Helping Self-Harming Students

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Schools can reduce the likelihood of self-harming epidemics and manage student difficulties when they occur by following a few practical guidelines.

Student self-harming is one of the most perplexing and challenging behaviors that administrators, teachers, nurses, and counseling staff encounter in their schools. Approximately 14 to 17 percent of children up to age 18 have deliberately cut, scratched, pinched, burned, or bruised themselves at least once (Whitlock, 2009), with 5 to 8 percent of adolescents actively engaging in this behavior (J. Whitlock, personal communication, September 27, 2009).

Self-harming behavior is not a new phenomenon among adolescents. Mental health and health-care professionals have typically viewed such behavior as a symptom of an underlying psychological or personality disorder as a possible suicidal gesture suggesting the need for psychiatric hospitalization or as a symptom of post-traumatic stress disorder caused by sexual or physical abuse.

However, both research and practice-based wisdom indicate that the majority of self-harming adolescents do not meet the criteria for diagnosable DSM-IV[1] psychological or personality disorders, have never had suicidal thoughts or attempted to end their lives, and have never experienced sexual or physical abuse (Selekman, 2009). Most self-harming adolescents use the behavior as a coping strategy to get immediate relief from emotional distress.

Preteens and adolescents today are growing up in a highly toxic and materialistic world. They are bombarded daily by violent, sexualized, and self-destructive media messages and themes that encourage them to grow up rapidly and become junior adults. They also have too many daily choices regarding specific material "must-have" possessions, extracurricular activities, dressing and fitting in with popular peers, possible college attendance, and so forth. Several stressors play a major role in fueling self-harming behavior among adolescents today.

Fitting in with Peers

In adolescence, being rejected by your peers is the equivalent of social death. The peer group is much more demanding today than it used to be, and it changes at a frenetic pace. Adolescent students who lack strong social skills often struggle to stay afloat and may resort to extreme behaviors endorsed by more popular and powerful peers; they may experiment with cutting as their entry ticket into the high-status, inner-circle clique. Adolescents who can't afford highly prized popular possessions like the iPhone or designer clothing may resort to stealing them.

Many adolescents and children also spend far too much time online, communicating with their peers on Facebook or on MySpace—or "Mean Space," as some people now call it. Some adolescents have been victimized by peers who play the on-and-off befriending game or spread terrible rumors about them as a form of underground psychological warfare. I have worked with a number of adolescents who were the victims of these vicious and emotionally devastating character assaults. Fitting in and staying connected to socially well-positioned and popular peers become more challenging because of the intense politics of these social networking sites.

Overloaded Stress Circuits

Another frequent complaint I hear from both self-harming and other adolescents is feeling overwhelmed by multiple life stressors. In addition to juggling their social connections, the students are trying to manage massive homework loads and are often pressured by their parents to perform at a high academic level. Some adolescents are growing up in achievement-oriented families, in which the parents put undue pressure on them to get straight *A*s. In addition, the parents often push their adolescents to schedule too many extracurricular activities to make them as attractive as possible to top colleges and universities. To cope with the stress, some of the more emotionally vulnerable adolescents turn to self-harm, resort to eating-distressed behaviors like bulimia, or engage in substance abuse.

Quick-Fix Solutions

Adolescents are growing up in a media world where one of the most popular messages is that we must obliterate stress and other problems as quickly as possible. What better way to get rid of all your problems than to take a pill, which many advertisements on TV suggest is the ultimate solution for physical, psychological, and behavioral difficulties.

In some cases, adolescents may witness their parents abusing prescription medications, smoking, and drinking for stress relief. The message they receive is that stress is a bad thing—that people can't channel it into constructive activities but must quickly eliminate it.

Self-harming adolescents have discovered that their brain chemistry can serve as a 24-hour pharmacy (Plante, 2007). When adolescents self-harm, their bodies immediately secrete naturally manufactured endorphins into their bloodstreams to protect them from physical pain. These endorphins rapidly numb the emotional distress they may be experiencing. As with drug addiction, longtime self-harming adolescents not only report feeling loss of control, compulsion to engage in this behavior, and physical tolerance of the pain but also experience mild withdrawal symptoms like anxiety and irritability when they abstain from self-harming (Selekman, 2009; Whitlock, Muehlenkamp, & Eckenrode, 2008). Thus, self-harming has become one of the most popular painkilling and sedative drugs for youth today.

Emotional Disconnection and Invalidation

In families of self-harming adolescents, emotional disconnection and invalidation are common family dynamics. For whatever reason, one or both parents are not emotionally and physically present to comfort their adolescents when they are emotionally distressed. When the parents are present, they tend to respond in invalidating ways, such as by yelling, threatening, becoming hysterical, dishing out extreme consequences, distancing themselves, or not listening. So some adolescents take matters into their own hands—they self-harm to soothe themselves.

Further, extreme emotional disconnection from their parents often leads self-harming adolescents to gravitate toward other disconnected and often unsavory peer groups, an affiliation that tends to reinforce their self-harming behavior. Adolescents may feel that they belong and are respected in these groups. However, their involvement may expose them to other self-destructive behaviors, such as bulimia, substance abuse, and risky sexual behaviors.

Another factor that contributes to emotional disconnection in families is the computer screen. Developing emotional intimacy by means of a screen of some sort has become much more important to some adolescents than having human contact. Brazleton and Greenspan (2000) found that children and adolescents spent, on average, five and one-half hours a day in front of a screen. On the basis of what I hear from adolescents and parents in my private practice, this figure has gone up. Close to 70 percent of 8- to 18-year-olds have a TV in their bedroom (Taffel, 2009); laptops or personal computers have most likely replaced many of these.

Parents often do not provide firm guidelines for screen usage and do not regularly monitor the Web sites their children visit. There are many toxic Web sites and so-called online support groups for self-harming individuals where adolescents can witness people brutalizing their bodies, see other graphic images, read poetry and stories with self-harming themes, and learn new methods for self-harming.

Fears About the Future

Some of the self-harming adolescents with whom I work are anxious about whether they'll get into college or be able to pursue certain career paths, especially given the current grim economic situation. Some have seen their parents lose their jobs as well as their retirement savings. Some have had difficulties finding part-time jobs because few places are hiring.

Those whose college attendance depends on getting a scholarship may experience high levels of anxiety about not letting their parents and themselves down with their academic and extracurricular performance. Self-harming and other equivalent behaviors can give some students temporary relief from these anxieties and fears.

Signs and Symptoms

On the basis of what we know from clinical experience and research as well as from the adolescents themselves, most adolescents who self-harm tend to cut or burn themselves on their arms, legs, abdomens, or the bottoms of their feet, all places they can cover up. Many self-harming adolescents wear pants and long-sleeved shirts even when the weather is warm to cover up their scars, fresh cuts, or burn marks.

We have to worry most about those who cut or burn themselves around their eyes and on their necks. These students—as well as those who deliberately display the scars, cuts, or burn marks on their arms and legs—are often waving a red flag, indicating they're in emotional trouble. In many cases, a friend or peer will become alarmed and seek out a teacher or other school staff member to share his or her concerns.

Many self-harming adolescents have difficulty managing their depressed, anxious, and angry feelings. In some cases, they cannot articulate their feelings, possibly because of repeated invalidation in their interactions with their parents. Self-harming, bulimia, and substance abuse are adolescents' solutions. Anthony Favazza, a leading authority on self-harming, found that close to 50 percent of his female patients had concurrent problems with bulimia (Favazza & Selekman, 2003).

On a cautionary note, tattoos, body piercings, or dark Goth-looking makeup and clothing may not indicate self-harming. There is a difference between self-decorating to be cool—as a symbol of peer group tribal connection—and engaging in these behaviors to rid oneself of emotional demons.

What Schools Can Do

School personnel need to be familiar with the territory of adolescent self-harm. They need to understand the common causes, signs, and symptoms; the difference between self-harming behavior and suicidal behavior; constructive and empowering ways to respond; and effective treatments.

Schools can provide two major interventions on the junior and senior high school levels that can help reduce the likelihood of self-harming epidemics.

Intervention 1: Create a Support Group

Once you have red-flagged self-harming students, you can refer them to an on-site intervention group that capitalizes on their strengths to teach them how to become more resilient, effectively cope with stress, and take on leadership responsibilities in their schools and communities.

I have developed one such model that improves students' coping skills—the Stress-Busters' Leadership Group.[2] Over nine sessions, students look at their strengths and "protective shields"; learn skills related to mindfulness, meditation, loving kindness, and compassion toward self and others; focus on finding balance and harmony in their lives; learn how to navigate family minefields; and acquire effective tools for mastering school stress. Ideally, a male-female cotherapy team of school social workers, psychologists, or counselors is best for gender balance. However, one counseling professional can also effectively run the sessions. (See p. 50 for a description of a session.)

Students who have completed the program often stay involved in prevention work in their schools and communities. Graduates serve as ideal gatekeepers for identifying self-harming students and for getting them to see a counselor or participate in a new group. Finally, groups like these can reverse self-harming and other self-destructive behavior epidemics in schools by accentuating at-risk students' strengths and honing their leadership abilities.

Intervention 2: Educate Responding Adults

Adult inspirational others serve a major protective function for at-risk children and adolescents (Anthony, 1984; Selekman, 1997, 2005, 2009). These can be teachers, coaches, extended family members, family friends, neighbors, clergy, and community leaders. Adult inspirational others are often compassionate, possess strong social skills, and are good at identifying and accentuating the strengths in children and adolescents. They consistently make themselves available to young people for connection, support, and advice. In every school, some staff members have served this role for at-risk students without even knowing it.

Eight practical guidelines can help adults effectively respond to self-harming students.

1. Because teachers and school nurses are often the first responders, it is crucial that they be respectful listeners to self-harming students; validate the students; build trust; and serve as a bridge to get the students to a school psychologist, social worker, or counselor for further help. If the self-harming student has a strong relationship with the teacher, it may be useful for the teacher to sit in on counseling sessions. Teachers and school nurses should ask the student these questions:
    - How can I help you?
    - How has the cutting helped you?
    - How does cutting fit into your life right now?
    - I'm happy to be there for you, but I also need to connect you with one of our social workers because of our school policy. Would you like to see a male or a female social worker (when the option is available)?
    - If I can arrange it, would you like me to sit in on your first meeting with your social worker?
2. At all costs, school personnel need to avoid responding to self-harming students with disgust, anxiety, or fear. They must not lecture the students about the dangers of this behavior, play detective and ask to see their cuts or burn marks, or interrogate and further invalidate them. Instead, they should strive to understand the meaning of this behavior *for the student*, how the behavior has been helpful, and how they can now be helpful to the student. It is important to remember that each self-harming student's story is unique. Self-harming students need to know that teachers and other school personnel care about them and are available for emotional connection, support, and advice when needed.
3. Once a referral is made to the school counseling staff member, the counselor needs to determine in conjunction with his or her supervisor and the student whether the school can successfully counsel the student on-site or whether parent involvement is required. For students who have just begun experimenting with self-harming or who have engaged in this behavior only intermittently, a trusting relationship with a school counselor may generate alternative coping strategies. I recommend that the student also participates in an on-site intervention group, such as the Stress-Busters' Leadership Group.
4. If the student has been self-harming regularly and is engaging in other self-destructive behaviors like bulimia, substance abuse, and risky sexual activity, the school needs to contact the parents immediately for referral to a private practitioner or community-based program for family therapy that specializes in treating these adolescent behavioral

difficulties. Concurrent participation in an on-site intervention group is also recommended.

5. For students who have been self-harming regularly; who are cutting themselves more deeply; or who are cutting or burning themselves around their eyes, necks, and private parts, this is a medical/psychiatric emergency. These students should be taken immediately to the nearest hospital emergency room for evaluation.
6. Although only a small percentage of self-harming students become suicidal, if these students have not responded well to both on-site and outside counseling, struggle to cope with multiple life stressors, and clearly voice suicidal thoughts, they need to be immediately taken to the nearest hospital emergency room.
7. Identified school personnel who have been serving as inspirational adults for other disconnected at-risk students can provide added support to self-harming students who are trying to reduce or stop engaging in this behavior. These adults can closely collaborate with the involved counseling staff members for guidance and back-up if necessary.
8. Graduates of intervention groups who are interested in schoolwide prevention work help identify at-risk students who are self-harming, get them to counseling staff, and spark their interest in participating in a new group for added support. The school can ask these graduates to cofacilitate new intervention groups and get involved in the school peer counseling program.

More Than Just a Problem

As provocative and perplexing as this behavior may seem, we must not lose sight of how bright, creative, and talented many self-harming students are. With compassion, guidance, and support, we can empower self-harming students by being respectful listeners and accentuating their natural gifts.