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).