College Students and Self-Injury: Intervention Strategies for Counselors

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This article provides an overview of self-injurious behaviors and provides intervention strategies for college counselors to use when working with students who self-injure. College counselors' roles in managing self-injurious behaviors are explored in relation to individualized treatment issues, outreach, education, advocacy, and prevention. Implications and recommendations for college counselors are provided.

Recently, self-injurious behavior has received increasing attention in the professional literature and in the popular media (Zila & Kiselica, 2001). Despite this increased attention, many counselors have not received specific training in how to treat clients who engage in self-injurious behaviors (e.g., self-cutting and self-burning), behavior patterns that can present unique challenges to effective counseling practice. A review of the topic indicates that college students' self-injury and college counselors' interventions with these students have not yet been adequately addressed in the professional literature. This article provides a brief review of client self-injury and provides intervention strategies for college counselors to use when working with self-injurious students.

Brief Overview of Self-Injurious Behavior

Definition of Self-Injury

All societies have culturally sanctioned and ritualized forms of self-injurious behavior (Favazza, 1996), which in fact can occasionally blur the line between socially deviant self-injury and socially sanctioned self-injury (such as tattooing and body piercing, which are common among North American college students; see Lord & Lehmann-Haupt, 1997). *Socially deviant self-injury* is often defined as self-injury that occurs in response to psychological crises and demonstrates a sense of disconnection and alienation from others (Dallam, 1997). When determining if self-injury is a pathological behavior or merely an act of expression (e.g., expressing creativity, individuality), Conterio, Lader, and Bloom (1998) suggested asking the following questions: (a) Is there a compulsive need to engage in the behavior? (b) Is the self-injury a result of artistic self-expression or does the person feel a "high" from the behavior? (c) Does the

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behavior consume the person's thoughts or interfere with daily functioning? and (d) Could the person realistically stop the behavior?

For the purposes of this article, *self-injury* is defined as a volitional act to harm one's body with no intention to die as a result of the behavior (Simeon & Favazza, 2001; Yarura-Tobias, Neziroglu, & Kaplan, 1995). Furthermore, in this article we limit the focus to the most common forms of self-injurious behaviors: self-cutting, self-burning, self-hitting, self-scratching, and interference with wound healing (Favazza & Conterio, 1988) that typically involve the arms and wrists, legs, abdomen, head, chest, or genitals, in that order of prevalence (Favazza & Conterio, 1989). We do not explore issues associated with hair pulling (e.g., trichotillomania) and extreme forms of self-injury (e.g., eye enucleation, amputation of body parts, bone fractures) because these are less commonly presented in college settings and they require different considerations.

Demographic and Clinical Correlates of Self-Injury

Individuals typically first engage in self-cutting behaviors in adolescence and early adulthood, with estimates of the first self-injurious episodes ranging from age 13 to 23 (Favazza & Conterio, 1988; Gardner & Gardner, 1975; Suymoto & MacDonald, 1995). Traditional college-aged (i.e., 18–22 years) students fall in the range of highest risk for self-injury. Depending on samples and definitions of self-injury, the frequency with which college students inflict self-injurious acts on their bodies varies. One survey of college students found that 12% of respondents reported engaging in self-injurious behaviors (Favazza, DeRosear, & Conterio, 1989). Survey findings indicate that self-injury occurs in 2% to 4% of the general population (Briere & Gil, 1998; Favazza & Conterio, 1988), and the incidence of self-injurious behaviors rises to 40% to 61% in adolescent inpatient settings (Darche, 1990; DiClemente, Ponton, & Hartley, 1991).

It is commonly assumed that female students are more likely to engage in self-injury than are male students (Briere & Gil, 1998). Although most studies have indicted that the majority of hospitalized and help-seeking self-injuring clients are female (Herpertz, 1995; Phillips & Muzaffer, 1961), one recent investigation of a community sample found no gender differences regarding self-injurious behaviors (Briere & Gil, 1998).

Various life factors and clinical correlates are related to self-injurious behaviors. Self-injury is most often associated with childhood sexual abuse and subsequent posttraumatic stress disorder reactions—thus a history of sexual abuse is one of the best predictors of self-injury (Darche, 1990; Favazza & Rosenthal, 1993; Ghaziuddin, Tsai, Naylor, & Ghaziuddin, 1992; Langbehn & Pfohl, 1993). Life conditions that are related to self-injury include loss of a parent, childhood illness including surgical procedures, depression, physical abuse, parental alcoholism or depression, parental marital violence, a significant loss, peer conflict and intimacy problems, impulse control problems,

and familial self-injury (Briere & Gil, 1998; Favazza, 1996; Walsh & Rosen, 1988). In addition to these factors, an inability to tolerate or express feelings and emotions, sexual assault/rape, perfectionism, eating disorders, and a negative body image have been linked to self-injury (Cross, 1993; Greenspan & Samuel, 1989; Strong, 1998).

Etiology of Self-Injury

Proposed theories of the etiology and function of self-injurious behaviors typically invoke biological and psychological explanations. Several biological theories of the etiology of self-injury include the ideas that people have genetic predispositions or chemical imbalances or experience addictive endorphin rushes when self-injuring, which may contribute to the repetition of the behavior (Dallam, 1997; Pies & Popli, 1995; Simeon et al., 1992). Psychological theories of the etiology and function of self-injury typically emphasize the potential for self-injury to regulate strong emotional responses (Suymoto & MacDonald, 1995).

Support for the hypothesis that self-injury is related to emotional regulation comes from qualitative investigations in which people who self-injure have been asked about their perceived reasons for self-injuring (Himber, 1994; Shearer, 1994; Strong, 1998). Individuals who self-injure often report that their actions help to relieve psychological pain and keep traumatic memories from recurring. Some people report that the self-injury helps them to express their emotions and allows them to release anger, depression, and anxiety. Self-injury has been reported as a means of reducing emotional numbness and promoting a sense of being real. Finally, self-injury has been reported to help people gain a sense of control over their lives and emotional experiences.

Taken as a whole, these findings yield several intervention implications for college counselors. For example, it is important for counselors to assess the function and meaning of the self-injurious behavior as perceived by the individual client. Other implications of current research and theory for college counselors' intervention in self-injurious behaviors apply to individualized treatment, outreach, education, advocacy, and prevention, each of which is addressed in the following section.

College Counselor's Role in Intervention

A college counselor's first awareness that a student is self-injuring can come from many sources: A counselor may observe signs of self-injury (e.g., scars) during interactions with the student; a student may share this information with the counselor; resident assistants, hall directors, professors, or parents may approach the counselor with concerns about a student; or other students who are aware of another peer's self-injury may seek help from a counselor. Often the student's friends or campus support persons will approach a college counselor and indicate that they have concerns about a student but do

not know how to intervene. In the following sections, we explore important issues to consider when a student is seeking help, as well as explore how a counselor might affect students who are not actively seeking counseling services.

Counselor Self-Awareness

One of the most important considerations when working with self-injurious students is the issue of counselors' personal reactions to self-injury. Many counselors confronted with self-injury feel horror, helplessness, frustration, anger, disgust, and sadness (Favazza, 1989). In fact, mental health professionals often identify self-injury as the most disturbing and frustrating client behavior (Gamble, Pearlman, Lucca, & Allen, 1994). With this in mind, counselors need to manage their personal reactions toward students who self-injure and monitor the limits that strong personal reactions place on their own ability to work with these students (Zila & Kiselica, 2001). Attempts to control the student by forcing him or her to stop self-injuring should be avoided. It is important to recognize that it is the student's responsibility to maintain his or her personal safety and that counselors can do harm in attempting to personally prevent student behaviors. Avoiding power struggles, considering the self-injury as a coping mechanism, monitoring personal reactions, and maintaining consultation and supervision can help in ensuring that counselors remain objective when working with this population (Deiter & Pearlman, 1998).

Individualized Treatment Interventions

Self-injury is sometimes viewed as an attempt to manipulate others (Simeon & Favazza, 2001), yet most people who self-injure attempt to avoid attention and purposefully hide their scars and injuries (Baral, Kora, Yuksel, & Sezgin, 1998; Courtois, 1988); many students who self-injure, therefore, might not be detected. Hence, even if a student does not overtly demonstrate signs of self-injury (e.g., cuts, burns, scars) or does not indicate the presence of self-injury on an intake form, college counselors may want to ask about these behaviors as a routine part of the intake (White, in press). Furthermore, some students who may admit to self-injury will not offer additional information unless directly asked specific questions about the behavior. For example, asking where the client self-injures and then inquiring about *additional* self-injury sites may encourage the student to disclose more openly (Dallam, 1997).

Because of the nature of self-injurious behavior and the associated negative social stigma, the primary treatment goal for college counselors working with students who self-injure is to create a safe, structured counseling environment characterized by consistency and respect for the students' dignity. After a positive relationship with the client has been established, a thorough assessment of the self-injurious behaviors is essential to effective treatment. Clients can be instructed to self-monitor the behaviors during the course of the week to better map the frequency, triggers, cues, and reducers of the behaviors. If the nature of the self-injury is particularly severe, the client can develop a

safety plan with the counselor that specifies steps to take to reduce the likelihood of serious injury.

The literature suggests two important factors that contribute to improvement from self-injury: (a) developing an ability to identify and express feelings verbally and (b) learning to use behavioral alternatives to self-injury (Dallam, 1997). Helping students to become aware of their feelings, label feelings, and manage feelings is an important initial step (Kehrberg, 1997). Writing assignments that emphasize expression of feelings can be helpful because the writing process helps students to identify, tolerate, and manage their feelings instead of self-injuring. Similarly, expression and management of feelings can be facilitated by having students document when they have impulses to self-injure, what precipitated the urge, and what the outcome would have been had they self-injured or not self-injured (Conterio et al., 1998).

Behavioral approaches that can be useful in helping students to manage self-injurious impulses include encouraging the use of self-soothing techniques such as breathing exercises, finding a "safe" place to relax, and using imagery (Kehrberg, 1997). Behavioral interventions successfully used by our clients as substitutes for self-injury include rubbing vitamin E or an ointment on the skin when feeling impulses to injure, using red markers as opposed to cutting one's self, or marking on a paper doll versus harming one's self. However, care should be taken not to develop an overreliance on these behavioral interventions because they may overstimulate the client, encourage regression, or reinforce harmful patterns and the notion that feelings should be managed through physical action (Conterio et al., 1998). Finally, a formalized plan that outlines specific behaviors the client will engage in when wanting to self-injure can be a means of fostering students' sense of control in managing the self-injurious behaviors (Kehrberg, 1997). A detailed behavioral plan includes identifying triggers, physical cues, and reducers related to self-injury; exploring safe people and safe places to go when wanting to self-injure; and deliberately avoiding objects that could be used to injure. Because self-harm is rarely performed in the company of others, the use of social supports and human contact may preclude self-injury (Dallam, 1997); thus, social supports may become an integral part of the student's behavioral plan and the counselor's overall approach to treatment.

To facilitate the well-being of students, counselors should also explore physical safety issues, such as neglecting wounds, using rusty blades, or sharing blades with other people who self-injure, to avoid exposure to disease (Dallam, 1997; DiClemente et al., 1991). Accidental death is another physical risk that should be explored, the severity of the behaviors as well as possible medical complications associated with serious injuries should be assessed, and referrals to the student health clinic for a medical assessment may be required. Finally, issues related to suicide should also be assessed. However, it is important to note that suicide and self-injury are not generally related. As with any client, a student should only be considered suicidal if he or she indicates suicidal ideation, plan, or intent. The relationship between suicide and self-injury is not always simple

because one can have suicidal ideation *and* self-injure, but not necessarily be considered suicidal (Simeon & Favazza, 2001). An overreactive stance (e.g., psychiatric hospitalizations) could alienate a student, preclude the development of a trusting therapeutic relationship, and prevent the student from sharing information in the future about self-injuries or obtaining college counseling services.

Outreach, Education, and Advocacy Interventions

College counselors serve as advocates of students while also educating students and staff through outreach initiatives (Komives & Woodard, 1996). Counseling center staff can provide training to campus personnel, particularly residence assistants and student life staff, on issues associated with self-injury. More specifically, staff may be trained in how to approach students whom they suspect may be self-injuring and in how to make effective referrals for such students.

Education can also serve as a means of preventing the stigma associated with self-injury—educating staff on the dynamics and purposes of self-injury can help them understand that students who self-injure are not "crazy." Visualization and awareness of feelings are techniques that can be used as a way to help staff become aware of their personal issues and feelings toward self-injury. For example, the counselor might ask the staff to take a moment, close their eyes, and consider the following questions: (a) What are your feelings when you hear the word *self-injury*? (b) Where in your body can you locate those feelings? (c) How might those feelings trigger you or get in the way of your ability to make informed decisions about student safety? and (d) Challenge yourself to uncover your feelings about students who self-injure—what are your beliefs about having them live in the residence halls? This intervention can be used as a catalyst for a discussion concerning staff members' perceptions of self-injury, and the discussion may help staff members develop empathy for self-injurious students' experiences.

Additional information can be provided through the counseling center Web site, and counseling center handouts can also be used as a means of educating people on campus (Davis & Humphrey, 2000; Komives & Woodard, 1996). There are numerous Internet Web sites that have information about self-injury (Prasad & Owens, 2001), and these can be linked with the counseling center home page. Mental health bulletin boards, located in all of the residence halls, can provide another source of information about self-injury to the student population.

Counselors can also serve as advocates of self-injurious students by educating student life and judicial affairs staff. A clear campus policy regarding self-injury is important because many campuses have mandatory withdrawal policies for students who engage in disruptive behaviors and suicide attempts (Hodges, 2001); and self-injury may be erroneously equated with attempted suicide. Counselors can play an important role in educating personnel and advocating for policies that are not overly reactive to students who self-injure.

If policies have been made on uninformed reactions, more education will be needed after the fact.

Prevention

Teaching general preventative coping skills, such as feeling identification and behavior management, to all students may prevent student self-injury because students who are at the beginning stages of self-injuring may be prompted to seek help before the behaviors escalate. Targeting populations that are at high risk for self-injury as early as possible may also be helpful. For example, because sexual trauma is sometimes a precursor for self-injury, attempts to intervene with identified survivors of sexual assault may serve a preventative function.

Counselors also need to consider the possibility of contagion, wherein two or more people influence each other's self-injurious behavior (Rosen & Walsh, 1989; Ross & McKay, 1979; Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, & Helenius, 1998; Walsh & Rosen, 1985). Social factors such as imitation do seem to contribute to self-injury in people who already self-injure or are at high risk for self-injuring. Research on this phenomenon has been specific to hospital and residential treatment settings in which the propinquity and close intimate connections among patients sometimes escalate the prevalence of self-injurious behaviors (Walsh & Rosen, 1985). However, this focus of current research does not eliminate the possibility of contagion in college residences (e.g., dorms, Greek houses) that share the characteristics of propinquity and close intimate connections between residents. College counselors can address the possibility of contagion in their prevention initiatives.

Conclusion

This article has provided intervention strategies that can be used in working with college students who self-injure. Literature in the area of self-injurious behavior indicates that the correlates and interventions associated with self-injury are diverse and varied. Until more is known about self-injurious behavior, college counselors must proceed cautiously when working with this population and make referrals to external mental health providers as needed. Despite the minimal knowledge base in this area, counselors can apply their basic skills in reaching out to this population.

Because there has been limited research about self-injurious behaviors in general and self-injurious behaviors in college students in particular, there is much room for future research in this area. Methodological issues related to self-injury make it a difficult area to investigate; obtaining samples of persons who self-injure and are willing to talk about these behaviors can be challenging. Specific to college counseling, future research might examine the effectiveness of various interventions such as individual and group counseling, as well as specific therapeutic approaches like behavioral theory and feminist theory. In addition, qualitative methodologies, such as interviewing methods or

focus groups, might be helpful in identifying what student-perceived campus supports can help students prevent and manage self-injury.

Counselors play an important role in intervening with students who self-injure. Individual counseling, referral, outreach, education, advocacy, and prevention are several ways that counselors can intervene with this population. College counselors must appreciate the individuality of all students (Hodges, 2001) in order to empathize, intervene, and support students who self-injure.

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