Adolescent Self-Injury

A Comprehensive Guide for Counselors and Health Care Professionals

Amelio A. D’Onofrio
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Self-injury—the intentional cutting, burning, or otherwise wounding of the body without the intent to die—once a behavior found primarily among the severely mentally ill, has, in recent years, grown to almost epidemic proportions in the general adolescent population. Counselors, health care professionals, and adolescents themselves tell stories of how cutting or other acts of self-mutilation have become pervasive in contemporary youth culture. These ubiquitous behaviors now compete for increased clinical attention and, as such, are beginning to take their rightful place in the pantheon of the more common, better understood, and perhaps more “acceptable” forms of self-destructive acts typical of the adolescent years.

Those of us who work with adolescents have become all too familiar with (and perhaps even somewhat immune to) the destructiveness of the more typical acting-out behaviors of the young people in our charge—binge drinking, drug use, unsafe sexual practices, and disordered eating, as well as the other high-risk behaviors that invariably compromise their safety and well-being. In fact, within some adolescent subcultures, behaviors such as these have come to be considered rights of passage or badges of honor required for group membership. The prevailing attitudes seem to suggest that if one doesn’t drink to the point of passing out, one is clearly not part of the fun in-crowd; or, if someone isn’t sexually active, there must be something seriously wrong with him or her. In turn, we professionals have become so familiar with some of these commonplace forms of negative self-expression that many of us feel desensitized to the shock value and, perhaps, even to the actual dangerousness of some of these behaviors.

Educators and mental health professionals in the school or college setting have accordingly come to expect that adolescents will drink to excess, act out sexually, develop disordered eating patterns, and engage in other high-risk behaviors. We have come to understand these indirect forms of self-harm to be “normal” ways adolescents struggle to find their place in the world and deal with their problems. Many numb, medicate, or otherwise distance themselves from the difficult-to-tolerate feelings they may have about their emerging adulthood, problems at home, or difficulties in their peer relationships. As we have come to better understand how their distress is voiced through these
indirect yet self-destructive ways, we have also learned how to more accurately conceptualize what those behaviors may represent and have, accordingly, developed effective approaches to respond, assess, and intervene.

More elusive, however, has been our understanding of the more direct form of adolescent self-destructiveness that, in recent years, has come to be embodied through the phenomenon of self-injury. Intentional self-injury refers to the deliberate, nonsuicidal disfigurement or destruction of bodily tissue, usually accomplished by cutting, scratching, or burning the skin, picking at wounds, inserting objects into the body, or banging one’s head. While self-injury is not a new phenomenon and has been an accepted form of self-expression in some cultures and traditions (Favazza, 1996), its current manifestation in the adolescent population is clearly disturbing and represents a socially unacceptable form of self-expression (Walsh, 2006; Walsh & Rosen, 1988). Until recently, self-injury has rarely been examined as a phenomenon in itself but has been associated with other forms of psychopathology, most notably with depression and suicidality and with borderline personality disorder (Favazza, 1998; Hodgson, 2004). It had predominantly been thought of as a behavioral characteristic associated with severely disturbed adolescents found on inpatient psychiatric units or in residential treatment programs. But, to the shock and dismay of many, self-injury has now become significantly more pervasive in the general adolescent population and is often seen in nonclinical settings such as schools (Muehlenkamp, 2005) and college campuses (Whitlock, Eckenrode, & Silverman, 2006). As a result, school counselors, teachers, coaches, nurses, social workers, psychologists, and student life personnel working in these settings have now become the frontline responders who are usually the first to identify individuals who engage in self-injury and who are, therefore, the first compelled to intervene.

Consequently, the educational environment has emerged as the primary place in which adolescents who engage in self-injury first come to the attention of others and, therefore, as the place where the provision of care can often begin. Typical scenarios include situations in which students who may be concerned about a friend may confide in a trusted teacher or counselor about the friend who is cutting or burning herself. Students may approach an RA or other student life staff member on the college campus about a roommate who cuts. Or, school personnel—coaches, nurses, and administrators—may inadvertently come across signs of scarring or other evidence of bodily injury and are then faced with the task of addressing what they have noticed. What characteristically follows is that these individuals (the untrained frontline responders) often become overwhelmed by the mysteriousness, irrationality, and seeming deviancy of the self-injurious behaviors they encounter and are usually at a loss as how to take action and be of help to the student in need.
The very thought of having to respond to someone who cuts and scars herself can evoke terrifying and disturbing emotions in helpers. They may feel horror and disgust, on one hand, and, on the other, may experience a profound sense of sadness and powerlessness. They may feel helpless at their inability to come to terms with the seeming senselessness of the behavior and may become anxious about not knowing how to best intervene. As a result of these powerful reactions, the quality of their responses can vary dramatically, and the care administered can be compromised. Some helpers, who may feel shocked, overwhelmed, or angered by the behavior, may trivialize or ignore it, attributing it to the manipulative, attention-seeking maneuvers of the adolescent. Others may misidentify it as a suicide attempt and then mobilize accordingly (Favazza, 1998). Unfortunately, neither approach is well suited to effectively facilitate either the immediate assessment needs of the situation or the longer-term treatment of the individual engaging in the self-injury.

**THE INTENT OF THIS BOOK**

This book is written with the intention of assisting frontline professionals in developing a thorough working understanding of the nature, meaning, and function of adolescent self-injurious behavior. In doing so, it draws together seemingly disparate but, in fact, converging perspectives from the research literature in psychology, psychiatry, nursing, sociology, and feminist studies in order to paint a textured landscape of the issues involved and of the individuals who engage in the behavior. Where appropriate, the words of self-injurers themselves will be used to tell their stories. Their words are particularly poignant as they come from individuals who generally experience themselves as silenced and voiceless. Self-injury, as presented in this book, is conceptualized as *symptom*. It is a symptom of a more complex phenomenon. It is a physical manifestation of profound psychological wounding that is often inaccessible to the sufferer and, as such, represents a kind of psychological pain that is literally *unspeakable*. Self-injurers speak their pain through their acts of self-harm.

The book begins by exploring the current proliferation of adolescent self-injury, examining its nature and complexity, and identifying the challenges frontline professionals face in addressing this new epidemic. The lack of understanding of the phenomenon has helped create, in the eyes of the uninformed, a new subculture of seeming deviants who cut and mutilate themselves and have come to be seen as “fringe” characters who are mysterious, bizarre, and, perhaps, also dangerous. Even counselors and health care professionals who have little experience working with these individuals are frequently hesitant.
to engage these clients and, when they do, do so with trepidation and fear. Because of their lack of training and understanding, many professionals report feeling ill prepared to respond effectively to these individuals. They lack confidence in their ability to help and, therefore, are less willing to more fully invest themselves in the service of these clients (McAllister, 2003; Rayner, Allen, & Johnson, 2005; Roberts-Dobie, 2005). The purpose of the first part of the book is to provide frontline professionals with a comprehensive understanding of the etiology, dynamics, and phenomenology of self-injury so that they can more clearly see and make contact with the person behind the behavior. With greater awareness and knowledge about the phenomenon (and the person), one can more readily experience empathy and bridge the psychological distance between the injurer and the helper. Understanding can powerfully transform revulsion and fear and can more authentically bring to the fore the humanity of the individual who presents him- or herself to us for help.

Following the examination of the core phenomenological issues related to self-injury, the focus of the book shifts to the integration of understanding with practice. The steps for engaging and assessing self-injurers are reviewed, and guidelines are provided that escort the helper through the process. The guidelines are written with the school or college professional in mind, as they are often the first to respond to distressed adolescents who intentionally wound their bodies. These frontline personnel are frequently in the best position to conduct initial assessments and mobilize the appropriate resources to best effect referral and initiate treatment (American Academy of Pediatrics, 2004; American School Counselor Association, 2004; Roberts-Dobie, 2005). The assessment, triage, and referral protocols provided herein will, in essence, walk the counselor step by step through the process, from the point of initial contact with the self-injuring student, to developing a working alliance, to treatment, to exploring posttreatment follow-up considerations.

The final section of this book explores the role of the frontline responder in working with parents, teachers, administrators, student life personnel, and other stakeholders. It offers suggestions for creating both effective pathways to care and establishing support networks that will facilitate the recovery and reintegration of the self-injurer into the school or college setting.

The reader will note that individuals who engage in self-injurious behavior are referred to in this book as “self-injurers.” The label “self-injurer” is used descriptively and for literary convenience. It does not imply that self-injury is the defining characteristic of who these individuals are. These are individuals who self-injure. The label should by no means diminish the complexity and depth of their humanity. They are much more than their self-destructive behaviors.

It should also be noted that in cases in which actual clients are quoted, names and other identifying characteristics have been changed. Additionally,
the feminine pronoun is used more frequently in most third-person refer-ences. Although the rate of self-injury among men is on the rise, to date the preponderance of self-injurers who have come to the attention of clinicians and who have presented for treatment have been overwhelmingly female.

ORGANIZATION OF THE BOOK

In order to accomplish these goals, the book is divided into three parts. Part I, *The Nature and Paradox of Self-Injury* (Chapters 1–5), provides a working overview of the central descriptive and classification issues of the phenomenon. Chapter 1 identifies the overarching challenges counselors and health care professionals on the frontlines face in responding to adolescent self-injury. Chapter 2 focuses on defining, categorizing, and situating self-injury in historical and psychiatric context. Chapter 3 explores the environmental and developmental conditions that may predispose an individual to self-injury. The hypothesis that early relational trauma serves as a foundational condition for the developmental of self-injurious behaviors is examined, and a tentative profile of self-injuring adolescents is offered. Chapter 4 presents the specific developmental effects of trauma by illustrating parallels between the trauma outcome literature and characteristics identified in self-injurers. Chapter 5 concludes Part I of the book with an explication of the adolescent’s phenomenological experience of the behavior itself and the role and function the behavior plays in maintaining the individual’s psychological equilibrium.

Part II, *Engagement, Assessment, and Treatment* (Chapters 6–8), constitutes the clinical core of the text. Chapter 6 outlines the difficulties of engaging self-injurers and advocates a firm yet empathic and compassionate approach in meeting the person behind the self-destructive behavior. Specific assessment guidelines are then presented in Chapter 7. This chapter outlines the necessary steps to be taken in regards to assessment, triage, and referral facilitation. Part II concludes with an overview of the longer-term treatment process and outlines interventions targeted to redress deficiencies in specific psychosocial domains of functioning.

Finally, Part III, *Creating Pathways to Care* (Chapters 9–10), addresses some of the important ancillary considerations vital to the intervention process. Chapter 9 explores mechanisms for creating an environment of care for the adolescent in the school environment and on the college campus. It outlines how the counselor can play a consultative role by coordinating communication among teachers, administrators, student life personnel, and parents and offers practical suggestions on developing institutional policies and protocols for
the effective management of students in distress like self-injurers. Chapter 9 also examines dispositional issues appropriate to the school and college campus setting, respectively, and provides guidelines for the prevention of contagion of self-injury in those settings. Finally, personal and professional challenges that responders face in working with this population are discussed in Chapter 10. Suggestions for self-care to help mitigate burnout are proposed, and strategies for maintaining hope in spite of the difficulty of the work are offered.
Acknowledgments

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PART I

The Nature and Paradox of Self-Injury

The body is the guardian of the truth, our truth, because it carries the experience of a lifetime and ensures that we can live with the truth of our organism.

Alice Miller, The Body Never Lies

In so far as the mind is stronger than the body, so are the ills contracted by the mind more severe than those contracted by the body.

Marcus Cicero, The Phillipics

Scars have the strange power to remind us that the past is real.

Cormac McCarthy, All the Pretty Horses
CHAPTER 1

Introduction: Self-Injury on the Frontlines

I want someone who I can talk to, who treats me like a real person and makes me feel that I’m cared about. I want help to understand myself and feel in control of my life. I want to stop hurting myself, to learn other ways of coping. I don’t want to be made to feel ashamed of myself anymore, ashamed of what I do to mentally survive.

Lucy (in Smith, Cox, & Saradjian, 1999, p. 72)

At the final bell announcing the end of the school day, you notice Jessica and Abby hesitantly standing near the door of the guidance office. In a reticent, barely audible voice, Abby asks if they can come in and talk with you. You invite them in and close the door, and after a few awkward seconds of silence—with Jessica and Abby exchanging glances as if to see who will speak first—Jessica cautiously offers that they have something important to tell you. She explains that they are “really worried” about their friend Beth. They go on to report that in the past several months Beth’s home life has deteriorated. Her father’s drinking problems are causing havoc in the family, and her parents are on the verge of divorce. Beth finds herself in constant arguments with her mother and seems always sad, and her own drinking on weekends has gotten out of control. They then add that this past summer Beth confided to them that she occasionally cuts herself with a razor on her arms and legs. They’ve tried to be supportive by being with her as much as possible in the hope that she wouldn’t cut herself, but that hasn’t worked. To the contrary, Beth is cutting more frequently now, and they’re “really scared.” They don’t know what to do, and they want you to help.
You are a psychologist at the college counseling center and receive a call from the Director of Residential Life informing you that the previous night, a female resident who was extremely intoxicated engaged in self-injury sufficient to result in admission to the emergency room at the local hospital. The student had inflicted deep cuts on her arms, resulting in significant bleeding, which was subsequently observed by her roommates, who were, understandably, very distressed about the incident. The student who self-injured was about to be released from the hospital after having her wounds treated, and she wanted to immediately return to her room in the residence hall. Her roommates do not want her to return because they believe she will do this again. The Director of Residential Life is calling you for help in deciding whether the student should be allowed to return to her room and is asking you to help address the roommates’ concerns.

Christine checks into the nurse’s office and asks to see you because she is not feeling well. As you finish with another student, you see Christine in the waiting area appearing tired and teary eyed. While escorting her into your office, you ask her how she is doing because she looks very sad. Christine begins to cry. Between her sobs, she shares with you that she didn’t sleep much last night because her parents were fighting. “They’re always fighting. They hate each other. I hate them. I wish they would stop,” she volunteers. “They’re always so self-absorbed and never listen to anything I have to say. It’s as if I don’t count at all. Every time I tell my mother how bad I’m feeling, she tells me to ‘get over it’ because there are lots of other people worse off than me. And my father, well, he doesn’t even know I exist.” As you continue to listen, she adds, “I can’t take this anymore. I don’t know what to do. I feel like I’m losing it. I’ve been doing some stupid things, and I don’t want to do them anymore but don’t know what else to do.” She then rolls up her sleeves to reveal four parallel vertical scratches starting at her wrists and moving up her arm. The scratches are superficial, but of greater concern are the other scars you notice on her arm. As Christine continues to cry, she tells you that she has been cutting for 2 years and that she does it because she feels better afterwards. She has reached the point now where she cuts twice a week, feels like her friends have abandoned her because she has become “too needy,” and feels even more lonely and helpless. With tears running down her cheeks, she whispers, “I don’t know what else to do. I hate my life!”

These three scenarios are only a few examples of what is becoming a commonplace reality in the daily work of many counselors and health care professionals in schools and on college campuses. While the act of cutting, mutilating, or otherwise injuring oneself has occurred throughout human history (Favazza, 1996), there has been a seeming explosion in both the occurrence and the public awareness of self-injurious behavior over the past
decade (Nock & Prinstein, 2005). Acts that are direct forms of harm perpetrated on the body, such as intentional and “delicate” cutting of the skin, have emerged as yet another common form of self-destructive adolescent behavior. The occurrence of these self-injurious acts is growing at a rate that has given mental health professionals pause. Self-injuring adolescents and young adults are beginning to compete for the clinical attention historically paid to those engaging in the better established, or more traditional, self-destructive activities of the adolescent years, such as substance abuse, eating disorders, or the myriad other high-risk, impulsive acts characteristic of this age group. Intentional self-injury is rapidly becoming the new adolescent pathology of the times and, as such, is still poorly understood.

SELF-INJURY: A NEW SYMPTOM FOR OUR TIME

Every age gives birth to new ways in which human beings give voice to their suffering, and our present age is no exception. Human beings have struggled throughout history to understand their own being-in-the-world and to make sense of the reality of suffering that being human sometimes brings. As our understanding of medicine, psychology, and the complexity of the human organism has become more sophisticated, we have moved from the more mythopoetic and, perhaps, simplistic explanations of difficult-to-understand psychological phenomena to ones that are more multifaceted and less dogmatic. For example, we no longer view those who experience hallucinations as “possessed” by demons or as inherently morally deviant. Rather, we are able to offer more informed explanations that speak to their symptoms as being a consequence of their genetic predisposition, neurochemistry, or developmental history, some combination of which may have contributed to their particular mode of psychological suffering.

Our understanding of psychological symptoms and the way we articulate that understanding are always culturally and historically situated (Berger & Luckman, 1967; Cushman, 1990). Our existence in a particular time and place unavoidably mediates what kinds of symptoms emerge from our suffering as well as how they manifest themselves in people’s lives. How we are situated in a particular place and time also contextualizes how we construct meaning around those behaviors and symptoms so that we can more accurately categorize them into new and more refined syndromes or disorders. This evolution in understanding is clearly evidenced in the psychiatric community’s ongoing revisions of The Diagnostic and Statistical Manual of Mental Disorders (DSM), which will soon be published in its fifth iteration. We have seen this process play out throughout the brief history of the formal disciplines
of psychiatry and psychology. For example, in Freud’s Victorian Age, “hysterical neurosis”—the conversion of psychological distress into symptoms of physical paralysis—emerged as the new pathology of that time. In fact, the attempts at treatment of the new disorder gave rise to the development of psychoanalysis. More recently, the 1970s inaugurated eating disorders as the new, emerging “it” pathology—the new modality by which some young women manifested and lived out their particular form of psychic distress. And it appears that in our current time and place, self-injury is quickly emerging as the “psychopathology of choice” in many young people.

As a relatively new behavioral manifestation of psychological distress, the phenomenon of self-injury constitutes an extension of the continuum of self-harm that ranges from the more hidden forms of harm (e.g., overwork, poor eating habits, smoking) to the more active and dramatic forms of destructiveness (e.g., substance abuse, sexual risk taking, eating disorders, suicidality, and, now, self-injury) (see Turp, 2003). Although all forms of self-harm are ways of living out and communicating one’s ambivalence, pain, and self-destructiveness, self-injury is an especially difficult and disturbing behavior because it perpetuates violence on the body (and onto the self) in direct, dramatic, and strident ways. It makes a powerful statement about the psychological distress of an individual and the distorted and harmful attempts made by that individual to manage and soothe her pain. It points to a sense of powerlessness experienced by the person and is often suggestive of a subtle and deeply buried trauma of psychological neglect, invalidation, and emotional abandonment suffered at the hands of a parent, a family, and, perhaps, even a culture. Self-injury, then, is a complex phenomenon that speaks loudly about an individual’s emotional pain and about her attempt to assuage it.

Clinicians and mental health researchers are finding that self-injury is closely aligned and highly correlated, in both form and substance, to eating disorders, and they suggest that these are clinically interconnected syndromes (Farber, 2000; Levitt, Sansone, & Cohn, 2004). In fact, Conterio and Lader (1998) have dubbed self-injury the “new anorexia” of our time. They explain that self-injury and eating disorders denote similar psychological dynamics. Cutting, like depriving oneself of food, represents a powerful form of communication. The behavior is a plea to have one’s voice heard, an attempt to break the silence that has been imposed by, in many cases, the very people who are most supposed to care and to listen. Cutting is a specific language of pain that communicates the suffering of past and current trauma, which is spoken loudly by the self-inflicted repetition of that trauma upon one’s own body (Conterio & Lader, 1998; Farber, 2000; Nasser, 2004; Strong, 1998).

Self-injury is the “new anorexia” also in the sense of its sudden emergence and swift proliferation in our society (Conterio & Lader, 1998; Farber 2000).
It appears to be closely paralleling the evolutionary footsteps of its eating disorders counterparts. In the 1970s, anorexia nervosa was just beginning to be recognized as a growing problem among young women. By the 1980s, however, it had reached full status as the most highly publicized disorder of the day, and clinicians were seeing young women with eating problems in high schools and on college campuses in increasing numbers. These young women acted out their psychological pain on their bodies through a deprivation of nourishment that poignantly mirrored the emotional deprivation they otherwise experienced in their lives (Hund & Espelage, 2005; Piran & Cormier, 2005). When the phenomenon of anorexia entered public discourse, in the 1970s, it was seen as a mysterious and incomprehensible illness that was thought to be intractable. The very thought of starving oneself seemed bizarre and frightening, both to the general public, which heard anecdotal descriptions of the deviant eating behaviors, and to the health care professionals who had to treat these individuals. As attention and research increased, however, a clearer understanding of the phenomenon filtered through to the public via the mass media. As a result, anorexia became less of a taboo subject and therefore, eventually, less stigmatizing for its sufferers. Likewise, as clinicians developed greater understanding of the illness, they also developed greater sensitivity to the dynamics and pain behind the disorder. They were better able to look for the human being behind the behaviors and no longer be diverted by the disturbing nature of how these individuals acted out against themselves. As clinicians were able to put a human face on the illness, working with these individuals became a less frightening and burdensome task. This shift in attitude contributed significantly to the creation of greater tolerance for the morbid and disturbing nature of the disorder, which, in turn, allowed clinicians to become more open to increasing their understanding and competence in treating these patients.

The emergence and proliferation of and the response to adolescent self-injury are following a pattern similar to the one that occurred with eating disorders 30 years ago. While self-injury is not a new psychiatric phenomenon, it has only recently become the focus of significant clinical scrutiny. Traditionally, it had been trivialized, misidentified, or considered solely as a symptom of some other syndrome. We are now finding that self-injury has “come of age” as its own discrete expression of profound psychological pain (Favazza, 1996, 1998) and is fast becoming the new mode by which many young women (and some young men) are now learning to give voice to their suffering.

As eating disorders challenged the conceptual understanding and practical experience of health care professionals 30 years ago, the advent of self-injury as the latest adolescent mental health malady of the new century offers similar challenges. We are at the infancy of our understanding of this phenomenon.
In fact, it is so novel as a syndrome that it has yet to be considered a discrete disorder in and of itself by the American Psychiatric Association (2000) but appears only in the DSM-IV-TR as a partial criterion for the diagnosis of Borderline Personality Disorder. Because we still know relatively little about the phenomenon, the rate and intensity with which mental health professionals encounter these self-destructive behaviors in adolescents far exceeds their understanding and expertise.

**SELF-INJURY IN THE PUBLIC EYE**

Public awareness of self-injury has been raised in recent years through extensive media coverage. Television dramas, entertainment news programs, feature films, and the print media have all contributed to heightening consciousness about the growing incidence of self-injury. In particular, the widespread coverage of celebrities and other high-profile individuals who have publicly acknowledged that they have cut or otherwise injured themselves has had a profound impact on the public’s willingness to begin to destigmatize the behavior and has opened the floodgates, as it were, for others to disclose their own behavior and seek treatment. Celebrities such as Princes Diana, Angelina Jolie, Johnny Depp, Drew Barrymore, Marilyn Manson, and Courtney Love have all publicly disclosed that they once inflicted on their bodies some form of direct and intentional injury. The phenomenon has also appeared in the plotlines of a number of popular television programs such as Beverly Hills 90210 and Seventh Heaven and in feature films like Girl, Interrupted and Thirteen (Adler & Adler, 2005). The effects of its presence in the entertainment media have, in a sense, legitimated self-injury as a real phenomenon that warrants attention, and disclosure of self-injury by celebrities may have helped create an atmosphere that has given other injurers the courage to come forward and seek help.

The national print media have also made contributions to this discussion with feature articles that have raised the public’s awareness even further about the growing “epidemic” (Nevius, 2005, April 19). The New York Times, the Boston Globe, the Chicago Tribune, Time, and Newsweek have all shed more light on the problem and have exposed some of the larger, more complicated issues related to the treatment and recovery from the self-damaging behaviors. The titles of some of these articles alone (e.g., “An Arm Full of Agony” [Kalb & Springen, 1998, November 9], “An Epidemic That Cuts to the Bone” [Nevius, 2005, April 19]), speak poignantly to a subtext of pain that has continued to capture the public’s attention. And, as an unintentional consequence, the broad and sometimes graphic coverage has helped mobilize professionals to become
better informed about the phenomenon and to learn more about assessing and treating adolescents who express this very powerful message of pain.

Self-Injury on the Internet

The other simultaneous development that has increased awareness and stimulated public discourse about self-injury has been the emergence of new Internet sites and chatrooms on the subject. Since the year 2000, the Internet has erupted with sites about and for people who self-injure. While not all sites are positive and pro-recovery, many are, in fact, devoted to helping self-injuring individuals better understand their behavior and offer support and resources to help in the recovery process. (A listing of a few of these sites is provided in Appendix III.) A number of the sites also provide discussion forums where injurers are able to anonymously and safely write about their struggles. Participants often share their stories, which resound with the pain of abuse and neglect and which speak deeply to their ingrained feelings of disconnection and invalidation. These sites provide a community of “understanding” that creates a safe space for participants to find greater courage to honestly share their experience and, as a result of doing so, to perhaps begin the process of unbinding themselves from their shame. Many of these sites offer opportunities to interact with others with similar experiences who, while not ready to relinquish their self-injury, may find comfort and develop hope through the anonymous, yet meaningful relationships they develop online.

What is clear is that the power of the anonymity of the Internet may make it easier for individuals to openly tell their stories. It affords participants the possibility of expressing those parts of their lives that may normally be inhibited in polite social conversation and to present more of their authentic selves (Adler & Adler, 2005). This authentic self-presentation and the experience of having that personal presentation accepted and supported can become a powerful foundation for the beginning of recovery. This supportive context can, in turn, then become the fertile ground to offer self-injurers hope to seek out assistance in more formal ways and begin the process of recovery in earnest. At the same time, the anonymity of the Internet can also create conditions under which individuals seeking connection and support can be influenced in negative ways by the relationships they develop online. Vulnerable individuals can be swayed by more forceful peers on the other end of the e-mail or the instant message. The danger is that self-injurers can become better at self-injury by learning from others they meet online (Whitlock, Powers, & Eckenrode, 2006).

Overall, though, the increased public awareness of adolescent self-injury resulting from greater media and Internet exposure has unmistakably generated
a proportional increase in the identification and reporting of the behaviors constituent of self-injury. As a result of these shifts in public consciousness, counselors, nurses, coaches, administrators, student life personnel, pediatricians, and youth ministers—all those professionals who work closely with adolescents—are now finding themselves the first adults to learn about a particular adolescent’s self-injuring behavior and, therefore, the first compelled to intervene and provide assistance. These are the people who have become our frontline responders to adolescents who, because of their pain, have paradoxically turned against themselves by “cutting away” at their own bodies as a way to ease and extinguish their distress and suffering.

THE PROBLEM FOR FRONTLINE PROFESSIONALS

To be sure, the Internet and the media’s coverage of self-injury have significantly raised the level of awareness about the phenomenon among the general public, health care professionals, and self-injurers themselves. This increased consciousness has decreased the stigmatization that self-injurers have historically experienced and has allowed many to feel safer in disclosing their behavior to others, thereby taking the first step in seeking assistance. Counselors and other frontline health care professionals, however, have been caught off guard by this newly emerging mental health problem and by its attendant “epidemic of disclosure” of recent years (Levenkron in Edwards, 1998, November 9). Consequently, helpers on the frontlines—in schools, doctors’ offices and emergency rooms, and on college campuses—have reported feeling inadequately trained and ill prepared to understand and work effectively with individuals who self-injure (McAllister, 2003; Rayner, et al., 2005; Roberts-Dobie, 2005).

Self-Injury and the School Counselor

The school setting has become one of the primary venues where adolescent mental health issues are first identified and where referral for treatment is often initiated (Dollarhide & Saginak, 2003). School counselors are, more often than not, the first mental health professionals that students encounter. In fact, school counselors may often be the first person to whom students would consider disclosing their personal problems, given the access and personal relationship they may have with them (Froeschle & Moyer, 2004). These professionals very often deal with the mainstream mental health concerns students bring to their attention—divorce, sexual abuse, substance abuse, dating violence, bullying, sexual identity exploration, and
so on. Unfortunately, self-injury is rapidly becoming one of those problematic behaviors that compete for professional attention in schools. A recent survey (Roberts-Dobie, 2005) of randomly selected members of the American School Counselor Association (ASCA), the largest school counselor organization in the United States, found that most respondents (81%) reported having worked with a student who self-injured. However, unlike their experience working with more common mental health issues, where counselors generally feel a sense of competence and expertise, only 6% of the respondents reported feeling highly knowledgeable about actually working with the self-injuring student. Overall, they rated themselves highest on knowledge of symptoms of self-injury, followed by knowledge of the root causes of self-injury, but lowest on knowledge of intervention strategies and treatment.

The high school years bracket the age range when self-injurious behaviors typically begin (Conterio & Lader, 1998), and, therefore, school counselors are in a uniquely powerful position to intervene in the lives of these individuals (Roberts-Dobie, 2005). The problem that arises, however, is that if counselors do not feel competent and confident, as the survey suggests, their effectiveness in appropriately intervening will necessarily be compromised. In order to identify self-injuring behaviors and take appropriate action, school counselors not only must understand the dynamics of self-injury itself but, more important, must possess, at the very least, a rudimentary knowledge of the necessary steps to take when confronted with a self-injuring student. Roberts-Dobie (2005) notes that while there is much extant literature describing school counselors’ work with other mental health issues such as suicidality and eating disorders, very little guiding literature exists regarding work with the self-injuring population in the school setting.

**Self-Injury and Student Services Professionals on the College Campus**

A recent study (Whitlock, Eckenrode, & Silverman, 2006) utilizing the largest sample to date of U.S. college students (ages 18–24) clearly suggests that self-injury is a serious problem on the college campus, as well. Seventeen percent (N = 490 of 2,875) of the respondents reported that they had practiced self-injury at some point in their lives, 7.3% within the last year. Twenty-one percent of all those who had self-injured had injured themselves more seriously than expected, but only 6.5% of all self-injurers ever sought medical attention for their injuries. Nearly 40% of all the respondents also reported that no one was aware of their self-injurious behavior.
If these data can be assumed to reflect trends across college campuses, then mental health and student life professionals in these settings find themselves facing a new student problem that must be addressed. The college or university setting, however, has its own unique problems for responders. First, most students in college are no longer minors and live independently. They are not a “captive audience” in the same way high school students may be. As a result, there are fewer opportunities for responders to be made aware of their self-injury unless the individual herself or people close to her reveal the information. Second, as the study confirms, self-injuring individuals on college campuses tend to avoid seeking professional help and, therefore, are less accessible and amenable to care. The implication of this, of course, is that college mental health and student life staffs must become increasingly sensitized to the presence of this new mode of self-destructive behavior in order to better identify and respond to individuals who may require help.

Self-Injury and Health Care Professionals

Self-injuring adolescents may also come to the attention of adults during a visit to the school nurse or at a routine visit to their pediatrician’s office. In more serious cases, they may be brought to hospital emergency rooms to have their injuries treated. Unfortunately, as Conterio and Lader (1998) observe, “many medical professionals are just as uninformed as lay people about self-injury and how to treat it” (p. 27). They are inadequately trained to treat the individual who presents with the self-injury; therefore, they often simply attend to the physical wounds and neglect the person behind the injuries. In fact, their attitudes toward self-injurers have occasionally been observed to be hostile and unhelpful (McAllister, 2003; Rayner et al., 2005). Self-injurious behaviors are commonly interpreted as “manipulative” or “attention seeking,” and the patients manifesting these behaviors are considered to be recalcitrant and unmanageable (Rayner & Warner, 2003). Medical professionals frequently report finding it difficult to connect to these patients on a human level. They, instead, divert their focus to patching up the wounds and sending the individual home. They report feeling helpless, ambivalent, and frustrated in dealing with these difficult-to-understand individuals (McAllister, Creedy, Moyle, & Ferrugia, 2002) and often become resentful at feeling “emotionally blackmailed” by them (Conterio & Lader, 1998). As a result of these attitudes, many of those who require medical attention because of their injuries have learned to present themselves to medical professionals as suicidal rather than as “pure” self-injurers, as the former approach is more likely to elicit compassion than the latter, which often evokes anger (Clarke & Whittaker, 1998; McAllister et al., 2002).
Frontline Responders, Countertransference, and the Crisis of Confidence

Do my scars embarrass you so much?
You make me feel like you do not want me near you.
The look on your face, your posture, the movement of your body, speak only of disgust.
I feel so alienated from you.
Like I was so alienated from my family, particularly my mother.
She never heard my fear, my pain, my shame, but was disgusted by me too.
I learnt to stay silent, and now it is so much easier to let blood flow than words.

Tyler (in Smith et al., 1999, p. 130)

Self-injury is a complex and multidimensional phenomenon, and self-injuring adolescents are very difficult to treat. The difficulty in engaging these individuals in treatment resides not only in the resistant, almost addictive quality (Turner, 2002) of the behaviors themselves but also in the fiercely distancing emotions they elicit in others. Self-injurers inevitably evoke compelling countertransferential feelings in the helper. The potent yet primitive statement that self-injury makes to others is one of profound pain and rage that is unsettling and often overwhelming for those who try to help—even for the most seasoned clinician.

In a recent conversation, a colleague who has worked in the field as a school counselor for close to 20 years spoke precisely to the kinds of mixed feelings counselors can have in dealing with self-injuring adolescents. He noted:

When a student walks into my office and begins to talk about one of her friends who is a “cutter,” I immediately start feeling anxious and go into crisis mode. I think to myself: Is she suicidal? Is this a cry for attention? Is she being manipulative? Should I call her into my office immediately? Should I check in with her parents? Should I let the administrators know? I’ve felt confused about how to handle these situations. I often feel incompetent in knowing what the right thing to do is. And that pisses me off. I think what gets in the way for me sometimes is that, frankly, I’m a little freaked out by someone cutting themselves on purpose. And, I know I’m not supposed to feel scared, right? I’m the student’s counselor. But I do, and it makes me want to avoid the situation altogether.

This reaction is typical of counselors and other health care professionals on the frontlines. The powerful feelings induced by self-injury destabilize
clinicians’ sense of competence and confidence, and these individuals often experience overwhelming feelings of helplessness (Connors, 2000). When feeling off-balance in this way, clinicians can also have extreme reactions to compensate for their feelings of impotence. On the one hand, for example, they might respond to the extreme pull of the self-injurer to be relieved of her pain. As a result, clinicians can be drawn into the client’s dynamics and may develop such compassion and a “need” to be helpful that they become overinvolved and lose their sense of professional boundaries. Soon enough, though, they may discover that what they offer is not enough or is blatantly rejected and sabotaged. The clinician’s stance can then easily shift from being overinvolved and supportive to being angry and rejecting of the client. This shift, in essence, plays out very dramatically the self-fulfilling prophecy for the self-injurer. It reinforces for her the belief that people are disgusted by her and her behavior and that no one truly cares or can help (Conterio & Lader, 1998).

The clinician’s professional equilibrium is additionally challenged by the struggle to determine whether this self-destructive behavior is necessarily suicidal. The cuts may be superficial, but the blood that flows is certainly real. What happens if the client cuts herself too deeply and does serious harm? Should she then be responded to as if she were suicidal, although she clearly denies it? This confusion is further intensified by the visceral reaction that one can have at hearing how the self-injury is caused or by actually seeing the client’s wounds and scars. The mere sight of blood can make some people nauseous, and seeing the wounds can produce deep feelings of disgust (Alderman, 1997); for one who is not prepared for the crudeness of the display, seeing someone’s open wounds or healing scars can be quite alarming and even traumatizing (Connors, 2000).

These factors eventually contribute to many clinicians’ developing negative attitudes toward self-injurers, and these attitudes in turn produce emotions in clinicians that are difficult to manage (Rayner et al., 2005). In a culture that openly values health and attention to self-care, intentional and repeated attempts at the wounding of one’s own body become incomprehensible. Particularly for health care providers whose very professional identity and self-worth are predicated on their desire and perceived ability to actually be helpful to others, the seeming senselessness of self-injurers’ actions can be devastating to the clinicians’ own sense of competence. Helpers want to help, and being able to help is based on one’s belief that he or she can actually be helpful to others and that his or her help will be accepted. The primitiveness and destructiveness of self-injury however, creates a scenario for helpers that flies in the face of their very self-identity and confidence in being helpers. As a result, they may become angry at and resentful toward their client, feelings that eventually may turn into guilt because of the common belief that “good
clinicians aren’t supposed to experience negative emotions about their clients.” These destabilizing feelings are then often conflated by the clinician into feelings of being deskill ed and incompetent, which strike directly at the heart of their professional confidence and their actual ability to provide good care to their clients (McAllister, 2003; Rayner et al., 2005).

This loss of confidence is ultimately responsible for what Connors (2000) refers to as compassion fatigue. Compassion fatigue occurs when clinicians come to feel so overwhelmed and helpless because of the pain and trauma of their clients that they have difficulty sustaining the capacity to respond usefully to those individuals. In these cases, it is easier to see self-injuring clients as uncooperative, self-sabotaging, and treatment resistant than to contain and be present to their powerfully primitive projections and behaviors.

The unfortunate outcome of this dynamic is that it leads the helper to therapeutically disengage from the self-injurer. When this occurs, counselors and other responders may ignore or be outright unwelcoming to students who self-injure (Austin & Kortum, 2004). They may make pejorative judgments about the character of the adolescent, and they may fail to follow through with a thorough assessment (McAllister et al., 2002). These defensive maneuvers on the part of helpers serve to restore in themselves a sense of equilibrium and allow them to protect themselves from their perception of having failed to be helpful. In the end, it is easier to locate the source of the difficulty in the client rather to look at one’s own incomplete knowledge or unhelpful attitudes and beliefs (Rayner et al., 2005).

The problem is that as professional helpers disengage from their clients, they obviate those conditions so necessary to conduct appropriate assessments and to facilitate care—they do not empathically communicate acceptance and thus fail to build trust. As a result, clients may not return for follow-up care, and the opportunity for further intervention is lost. Inadequate assessments of self-injurers can be catastrophic, as it can increase the risk of repetition of the behaviors, and with the increase of repeated self-injury comes a significant greater risk (as much as an 18-fold increased risk) that the individual will eventually become suicidal (McAllister et al., 2002).

School and college counselors are usually in the best position to become involved in the lives of adolescent self-injurers. As such, they hold a great responsibility in making a positive first contact, as the nature and tone of that first contact is crucial to setting the stage for future treatment (McAllister et al., 2002). These professionals, in their ability to intervene early and well, serve as a bridge to more intensive and specialized later treatment (Roberts-Dobie, 2005). Therefore, their ability to be empathic, to engage, and to not be incapacitated by the behaviors are paramount in beginning to
establish the trust so necessary for the adolescent to remain connected and receive help. In fact, when clinicians feel helpless in working with traumatized clients, they actually have a higher likelihood of feeling traumatized themselves. Through their feelings of helplessness, their sense of competence is directly challenged, and, with that challenge, their confidence as caregivers plummets, as well. If they perceive themselves as having the skills to address the needs of self-injurers, however, “they are more likely to feel worthwhile working with such clients and less likely to demonstrate negative attitudes” (McAllister et al., 2002, p. 583).

The chapters that follow are written with the intent to increase awareness for frontline responders about what self-injury is—its nature, dynamics, and manifestations—and to increase their ability to respond effectively by providing practical guidelines for engagement, assessment, and intervention. With an increased understanding of self-injury and the development of the appropriate response and practice skills, frontline responders can come to see more clearly the person behind the behavior and thereby increase the likelihood of remaining therapeutically engaged with the suffering individual.

**SUMMARY AND CONCLUSION**

When human beings harm themselves intentionally, it is a sign that something has gone dreadfully wrong (Farber, 2000). We have seen, in recent years, that the incidence of self-injury is on the rise and that adolescent self-injurers are coming to the attention of frontline health care professionals as never before. At the same time, these professionals—counselors, nurses, social workers, and others—are finding that working with self-injurers, even at the initial stages of engagement and assessment, is extraordinarily demanding. The work with this population tests one’s professional know-how; it challenges one’s ability to be empathic and compassionate; and it can turn a normally patient and persistent helper into one who withdraws and disconnects. The drama of self-injury and its complicated processes immobilize highly skilled and competent clinicians and usurp their confidence in their ability to provide appropriate clinical care to their clients.

The awareness of this dynamic is the starting point in developing the knowledge base and skills necessary to tackle this client population. Understanding that one’s negative reaction to a self-injurer may be more typical than not may actually liberate us to more honestly assess our own skills and to work toward developing greater competence. The purpose of this first chapter has been to present self-injury as a rapidly growing symptom of adolescent distress, to highlight the likely role of counselors and other health care providers
as frontline responders, and to paint a realistic picture of some of the personal challenges that may make it difficult for some to work with self-injuring adolescents. Nevertheless, the reality is that on the frontlines, we have no choice—self-injurers will be brought to our attention and will need our care.

To this point, Farber (2000) captures very poignantly the challenge of the work that lies before us:

It is very difficult to treat patients who court death. It is a challenge to connect empathically with them, so we tend to resist the complex attachments that must develop if we are to treat these patients. It is much easier to see them simply as the sum of their symptoms, and to collude unconsciously with them in maintaining their symptoms and their sense of identity that is bound up in them. Understanding the mystery of self-harm … means getting in touch with the darkest, most violent, and primitive aspects of ourselves, a venture into unknown territory that evokes fear. It means bending toward the patient’s unconscious to face the monsters and demons in them and in ourselves. It means facing truths about ourselves, our families, and our society that we do not want to face. Trying to understand self-harm means entering into our patients’ darkest states of being, to tolerate dwelling there for a time, confident in one’s ability to emerge from it. (pp. 6–7)

In the next chapter we will turn our attention to defining self-injury, delineating its forms and manifestations, and to exploring the sociocultural factors that contribute to its growing proliferation.