, attribute to, or even continue the behavior of the individual who engages in self-harm or self-injurious behaviors. Favazza's rationale is that the behavior is "reinforced either through external reactions resulting in secondary gain" (Favazza, 1989; Offer & Barglow, 1960), or "through the feeling of relief or release that cutting engages (Simpson, 1980)" in an individual who engages in self-injurious behaviors (Suyemoto & MacDonald, 1995, p. 163). Thus, this behavioral model stresses that one who exhibits behaviors such as cutting or burning connect this behavior, including the pain it causes and the after care received, to an earlier event that somehow reinforces this behavior. This would attribute this behavior to predictable changes following the engagement of self-harm or self-injurious behaviors. Researchers Zila and Kiselica (2001) state that self-injurious behavior "often elicits an active response from members of the individual's environment, which serves to diminish the number of subsequent attempts" (p. 47). Although Nock and Prinstein (2004) stated that there was significant evidence that individuals who self-harm or engage in self-injurious behaviors in order to get attention, this theory has been far outweighed, even through their own research, and published in recent literature (Hilt & Nock & Lloyd-Richardson, Prinstein, 2008, p. 457). Thus, there is still much research to be done within this area of study; and moreover, this specific model.

The systemic model states that the self-harm or self-injurious behavior stems from an attempt to have family and/or environmental dysfunctions remain at the status quo. Further, this model states that the individual who engages in this behavior may do so in order to protect himself/herself from a negative element within his/her environment, and/or may use the behavior to express feelings or emotions that have been fixed within this dysfunctional

environment (Suyemoto & MacDonald, 1995, p. 163). The individual who chooses to engage in this behavior is an individual who views himself/herself as powerless. Regardless of his/her outward appearance to others, this individual feels different from everyone else. This feeling is usually unspoken to others who surround this individual, and is often vulnerable to normal experiences. The behavior of self-harm or self-injury then becomes an alternative, or a redirection from the systemic dysfunction.

The suicide model sustains that self-harm and self-injurious behaviors are distinct from the act or intent of suicide. Researcher and author Michelle Onacki (2005) states, “There are several things that self mutilation is not. It is not an attempt at suicide, although it may appear so if cuts are life threatening. Initially, people who self mutilate are not trying to alarm, annoy, anger, or irritate others” (p. 400). Thus, both Favazza and Onacki believe that some acts of self-harm and self-injurious behavior are a coping mechanism which is often used by adolescents to not achieve suicide, but to avoid it completely. In the book *Bodily Harm: The Breakthrough Healing Program for Self-Injurers*, authors Karen Conterio, Wendy Lader, Ph.D. , and Jennifer Kingson Bloom (1998) state:

Paradoxically, self injury is usually a *life sustaining* act, a mechanism to cope with stress, relieve inexpressible feelings, and gain attention. Most sufferers say it is a mechanism to stave off suicide or more serious forms of emotional disorganization; it is a ‘life preserver’ rather than an exit strategy. Indeed, in many cases the type of superficial cutting and burning patients use is not the type of behavior usually associated with people who kill themselves (p. 29).

Thus, self-harm and self-injurious behaviors by individuals must be viewed as clearly far removed from that of a suicide attempt.

The sexual model with Favazza's study examines the connection between the act of self-harm and self-injurious behaviors to that of sexuality or sexual development. According to Suyemoto and MacDonald (1995), Favazza relates this model to sexual gratification, attempts to control sexuality or sexual maturation, or avoidance or sexual feelings and/or actions (p. 163). Thus, according to Lynn Ponton, a psychiatrist at the University of California, San Francisco, "about one in ten women and men intentionally injure themselves. Most start as teenagers. Many have been sexually, physically, or emotionally abused as children" (Rochman, 2000, p. 28). Strong (1998) states, "Two important 1997 studies of teenage girls, one by the Commonwealth Fund and the other by Alan Guttmacher Institute found that one in four had been sexually or physically abused (p. 64). Author Sue Rochman (2000) states that, "whether self-mutilation is more common among gay and lesbian youth than it is among heterosexual youth isn't known" (p. 28). What is known, however, is that many individuals who display acts of self-harm, including gay/lesbian adolescents and heterosexuals, have been physically and/or sexually abused in their past. Moreover, Lieberman (2004) states, "broad research indicates that there is a strong correlation between chronic Repetitive Self-Mutilation Syndrome (RSM) and a history of childhood physical or sexual abuse" (p. 11). Thus, this model includes individuals who self-harm due to conflicts over sexuality or the culmination of a series of physiological and anatomic processes of puberty. Because this area of concern involves a massive force of psychological and social implications on the individual who has experienced the abuse, the damage caused to the individual's psyche is far from being understood in current research.

The expression model developed by Favazza "views self-mutilation as stemming from the need to express or internalize excessive anger, anxiety, or pain caused by perceived

abandonment” (Suyemoto & MacDonald, 1995, p. 163). Furthermore, these individuals redirect their expressions of negativity through the exercise of self-injury. Ettinger (1992) states that this allows these individuals “to have physical evidence of their injury in order to feel that their emotions are real, justified, or able to be tolerated”(p. 11). Also, many individuals who engage in these behaviors do so because they feel their emotions are unjustified or discounted. Thus, they seek a response, either through the act of self-harm or the response the act achieves. In the book, *The Disappearing Girl: Learning the Language of Teenage Depression*, author Dr. Lisa Machoian (2005) states, “Girls also show impressive tenacity. Girls’ depression is not as hopeless as it is in women. Instead their efforts to communicate and to cope express their hope for the future. Girls’ suicidal behavior peaks at the ages thirteen and fourteen because it is a time when girls are fighting for themselves and for relationships that are real” (p. 176). Thus, the individual who engages in self-injurious behavior is very sensitive to her emotional pain and the self-harm that occurs is a short-term expression of the severity of her individualistic experience.

The control model maintains that a self-injurious individual requires a sense of needing to regain control over his/her emotions. This often includes the feeling of a sense of abandonment, anger, or helplessness. The act of self-harm allows the individual to predict and maintain control over their emotions and/or environment and thus, enables this individual to turn the abstract into the concrete (Suyemoto & MacDonald, 1995, p. 163-164). The behavior of self-injury is merely a response to a belief that it is the only way to be in control of one’s own mind and body. Yet, in reality, this behavior is actually an expression of lack of control.

The boundaries model asserts that through the act of an individual engaging in self-injurious behaviors, this individual sets a variety of distinctions. First, a physical boundary may be set of the individual. Second, the individual begins a personal boundary in his/her ability to have control over his/her well-being and/or death. Third, the individual creates uniqueness unto only himself/herself. And, finally, the individual institutes within himself/herself an identity as an individual who engages in self-injurious behaviors (Suyemoto & MacDonald, 1995, p. 164). These boundaries reinvent the individual who participates in these behaviors. Strong (1998) states:

Cutting redefines the body's boundaries, differentiating self from others. Blood flowing from the wound proves there is life inside the body instead of nothingness. On a subconscious level, according to psychoanalytic theory, stimulation of the skin through self-mutilation help reintegrate the splintered sense of self by reactivating the body ego – perhaps by re-creating a tactile experience that, at least to cutters, is pleasurable and soothing (p. 47).

The depersonalization model clearly expresses the state of disassociation that follows the numerous emotions that may lead up to the act of self-injury. During and after the act of self-harm, the self-injurer is often temporarily disconnected with the experience of the physical pain caused by self-injurious behavior. Favazza (1989) states that “the act of self-harm effectively ends the disassociation (p. 239). Furthermore, Suyemoto and MacDonald (1995) claim, “the depersonalization model focuses on creating or maintaining a sense of self or identity in the face of overwhelming internal emotion, rather than in the face of merger with another person as in the boundaries model” (p. 165). At this point in research, it is still unclear how this disassociation is truly broken down, chemically and/or emotionally, within

the individual who self-harms (Suyemoto & MacDonald, 1995, p. 165). Yet, it is clear that it is known that “self-injurers separate the experience of their bodies from the experience of their minds and thoughts” (Conterio, Lader, & Bloom, 1998, p. 57).

Understanding who exhibits self-harm or self-injurious behaviors

According to Researcher M.A. Darche (1990), “many authors describe the typical self-mutilator as female, adolescent or young adult, single, and usually from a middle- to upper-class background, and intelligent” (p. 32). Also, it is stated that “self-injury is predominately female for all age categories except the oldest ages” (Jarvis, Ferrence, Johnson, Whitehead, 1976, p. 149). Furthermore, author Richard Lieberman states, “for every 100,000 adolescents, it is estimated that between 750 and 1,800 will exhibit self-injurious behaviors (p. 10). Yet, unless the injury is so bad that it requires medical treatment, these statistics may be only a portion of the actual numbers of individuals who self-harm.

Authors Jeanette Cueller and Theodore R. Curry (2007) found that, “understudied groups, such as Hispanic girls, may exhibit high levels of problematic behavior but because of lack of knowledge and understanding, be dramatically underserved by social agencies, policy makers, and researchers in general. This intention is detrimental because the structural positions Hispanic females occupy and the cultural factors they experience place them at risk not only for delinquency and drug use but also for related issues, such as suicidality and sexual and physical abuse (p. 69). Furthermore, a higher percentage of Hispanic girls have been reported to attempt suicide when compared with Caucasian and African American females (Cueller & Curry, 2007, p. 69). Thus, to sum up, in the populations of individuals who self-harm and engage in self-injurious behaviors, young female adolescents lead the group. These females are often emotionally inarticulate and imperceptive. This lack of

emotional security often leads to emotional isolation, and thus, yields an adolescent whose coping mechanism is emotional survival. Yet, what the self-injurer fails to recognize is that the act of self-harm never truly allows her to confront her feelings, it only allows for a short-term diversion from the actual problem.

Understanding the various forms of self-harm and self-injurious behaviors

There are many forms of self-injurious behaviors. Recently, much research has been conducted to analyze why individuals choose various methods and/or techniques of self-injury. Although these forms of self-injury are not recognized as an isolated mental disorder by the 4th Edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the practice of these behavior are becoming clearer in their evidence of chronic, repetitive, and episodic frequency among adolescent females. Author Marilee Strong (1998) states, “Favazza, as a result of his research, classifies self-mutilation into three types, based on the degree of tissue damage and frequency, each having its own roots and motivations” (p. 26).

Favazza’s first category of self-mutilation is “Major self-mutilation” (Strong, 1995, p. 26). This category includes the most extreme and radical acts of self-harm reported. Examples of acts of self-injurious behaviors within this category would include “self-castration, amputation of a limb, or the removal of an eye” (Strong, 1995, p. 26). The self-injurer often has co-morbidity factors that add-to and/or parallel his/her psychological state of mind and experiences a sense of disassociation within the act which often alleviates the discord that lies within him/her.

The second category is classified as “stereotypic self-injury, which includes hand banging, biting, and skin scratching” (Strong, 1998, p. 27). Within this category, there are various theories that attempt to explain these behaviors. Most often, these behaviors are

associated with other forms of disabilities and/or mental disorders, such as mental retardation, autism, and Tourette's syndrome. Many researchers hold different theories as to why individuals practice these behaviors, such as head banding resulting in a numbing effect to the self-injurer, but there is no concrete evidence as to the exact reasoning for this behavior (Strong, 1998, p. 27).

The final category in which Favazza classifies self-injury is "moderate/superficial self-mutilation" (Strong, 1998, p. 27). This category includes individuals who cut. Strong (1998) states, "Some people engage in this only episodically; others engage in it repetitively, taking on an identity as a 'cutter,' feeling preoccupied by thoughts of cutting and feeling addicted to the behavior" (p. 27).

Although Favazza's work has proved beneficial to the area of self-harm and self-injurious behaviors, the isolation of a new diagnostic category within the *Diagnostic and Statistical Manual of Mental Disorders* would allow for further research within the frequency and severity of the act of self-injurious behavior, as well as state of mind of the self-injurer.

Treatment, education, and support for individuals who have been affected by self-harm
and self-injurious behaviors

The act of self-harm and self-injurious behaviors remains widely misunderstood. Conterio and Lader (1998) state, "Most treatments that do exist focus on the act of self-injury itself: how dangerous it is to harm one's body, what a toll it takes on the patient and the people around her, how aberrant or bad it is to take arms against one's skin" (p. 209). Yet, until our society, and more specifically, our medical community acknowledges and views the act of self-injurious behavior as an isolated mental disorder, the hidden culture of self-harm will cease to hinge on the appropriate treatment needed to provide the structural approaches

for successful treatment. Therefore, in the meantime, individuals who interact with those who self-harm must allow for a continuum of treatment which engages not only the physical recovery for an individual who self-injures, but also the mental and emotional influences behind the reasoning for self-harm, including the reality of a mental disorder/chemical imbalance in the brain. Also important within the treatment is the encouragement for the confrontation of abuse, making sense of the self-injury and making it clear that self-injury, including the parallels of blaming, self-esteem, and regret are appropriate to talk about and work through. However, the foundational level of treatment must be based on altering the value that the individual places upon her own self. This current lack of value may be attributed the neglect that our society has endured in its acknowledgment of identifying self-injurious behavior as a true mental disorder, and thus, emerging from outdated research into a recognition that this area of concern is silently progressing into a rising epidemic amongst our nation's female adolescents.

Conclusion

There are many changes that need to be made within current society to help cease the self-injurious behaviors of young female adolescents. Gender role expectations play a significant role in how self-injurious patients are treated and more specifically, females are much more likely to receive a parallel diagnosis of emotional disturbance or indicators of depression/personality disorder. It is true that physicians and society as a whole take the suggestion of self-injurious behaviors in female adolescents more seriously. The act of isolating self-harm or self-injurious behaviors as a recognized mental disorder by the 4th Edition of the *Diagnostic and Statistical Manual of Mental Disorders* would assist to cease the continuation of this problem that has proven to be a silent, and sometimes, deadly behavior among today's

female adolescents.

Methodology

Research Stance

The goal of this project is to help educators, parents, staff members, and general society familiarize themselves with the lack of recognition of self-injurious behavior of female adolescents as an isolated mental disorder. It is research's belief and prior experience that female adolescents who participate in self-harm or self-injurious behaviors are misdiagnosed or goes undiagnosed due to preconceived notions or lack of knowledge surrounding the self-injurious behavior. Within the review of literature, surveys and data collected, the researcher will interpret how individual behavior by these female adolescents may be remedied if only these behaviors were acknowledged for what they truly are: a mental disorder worthy of an isolated definition within the 4th Edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

Design

There was a numerous amount of research that was examined and analyzed surrounding this exploratory examination. A collection of data from two rural school districts was gathered and compared. This data was then interpreted to see if there were age and/or gender similarities amongst the findings. All of the findings were then analyzed to base a hypothesis as to whether or not the diagnosis of self-harm or self-injurious behaviors among female adolescents should be classified as an isolated mental disorder within the 4th Edition of the *Diagnostic and Statistical Manual of Mental Disorders*. All participants were asked to complete a series of questions within a survey about their feelings and/or experiences concerning self-injurious behaviors. They were contacted personally at their current high

school setting and asked to correspond and submit their surveys via email. The survey was broken down into five sub-categories: emotional, family/peer awareness/support, substance abuse, treatment, and diagnoses. All answers were submitted on a voluntary basis and allowed for each participant to explain her answers. All answers were submitted via email. Because of this nature, the researcher was then able to organize and track each answer and analyze the data received based on each school district, age of the participant surveyed, as well as organize the comments received.

Participants

The participants who were included within this research were chosen from two seventh to twelfth grade rural high school districts with the upstate New York region. Participants were originally chosen through personal contacts within the school districts, such as school counselors and experienced educators. Overall, 25 female adolescents participated in the survey. The research utilized data and observations along with current event logs to perform this study. Moreover, all students were observed and surveyed within their normal classroom within a high school setting. The students observed, surveyed, and analyzed were both students with special needs and students within the general education population.

Limitations of Study

This research study was met with great limitations, due to confidentiality issues imposed by the school districts reviewed. It was very difficult to have the student complete the surveys in a timely manner and receive back the information. Many students were hesitant about disclosing information regarding such a sensitive topic. Also, many students were apprehensive as to the reasoning behind the study. Many of the respondents did not elaborate in their answers, but rather provided short, brief answers to the questions posed. The

researcher believes that if the questions were generated in an interview scenario, the data collected would have been more expansive and the insight into why female adolescents engage in self-injurious behaviors may have been better detected.

Findings and Discussion

Within the information gathered from school personnel who directly deal with the acts of adolescents who engage in self-injurious behavior, research concluded that there is a very common protocol within these two school districts when reporting self-mutilation/cutting. All answers submitted were vague in the fact that all responses noted that action was “dependent of the severity of the case.” However, when asked more specifically about general acts of cutting or non-life-threatening injuries, responses became more clearly interpreted. First, if noted by the school nurse, the nurse will make a referral to PSO (Pupil Support Office) where the student will be questioned about her behavior, the occurrence, the student’s understanding of why they are engaging in this behavior, whether the parents are aware of the behavior, and then attempts will be made to assist the student in relieving the pain/stress present. If noted by the counselor, the same protocol as above was used. However, the counselor would then ask the student if the nurse could examine the cuts. The areas of the arms, legs, and abdomen would be examined and documented for size, number, level of healing, any signs of infection, signs of repeated cutting behavior including various levels of healing. This information is documented by the nurse in the student’s file/chart. The counselor then talks with the parent of the student to alert them of the incident and recommends outside counseling. If the parents do not follow through or the student continues acts of self harm, continued documentation is maintained and if necessary, CPEP (a mental health crisis team) is alerted and the student is taken to an area hospital for evaluation. If the

counselor feels the student is in imminent crisis, the student's parents are notified and the school transports the student to a local hospital for evaluation. See Appendix 1 and Appendix 2 for pictures of minor cutting behavior reported at a local high school versus an imminent crisis situation reported at the same school.

Within the information and responses gathered from female adolescent students, there were substantial similarities in the comments received from those participants who were surveyed. The first subsection of the survey involved the emotional state of the self-injurer before, during, and after the act of self-harm as reflected on Table I. Of the 25 participants surveyed, 24 out of the 25 participants submitted similar responses to their emotional state prior, during, and after to the act of self harm. Some of these responses are shown on Table I. Also, when asked the duration of the act of self-harm, 16 out of the 25 surveyed had similar responses. Moreover, 21 out of the 25 surveyed stated they had a ritual within their engagement in self-injurious behavior.

The second subsection was based on peer relations and family support and is reflected on Table II. Participants were asked if their peers were aware of their engagement in self-injurious behavior. The responses were alarming. All 25 participants surveyed stated that their friends were aware of their self-harming behavior. When this information was further analyzed, the researcher concluded that the question might have been too vague in the sense that it did not detail the true closeness of these relationships. For example, the question did not detail whether or not these individuals identified were true friends or simply associates being aware of the adolescents' behaviors. Within email correspondence, I then modified this question to reflect whether the participant was "out" about self-injury, whether they hide their behavior and/or if the participant is aware of others who participated in this kind of behavior.

Of the updated responses, not one female participant stated that she was “out” about self-injury. However, two participants did state that others were aware of their behavior. All 25 out of the 25 participants questions stated that they do try to hide their behavior. Of the 25 participants surveyed, only 6 stated that their family knew of their self-injurious behavior. This contrast in awareness from friends to family members was also shocking. And, finally, 19 stated that they were aware of others who participated in self-injurious behaviors. Within this specific question, there were many personal comments included with the participants’ answers. Some of these comments are documented on Table II.

The third subsection asked participants to reflect on their use/abuse of alcohol/illegal substances. Their responses are detailed on Table III. The first question asked if the adolescents have ever used alcohol. Of the 25 surveyed, 25 stated that they had used alcohol at least one time in the lives. The second questions asked the students if the have ever smoked marijuana. Of the 25 surveyed, 18 of the students responded that they had used marijuana. The third question within this subsection asked the participants if they had ever used illegal substances other than alcohol/marijuana. Of the 25 participants surveyed, 10 stated that they had used illegal substances. The comments on Table III documents some of the detailed responses received. The final question given to the participants within this subsection asked them to reflect on whether or not they believed their individual alcohol/substance use played a role in their self-injurious behavior. Out of the 25 surveyed, only four believed that their use did play a role in their self-injurious behavior.

The fourth subsection of the survey given regarded treatment received for their self-injurious behaviors. When asked if the participants ever received treatment for their self-injurious behavior, 7 out of the 25 surveyed stated that they had received some form of

treatment. This is evidenced on Table IV. Furthermore, as documented within the findings, 3 stated that they took part in a self-injurious treatment program within a treatment facility/hospital/private counseling, while the remaining 4 stated that they received school counseling for their self-injurious behaviors.

The final subsection of the survey conducted focused on prior diagnosis of the individual who engage in self-harming behaviors. Of the 25 surveyed, 18 stated that they had been diagnosis with a mental disorder of some type. See Table V for specific diagnoses. The remaining 7 stated that they felt they should be diagnosed with a mental disorder due to their engagement with self-injurious behaviors. Again, the researcher received detailed commentary from the participants involved that was emotionally raw and devastating. Some of the comments are also listed on Table V.

Discussion

The basis of the research conducted was very personal to the researcher as I have observed and worked with many female adolescent who engage in self-harm and self-injurious behaviors. Of the past 20 years, the researcher has seen an explosion on the number of female adolescents within the school systems who engage in this type of behavior. The evidence strongly suggests that this is more than attention-seeking behavior and that the time is now to make a difference in these adolescents' lives.

As a result of the research conducted, it is apparent that educators play a primary role in recognizing the warning signs of self-injurious behaviors and must act as first responders to his crisis situation. When comparing the data received in this survey to the data currently publicized, an alarming acknowledgement that something must be done for society's female adolescents emerges. There is a clear discrepancy between the behaviors and/or emotions

that exists within these teens and the treatment/education regarding this matter. The awareness of the situation is often gone unacknowledged and resources for these adolescents remain inadequate. Furthermore, great discrepancies exist for educators in the resources available to help these adolescents when compared to the number of adolescents who engage in this type of behavior. This opinion is also supported by the information presented by many scholars in literature. The answer does not only lie within educators, however, but all individuals who interact and/or work with female adolescents. These individuals need the resources and opportunities to acknowledge that self-injurious behaviors is a growing epidemic amongst female adolescents and have the resources readily available to help these adolescents.

The female adolescents who participated in this research were very aware of the secrecy and shame that lies behind their behavior. However, within an educator's everyday interaction with these teens, oftentimes these emotions go disregarded or unnoticed for the true extent of the extremity of the situation. Educators cannot separate themselves from an adolescent's emotional state while teaching. This state of being is one of the main contributors to whether this adolescent will be successful in school. Therefore, society must embrace all that goes into an adolescent's learning: social, emotional, and physical development and treat and care for all aspects of that adolescent. The recognition of the engagement in self-injurious behavior is only the beginning step to helping these adolescents truly be successful in life. Thus, it is evident that the approval of a classification of self-harming or self-injurious behavior as an isolated diagnosis within the 4th Edition of the *Diagnostic and Statistical Manual of Mental Disorders* would provide these female adolescents with opportunities for change and treatment that is needed for the adolescents to reach their true potentials in life.

Table I

Emotional State of Self Injurious Participants

<p>1. Do you feel emotional pain prior to the act of self-harm?</p> <p style="text-align: center;">Yes = 24 No = 25</p> <p>Comments</p> <p><i>“Absolutely. If I am hurt emotionally, I cannot stop myself from wanting to hurt physically.”</i></p> <p><i>“Yes. It can be caused from someone giving me a weird look in the hallway to someone saying something to me. I am very easily hurt.”</i></p> <p><i>“I am always hurting.”</i></p>
<p>2. Do you feel pain during the act of self-harm?</p> <p style="text-align: center;">Yes = 3 No = 22</p> <p>Comments:</p> <p><i>“No. I feel a sense of release.”</i></p> <p><i>“No. I block everything else out.”</i></p> <p><i>“Never. The physical distance that occurs is my escape.”</i></p>
<p>3. How do you feel after engaging in the act of self-injurious behavior?</p> <p>Comments:</p> <p><i>“Guilty. Alone. Sad. Angry with myself.”</i></p> <p><i>“Better than before. It is like a release.”</i></p> <p><i>“Scared that someone will find out what I have done.”</i></p>

4. How long is the typical duration of your act of self-injurious behavior?

16 = 15 minutes or less

3 = half an hour or less

2 = everyday

4 = varied/staggered timing

Comments:

"The act of cutting is much shorter than the pain my heart feels."

"I never spend a lot of time in the act. I just do it and it makes me feel better."

5. Do you have a ritual within your self-injurious behavior?

Yes = 21 No = 4

Comments:

"I also do it in my room. Everybody is always home, but no one notices me or what I am doing."

"Yes, I do it at home and at night when no one is around."

"Yes. I always cut where it cannot be seen."

Table II

Peer/Family Involvement of Self-Injurious Participants

<p>1. Are your peers aware that you injure yourself?</p> <p style="text-align: center;">Yes = 25 No = 0</p> <p>Comments</p> <p><i>“Yes. They have seen it and asked me about it.”</i></p> <p><i>“Yes. Some of my friends do it too.”</i></p> <p><i>“Yes. When my friend saw that I did, she then did it like a month later. I felt like maybe she only did it because I did.”</i></p>
<p>2. Are you “out” concerning your self-injurious behavior?</p> <p style="text-align: center;">Yes = 0 No = 25</p> <p>Comments:</p> <p><i>“No. I do not want anyone to know.”</i></p> <p><i>“No. I hate myself for doing it.”</i></p>
<p>3. Do you try to hide your self-injurious behavior?</p> <p style="text-align: center;">Yes = 25 No = 0</p> <p>Comments:</p> <p><i>“Yes. I want to be alone when I cut and I do not want anyone else to be involved.”</i></p> <p><i>“Always. I only cut where it can’t be seen.”</i></p> <p><i>“Yes. I am scared that I will be put in a hospital.”</i></p>

4. Is your family aware that you participate in self-injurious behaviors?

Yes = 6 No = 19

Comments:

"No. I do not want anyone to know. It is too personal."

"My mom saw the cuts on my wrist and made me see a doctor. She cried for days."

"My family does not understand why I do it. I guess I don't even understand why I do it really."

5. Do you know others who engage in self-injurious behavior?

Yes = 19 No = 6

Comments:

"A lot of my friends do it, but not like me."

"Yes, I see a lot of my friends do crazy stuff."

"No. There is nobody else like me."

Table III

Use of Alcohol/Illegal Substances of Self-Injurious Participants

<p>1. Have you ever used alcohol in your lifetime?</p> <p style="text-align: center;">Yes = 25 No = 0</p> <p>Comments</p> <p><i>“Yes. You can get it anytime, anywhere around here.”</i></p> <p><i>“Yes. I usually go to parties with my friends on the weekends and we drink...never drugs though.”</i></p> <p><i>“I like the way I feel after drinking...it helps me forget my pain.”</i></p>
<p>2. Have you ever smoked marijuana?</p> <p style="text-align: center;">Yes = 18 No = 7</p> <p>Comments:</p> <p><i>“Yes. It is at all of the parties around here.”</i></p> <p><i>“Yes. Me and my friends do it a lot.”</i></p> <p><i>“Never. I am too scared of getting caught.”</i></p>
<p>3. Have you used any other illegal substances besides alcohol or drugs, even once?</p> <p style="text-align: center;">Yes = 10 No = 15</p> <p>Comments:</p> <p><i>“Yes. I have used LSD a lot and I tried heroin a couple times, but it made me flip out, so I quit.”</i></p> <p><i>“Yes. I take a lot of pills to try and feel better. I have took Ritalin by the mouthful, doesn't help.”</i></p>

4. Do you think your use of alcohol and/or illegal substances has in any way contributed to you act of self-injurious behavior?

4 = Yes 21 = No

Comments:

“No. I only drink at parties.”

“I guess so. I never really thought about it before, but I know I never feel good when I drink or smoke pot – I usually feel worse.”

“I hate this question. Everybody always tries to say it does, but I feel better when I am not myself.”

Table IV

Treatment within Self-Injurious Participants

<p>1. Have you ever received treatment in a hospital for your self-injurious behaviors?</p> <p style="text-align: center;">Yes = 7 No = 18</p> <p>Comments</p> <p><i>“Yes. I had to go to Clifton and they said I was crazy.”</i></p> <p><i>“Yes. I was sent to Rochester until I told them I wouldn’t do it anymore.”</i></p> <p><i>“No. No one knows I do this.”</i></p>
<p>2. Do you see at counselor at school for your self-injurious behavior?</p> <p style="text-align: center;">Yes = 4 No = 21</p> <p>Comments:</p> <p><i>“No. They don’t know anything.”</i></p> <p><i>“Yes, but it is a waster of time. She actually wanted me to play a board game with her!”</i></p> <p><i>“No – no one at school knows.”</i></p>
<p>3. Do you receive any other type of outside counseling for your self-injurious behaviors?</p> <p>Comments:</p> <p><i>“My teacher talks to me sometimes about it. I told her I didn’t want anyone else to know.”</i></p> <p><i>“I had to go to the doctor the first time my mom saw my cuts on my arm.”</i></p>

Table V

Diagnoses of Self-Injurious Participants

<p>1. Have you ever been diagnosed with a mental illness/disorder (for example, depression, mental retardation, psychosis, etc...)?</p> <p style="text-align: center;">Yes = 18 No = 7</p> <p>Comments</p> <p><i>“Yes. When my mom took me to the doctor because of the cuts on my arm, he said I was depressed.”</i></p> <p><i>“Yes. The doctor told my mom I may be bi-polar, but she said I just wanted attention because of the divorce.”</i></p> <p><i>“I have depression.”</i></p>
<p>2. If you have not been officially diagnosed with a mental disorder, do you feel that you should be because of your engagement with self-injurious behavior?</p> <p style="text-align: center;">Yes = 7 No = 18</p> <p>Comments:</p> <p><i>“Probably. I may be able to get help then. I don’t want to be a cutter.”</i></p> <p><i>“Yes. I know I’m not right.”</i></p> <p><i>“Yes. Why else would someone cut themselves?”</i></p>

Appendix 1



Appendix 2



References

- Conterio, K., Lader, W., & Bloom, J.K. (1998). *Bodily harm: The breakthrough healing program for self-injurers*. New York: Hyperion.
- Cueller, J., & Curry, T.R. (2007). The prevalence and comorbidity between delinquency, drug abuse, suicide attempts, physical and sexual abuse, and self-mutilation among delinquent Hispanic females. *Hispanic Journal of Behavioral Sciences*, 29(1), 68-82.
- Darce, M.A. (1990). Psychological factors differentiating self-mutilating and non-self-mutilating adolescent inpatient females. *Psychiatric Hospital*, 21, 31-35.
- Ettinger, S.L. (1992). *Transforming psychic pain: The meaning and function of self-injury in women's lives*. Unpublished Master's Thesis, Smith College School for Social Work.
- Favazza, A.R. (1989). Why patients mutilate themselves. *Hospital and Community Psychiatry*, 40, 137-245.
- Favazza, A.R. (1996). *Bodies under siege* (2nd ed.) Baltimore, MD: Johns Hopkins University Press.
- Hilt, L.M., Nock, M.K., Lloyd-Richardson, E.E., & Prinstein, M.J. (2008). Longitudinal study of nonsuicidal self-injury among young adolescents: Rates, correlates, and preliminary test of an interpersonal model. *The Journal of Early Adolescence*, 28(3), 455-469.
- Jarvis, G.K., Ferrence, R.G., Johnson, F.G., & Whitehead, P.C. (1976). Sex and age patterns in self-injury. *Journal of Health and Social Behavior*. 17(2), 45-154.
- Lieberman, R. (2004). Understanding and responding to students who self-mutilate. *Principal Leadership*, 4(7). 10-13.
- Machoian, L. (2005). *The disappearing girl: Learning the language of teenage depression*. New York: Plume: Penguin Group.

- Onacki, M. (2005). Kids who cut: A protocol for public schools. *The Journal of School Health*, 75(10), 400-1.
- Rochman, S. (2000). The cutting edge: Anxious about their sexuality, young lesbians sometimes turn to self-mutilation. *The Advocate*, 812, 28.
- Strong, M. (1998). *A bright red scream: Self-mutilation and the language of pain*. New York: Penguin Group.
- Suyemoto, K.L., & MacDonald, M.L. (1995). Self-cutting in female adolescents. *Psychotherapy*, 32(1), 162-171.
- Zila, L.A., & Kiselica, M.S. (2001). Understanding and counseling self-mutilation in female adolescents and young adults. *Journal of Counseling and Development*, 79(1), 46-47.