

Understanding Self Injury: The Basics

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Self-Injury (SI) is defined as intentional, self-inflicted harm that serves to mediate the intensity of mood states. The most common method of SI is cutting. Other forms include: burning, scratching, picking, head banging and interfering with the healing of wounds. SI is learned to be used as a vehicle through which an individual externalizes unbearable emotions by conveying them physically. Injury can transform abstract emotional states into tangible pain, providing greater control to the suffering individual. SI can also communicate to others the level of internal discomfort, which can be positively reinforcing if others' empathic responses are contingent on the presence of physical injury. In addition to examining closer the aforementioned dynamics of a cutter, the presenters will discuss current trends in the area of SI, provide most recent statistics and explore issues concerning the mental-health professional (MHP) who provides services to this specific population.

Prevalence rates of SI in the general population are estimated at 1.4%, with females comprising the vast majority of this population. Fourteen percent to 21% high school students, and 17% to 19% undergraduate college students are estimated to engage in SI behavior. Studies suggest that 90% to 99% of those who self-injure are also diagnosable with one or more comorbid disorders, such as Post Traumatic Stress Disorder, Generalized Anxiety Disorder, or Borderline Personality Disorder. Among those individuals diagnosed with the aforementioned, literature estimates that 48-80% will use SI as a coping strategy, depending on the comorbid diagnosis.

Of concern to the MHP is the recent trend showing increasing numbers of children under the age of 10 engaging in SI behavior. Literature also suggests that a significant number of those who seek out psychological services do not report SI, which leaves this important clinical issue unaddressed. These and other developing issues in the area of SI will be explored in more detail.

A seemingly obvious fact is that when faced with a self-injurious client, the MHP takes on a great responsibility. These interactions can be intensely scary, and may leave the MHP emotionally drained. Often, when faced with this population, the initial urge is to "fix" the problem by finding a way to convince the cutter to put away the razor and find other, more adaptive forms of coping. An important implication for intervention is the nature of SI as a coping mechanism, which - when unavailable - may bring to mind other, more extreme means to manage pain, such as suicide. It is also important to emphasize that the cutter is probably aware that what he or she is doing is maladaptive. In essence, telling a cutter to stop cutting is like telling a depressed individual to cheer up.

Although, it is imperative for the MHP to initially conduct an accurate assessment of the client's present safety, a client-centered approach is strongly recommended once physical safety has been insured. That is, understanding the behavior as a solution to an individual's problem and conveying that understanding via a genuine empathic statement is among the most effective interventions an MHP can employ. This is easier said than done; therefore, the presenters will simulate an interaction of an MHP with a cutter in a clinical situation. The focus of the role play will be to demonstrate technique as well as process counter-transferential issues that may emerge during these and similar clinical interactions.