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# SELF-MUTILATION: INFORMATION AND GUIDANCE FOR SCHOOL PERSONNEL

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Violence in our schools and communities has prompted significant interest in systemic prevention and intervention efforts to reduce aggression and bullying behaviors. However, self-mutilation, a less obvious and self-inflicted violent behavior, appears to be on the increase among adolescents. High school and middle school mental health professionals as well as secondary education teachers likely will encounter this behavior at some point in their professional careers. Interacting with a student who self-mutilates can be upsetting, frightening, and perplexing. How school personnel respond to these students, however, can be critical in ensuring both their safety and appropriate intervention.

## Defining Self-Mutilation

Many different terms have been used to describe when individuals intentionally harm themselves, including self-mutilation, self-injurious behavior, deliberate self-harm, parasuicidal behavior, and self-wounding. Additionally, this behavior has been classified into three types: major self-mutilation, stereotypic self-mutilation, and superficial self-mutilation.

**Types of self-injury.** Major self-mutilation is an extreme form of self-injury with a low incidence rate, and includes self-amputation of body parts.

Stereotypic self-mutilation is self-injurious behavior that is rhythmic and repetitive, such as head banging or arm biting, which is most commonly seen in children with mental retardation and autism.

In contrast, superficial self-mutilation, the focus of this handout, is an intentional act that is socially unacceptable, repetitive, and results in minor to moderate harm without the intent to die. Superficial self-mutilation often occurs in secret as an expression of deep pain and emotional unrest. The most common forms of superficial self-mutilation are self-cutting, followed by self-burning, pin-sticking, scratching, self-hitting, interference with wound healing, and bone breaking.

Injuries are most commonly inflicted on the wrists or forearms, although cuts to the face, genitals, thighs, legs, abdomen, and breasts have been observed. Cutting is reported as the most common practice of self-mutilation, and individuals who cut are often referred to as “cutters.”

**Is self-mutilation related to suicide.** A student who cuts himself or herself may be perceived by school personnel as attempting to commit suicide; however, important distinctions exist between self-mutilation and suicide attempts. For example, 8 out of 10 individuals who are suicidal report suicidal ideation and give advance warning of their suicidal intentions. In contrast, rarely does the person who self-mutilates report suicide ideation or give any advance verbal warning of his or her self-mutilation behaviors. For the most part, the intention behind self-mutilation is not to stop living, because most individuals who self-mutilate make only superficial cuts or marks to their skin. Moreover, individuals who self-mutilate are likely to continue to repeat the behavior over a long period. Reports indicate that approximately 63% of individuals who cut themselves experience multiple episodes. In contrast, suicide attempts are usually temporary and occur much less frequently.

## Prevalence

Self-mutilation is difficult to monitor, and epidemiological studies are difficult to conduct given the secretive nature of self-mutilation and the frequent overlap in the use of the terms *self-harm* and *suicide*. In the general population, the prevalence rate is estimated to be 750 per 100,000. Across studies, approximately 12–14% of adolescents reported self-mutilation behavior, and many studies suggest that the rate of self-mutilation is increasing among teenagers.

In general, the onset of self-mutilation behavior has been determined to be in early adolescence and, when undetected, continues into adulthood. Girls are significantly more likely to self-mutilate than

boys. Inconclusive findings have been reported on specific ethnicity prevalence rates.

In summary, most people who self-mutilate are middle and high school girls and college women who have average to high average intelligence.

## Causes of Self-Mutilation

Sociologists have proposed that there is a continuum of self-mutilating behaviors, some of which are acceptable and dependent on culture (e.g., tattooing and piercing) and others which are upsetting to mainstream culture. One distinction between acceptable body modification and self-harm to the body appears to be based on the intent and purpose, for public display of body decoration versus for private release of emotions.

Reasons for self-mutilation are many and vary from individual to individual. Some of the reasons may include one or more of the following:

- To escape from emotional pain such as anger or anxiety
- To release tension
- To induce a pleasure state from the endorphins that are released
- To gain control over seemingly out-of-control emotions
- To physically express pain

A commonly supported theory behind the motivation of self-mutilation is that it is a way to achieve emotional equilibrium. Cutters describe an increasing feeling of tension, which immediately diminishes after the act of self-mutilation. In most cases the self-mutilation is not motivated by interpersonal manipulation, but rather by the individuals' attempt to manage themselves.

Paradoxically, in some self-mutilators the pain from the self-mutilation causes an increase in the production of endorphins, which inhibits the feelings of pain and tension. Many cutters reported feeling an emotional release during an episode of cutting. Other cutters report that the sight of blood flow was central to the self-cutting experience.

Self-mutilation can become addictive, making it difficult for the self-mutilator to control the impulse to harm himself or herself. Researchers suspect that problems in the production of the neurotransmitter serotonin may affect emotional equilibrium and impulsivity among cutters.

No single cause can be assigned to every incident of self-mutilation. Self-mutilation behavior has been associated with individuals who have histories of one or more of the following: sexual abuse, emotional abuse, insecure caregiver attachments, invalidating environments, substance abuse, or eating disorders.

Adolescents who self-mutilate have been shown to be significantly more likely to meet the diagnostic criteria for depression than those who do not self-mutilate. Those who report that they self-mutilate also report feeling lonely, sad, alone, and having poor problem-solving skills. Additionally, self-mutilation is highly associated with Borderline Personality Disorder (BPD).

## Interventions

Limited research has been conducted on the effectiveness of treatment for adolescents who self-mutilate. The treatments that have been found to be *unsuccessful* with individuals who self-harm include: physical restraint, hypnosis, chemotherapy, no-cutting contracts, faith healing, group psychotherapy, relaxation therapy, electroconvulsive therapy, family therapy, and educational therapy. Other interventions such as S.A.F.E. (Self Abuse Finally Ends) alternative programs have not been systematically researched concerning their effectiveness.

### Effective Approaches to Treating Self-Mutilation

The interventions that have been found to be the *most effective* in symptom reduction generally involve a combination of behavioral therapies and medication. Medication is often prescribed to address concomitant symptoms of depression, anxiety, and "racing thoughts."

Successful therapies have incorporated Marsha Linehan's *Dialectical Behavior Therapy* (DBT) into various formats. DBT combines eastern meditation philosophy and psychodynamic principles with cognitive behavioral approaches. The model incorporates skill training in the areas of mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance.

Similarly, *Manual-Assisted Cognitive Behavior Therapy* (MACT), which is based on DBT techniques, has been found to decrease the number of incidents of self-mutilation behaviors, and reduce anxiety symptoms in participants. Manuals are given to the self-mutilators, and they are asked to use the manuals at home.

If self-mutilation is accompanied by other disorders or dysfunctional behavior patterns such as substance abuse or eating disorders, additional forms of treatment for the individual and family may be integrated with these interventions. While treatment often can be provided on an outpatient basis, inpatient (hospitalization) may be necessary if self-injurious behavior is life threatening or otherwise severely limits daily living activities.

### Intervening in School Settings

Interacting in the school setting with a student who self-mutilates can be upsetting, frightening, and

perplexing. How school personnel respond to the student, however, can be critical in providing the most effective interventions for the student.

Students who report to hospitals with self-mutilation along with a severe mental illness and a high risk for suicide require relatively straightforward treatment. Students who do not meet these criteria present a difficult challenge for school personnel and mental health care providers. The lack of research supporting specific treatment strategies for self-mutilation makes it difficult to know how to manage self-mutilation behavior.

**Awareness and detection.** Teachers, coaches, nurses, counselors, and school psychologists are not responsible for *treating* the student in the schools. A major component of effective interventions in the school is for school personnel to be aware that the behavior exists, detect the behavior, and react appropriately so as not to further isolate the student. Unless caught or observed in the process of self-mutilating, students who self-mutilate will not have behaviors that are significantly different from other students in the classroom. Self-mutilators are typically secretive about their self-harming behavior and tend to find a private place to cut themselves.

Coaches, physical education teachers, nurses, and peers will be in the best position to detect the physical scars left by the self-mutilation behavior. When students wear long sleeves in warm weather, when they have parallel scars, or scars on only one side, it would be beneficial to have a conversation with the student about these observations. It is essential for school personnel to restrain their fear or repulsion toward the self-mutilation behavior. When this fear prevents school personnel from asking students about the behavior, students who self-mutilate may feel unheard and misunderstood, further isolating the student.

**Peer involvement.** Often the student's peers may be more aware of the occurrence of self-mutilation behavior. They may observe the scars when undressing in the locker room or at sleepovers. Talking to peers or having a presenter talk about what to do if peers suspect a friend self-mutilates helps demystify the behavior, as well as providing them with resources about what to do and to whom to talk about getting help for friends.

**Stop the behavior.** When the student is discovered harming himself or herself in school, it is important to stop the behavior, talk to the student, and stay with the student until a school counselor or school psychologist can meet with the student. An open attitude and willingness to listen is one of the best responses when dealing with a student who self-mutilates.

When a student is caught cutting himself or herself on school grounds, the school counselor or school psychologist can help in the process of differentiating between a suicide attempt and an act of self-mutilation. For the school mental health provider who works in the middle and high school, standard interview procedures should incorporate questions about whether the student cuts or does any other self-mutilation behavior, and explore the student's coping mechanisms.

**Refer for help.** Additionally, the school counselor's or school psychologist's role is to assist the student and the family in finding a mental health provider in the community who treats adolescents who self-mutilate. This mental health provider will provide the necessary support and skills for the student to learn how to identify, regulate, and communicate emotions in adaptive ways.

## Resources

- Holmes, A. (2000). Cutting the pain away: Understanding self-mutilation. In *Encyclopedia of psychological disorders*. Philadelphia: Chelsea House. ISBN: 0-7910-4951-5.
- Levenkron, S. (1998). *Cutting: Understanding and overcoming self-mutilation*. New York: W.W. Norton. ISBN: 0-393-31938-5pb.
- Reid, S., & Henry, J. (2001). Deliberate self-harm. *Primary Care Psychiatry*, 8(1), 1–7.
- Safe Alternatives: 1-800-DONTCUT (1-800-366-8288).
- Ungerleider, S. (Ed.). (2000). Self-mutilation [Special issue]. *The Prevention Researcher*, 7(4).
- Zila, L., & Kiselica, M. (2001). Understanding and counseling self-mutilation in female adolescents and young adults. *Journal of Counseling and Development*, 79, 46–52.

## Websites

- American Self Harm Information Clearinghouse—  
<http://selfinjury.org>
- Focus Adolescent Services—  
[www.focusas.com/SelfInjury.html](http://www.focusas.com/SelfInjury.html)
- National Mental Health Association (fact sheet)—  
[www.nmha.org/infoctr/factsheets/selfinjury.cfm](http://www.nmha.org/infoctr/factsheets/selfinjury.cfm)
- Secret Shame/Self-Injury Information and Support—  
[www.palace.net/~llama/psych/injury.html](http://www.palace.net/~llama/psych/injury.html)

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