

Initial Responses to Cutting by Front-Line Workers in Schools

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## ABSTRACT

In this thesis, I explore cutting, one form of self-harm, in the context of how teachers and other front-line workers might respond to a student who is cutting. Researchers recognize that this coping behaviour is used by many youth to deal with an array of intrapersonal and external stressors, including anxiety and depression. Cutting can be explained through a variety of models that include psychological, biological, developmental, and social contagion. The underlying factors behind the behaviour are multifaceted and, for any one individual, it is likely that multiple theories must be considered simultaneously to explain its occurrence. Beyond the scars and shame that can result from cutting, for some, self-harm can develop into an addiction. Youth who struggle psychologically, as indicated by self-harm, may need professional support. Responses of shock, panic, and disgust at another's self-harm can be detrimental and may discourage students from seeking support. School staff have an opportunity to alter the course of a student's self-harm and mental health issues. Through professional development that focuses on awareness and understanding, and responding in a calm, nonjudgmental manner, front-line workers can develop an appropriate response to cutting. While cutting is a coping behaviour and not an attempt at suicide, a response protocol must be in place in order to assess how much a student is at risk for serious harm.

## PREFACE

I had the idea for this thesis when I was volunteering at a local crisis and suicide prevention centre while completing my Master's of Counselling. Many adolescent and young adult callers disclosed to me that they cut while trying to cope with challenges. They were often caught between a strong desire to cut and an equally strong desire to refrain. It seemed they needed an alternative method for managing their stressors. Talking to a nonjudgmental listener appeared to help many of them get through their urges to inflict self-harm. As I was becoming familiar with cutting in this volunteer role, I realized as a teacher that this topic was something many of my colleagues did not know about or discuss. I began to see the need for a conversation about cutting, one form of self-harm; it would be the first step in bringing support to those who are struggling.

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DEDICATION

This thesis is dedicated to my daughter for inspiring me to learn.

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## CHAPTER 1: INTRODUCTION

Many youth engage in self-harm—also known as non-suicidal self-injury (NSSI)—as a strategy to cope with feeling overwhelmed, sad, angry, and to feel calm (Klonsky, 2009). Self-harm is a common way for some youth to relieve psychological distress (Carr-Gregg, 2006). The purpose of this thesis is to explore the literature on self-harm, in particular non-lethal cutting of skin. In doing so, I wish to increase awareness and knowledge of this topic for those who work with youth, primarily teachers and other front-line workers. It is my hope that findings from this study can assist—and be a resource for—people working or perhaps those living with youth who cut.

Research indicates that self-harm is increasing among adolescents (Olfson, Gameroff, Marcus, Greenberg, & Shaffer, 2005), especially cutting (Gregory & Mustata 2012). This phenomenon is occurring across the globe. While it is difficult to know how common self-harm used to be in community samples of youth, there is a consensus among researchers and those who work with young people that the behaviour is becoming increasingly popular (The Cornell Research Program for Self-Injury Recovery, 2015). Walsh attributes the phenomenon of increasing self-harm among students to a “social contagion”—the idea that self-harm is the current expression of adolescent distress (Van Nuys, 2009). In a comparative study of youth (age 14-17) in seven European countries, the average lifetime prevalence (as opposed to any time in the previous month or year) was estimated to be 17.8% (Madge et al., 2008). The lifetime prevalence of self-harm for adolescence in Australia (age 15-19) is 14.1% (Martin, Swannel, Hazell, Harrison, & Taylor, 2010). A survey in Hong Kong revealed that 32.7% of secondary students had used at least one form of self-harm in the past year (Shek & Yu, 2012). A study in Western Canada revealed that 15% of high school students had reported self-harm (Laye-Gindhu



& Schonert-Reichl, 2005). A more recent survey conducted in Victoria, British Columbia indicated that 16.9% of youth had self-harmed, with cutting, scratching, and hitting being the most common methods (Nixon, Cloutier, & Jansson, 2008). This prevalence suggests that self-harm is a topic worthy of attention (Jutengren, Kerr & Stattin, 2011). Cutting is believed to be the most common form of self-injury (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). The age of onset is typically between 12 and 14 years old (Kumar, Pepe, & Steer as cited in Miller & Smith, 2008). The actual frequency of self-harm is difficult to determine, as it is rare for young people to be assessed by health-care professionals following each episode of self-harm (Hall & Place, 2010). Given the prevalence of self-harm among youth, and given that some who self-harm are at higher risk for suicide (Kapur, 2014) the issue needs to be addressed systemically.

### **Self-Harm and Schools**

Best (2005) maintains that in schools self-harm is often unrecognized or misunderstood: “What is needed is a measured, informed and systematic response which achieves the maximum effect at the level of front-line workers in schools—specifically, teachers and support staff (e.g. mentors)—before being referred elsewhere” (Best, 2005, p. 285). Teachers could benefit from developing their awareness and knowledge of cutting, a common form of self-harm. There are two main reasons for this. First, becoming knowledgeable could help teachers reduce the myths and ensuing stigma around cutting. Second, teachers would be seen by their students, particularly those who engage in cutting, as approachable adults who could interact with them in an informed and measured way. An initial response from a teacher or support staff is extremely important in determining whether or not a youth will pursue help (Toste & Heath, 2010). Negative attitudes from professionals can compound an existing sense of shame (Long,

Manktelow, & Tracey, 2013). Youth may need safe and comfortable conversations in schools for them to be willing to disclose and seek support from teachers or other front line workers. These initial conversations could possibly prevent or alter the course of a student's self-harm. The costs are high for the emotional health of too many youth if proper interventions are not accessible and available by those who care for them, to not intervene.

The opportunity for psychoeducation exists for youth through British Columbia's Ministry of Education prescribed learning outcomes in Health and Career, a provincially mandated subject for students from K to 9. Within Health, suggested topics are healthy living, healthy relationships, safety and injury prevention, and substance misuse prevention (Ministry of Education, 2005; Ministry of Education, 2006). Safe sex and healthy eating (including eating disorders) are also included in the curriculum. Lots of media coverage for anorexia nervosa and bulimia has perhaps enabled teachers and students to discuss more comfortably these two disorders that often begin during adolescence. A great deal of attention has been given to risky behaviours such as substance use too, but much less attention has been given to self-injury in the general adolescent population (Alfonso & Dedrick, 2014). The topic of cutting as a form of self-harm is often not addressed within British Columbia's curriculum.

Some youth talk about self-harm, others don't (Alfonso & Dedrick, 2014; Toste & Heath, 2010). Without proper information being taught, as it is for safe sex, eating disorders, and alcohol and drug use, it is understandable that numerous myths and stigma envelope self-harm. This may in part be because it is a shocking and confusing behaviour to most people (Best, 2006; Gratz & Chapman, 2009). Self-harm is a subject worthy for school staff to become informed about and comfortable discussing with their colleagues and students (Best, 2006). Indeed, school staff have a unique opportunity to alter the course of cutting for many of their students by first

increasing their knowledge about self-harm and creating an environment where students feel comfortable to seek support for their problems.

There are many things that schools could do around self-harm, but this study will be limited to how teachers or other front-line workers might respond when approached by, or become aware of a student who is cutting. Self-harm, if disclosed at all, is most likely to be disclosed in the school setting (Hall & Place, 2010). For most people, understanding self-harm is challenging—it provokes a mix of emotions whereby anxiety, panic, shock, and revulsion create a “flight” response (Best, 2006). Given the prevalence and the response that many experience after learning about self-harm, it is important that schools first become aware of the issue and then become knowledgeable about how to respond (Best, 2006). Schools can take an active role to reduce the prevalence and/or counter cutting. It will be through informed and caring teachers and other front-line workers that many students may have an opportunity to get the help they need to deal with their problems in a safe and healthy manner, setting them up for a future of emotional well-being.

### **Cultural and Scholarly Context**

Cutting has entered popular culture through movies, songs, and celebrities (Shapiro, 2008). Movies such as *Girl Interrupted*, *28 Days*, and *Secret Cutting* (Shapiro, 2008) have informed many youth about self-harm and/or cutting. Princess Diana, Angelina Jolie, and Johnny Depp have all self-harmed (Shapiro, 2008) and have publicly discussed cutting as one of their types of self-harm. In doing so, what do these popular culture icons impart to youth? Perhaps they feel that cutting is a viable way to cope with overwhelming emotions.

There are several theories about self-harm or cutting. Klonsky (2009) found that youth who cut often cite that they do it to “release emotional pressure,” “to control how I am feeling,”

and “to get rid of intolerable emotions.” His work in this area also claims that secondary reasons include self-punishment. Less common reasons were sensation-seeking, anti-dissociation, interpersonal-influence, and anti-suicide (Klonsky, 2009). Other studies that explain self-harm include a biological predisposition mixed with environments that involve trauma, abuse, or poor parental bonding (Gratz & Chapman, 2009).

Self-harming behaviours such as cutting can become a preoccupation, but can also be very difficult to stop, as they can begin to have an addictive quality (Walsh, 2007). Some youth report that it creates pleasurable feelings (Carr-Gregg, 2006). Furthermore self-harm can replace or cause other healthy coping skills to wane. Self-harm doesn't actually solve the personal problems that youth experience. While it may bring temporary relief in the short-term, the problems causing the behaviour are not resolved (Gratz & Chapman, 2009). In this perspective, cutting is then not the problem, but the attempted solution. Lack of emotional resources is then the problem. This will be further discussed in following chapters.

Cutting can create its own set of problems, evoking guilt and shame (Butler & Malone, 2013). Permanent scars can affect current and future relationships and these scars are visible reminders that can lead to fear, anger, helplessness or sadness (Gratz & Chapman, 2009). Over time, self-harm can be lethal. Evidence suggests that self-harm with no reported suicidal intent is related to a higher risk of further self-harm and suicide compared to the general population (Kapur, Cooper, O'Connor & Hawton, 2013). People who self-harm sometimes have the unintended result of harming more than they wanted to, leading to trips to emergency rooms and confusion with medical personnel about their actual intentions (Gratz & Chapman, 2009). This is likely because the intensity and frequency of self-harm must continually increase in order to feel a sense of release (Walsh, 2002). The risk of accidental death increases with each event

(Best, 2005). They may also experience symptoms of withdrawal when not self-harming (Gratz & Chapman, 2009).

### **Method**

The structure for this thesis will be manuscript-based. Three separate essays will follow that will allow for a more cohesive understanding of why self-harm is a worthy subject for schools to consider in fostering the healthy development of their students and how teachers or other front line workers can respond when approached by or become aware of a student who is cutting.

### **Defining Key Terms**

Part of the difficulty in discussing self-harm is the numerous terms and definitions found in the literature. Much of the academic literature I will be using will use a variety of terms for self-harm and may not specifically identify cutting as the particular type of self-harm that they are discussing. However, I will limit my focus on cutting while inferring that much of what is researched about self-harm is applicable to cutting.

There is no universally agreed upon term or definition for self-harm. This can make interpreting the research difficult because investigators use different terms to describe similar phenomena (Gregory & Mustata, 2012). Non-suicidal self-injury (NSSI) has become a common term in the United States as researchers acknowledge that not all youth who self-harm meet the criteria for a psychiatric illness or wish to die (Kapur, Cooper, O'Connor, & Hawton, 2013). In contrast, European researchers typically use the term self-harm as it refers to self-injury regardless of whether suicidal intent is present or not (Ougrin, 2012). The term self-harm is also used by some American researchers, such as Gratz and Chapman, without attaching suicidal intent, and appears to be frequently used by lay people as well when discussing this behaviour.

For the purpose of this study, the term self-harm will be used and is defined according to Klonsky and Muehlenkamp's (2007) definition of self-injury as the intentional damage of body tissue without suicidal intent and for purposes not socially sanctioned (Klonsky & Muehlenkamp, 2007). Damage could be, but not limited to, in the form of lacerations, bruises, broken bones, burns, or cuts. Because the harm is immediate and can be seen, other types of behaviour that can lead to eventual harm are not included. These harmful behaviours could include smoking, drinking, drug misuse, eating disorders, body piercings, and tattoos.

Other terms that may be interchangeable with self-harm include, but are not limited to, superficial self-harm, deliberate self-harm (DSH), self-injury, self-injury/injurious behaviour (SIB), non-suicidal self-injury (NSSI), self-inflicted injury (SII), self-mutilation, and self-destructive behaviour.

The possibilities of behaviours that can be described as self-harm are vast. Examples of self-harm include cutting, burning/scalding, scratching, picking, hitting/punching, pulling out hair, biting, swallowing objects/toxins, or purging (Bywaters & Rolfe, 2002). A Child and Adolescent Response Team (CART) responder recently reported that burning often occurs with candles, lighters, and more recently a relatively new technique involving salt and ice (L. Hamilton, personal communication, March 20, 2014). This same professional also claims that some youth get tattoos as a way to feel pain. It is the pain and not the body art that they are most interested in. She also pointed out that it is crucial to understand the reason behind the behaviour in order to understand if it is a form of self-harm.

### **Motivation for this Thesis**

The motivation for this thesis topic developed as I became aware of cutting as a form of self-harm, first as a parent and then as a volunteer at a local crisis and suicide prevention centre.

I was encountering cutting almost weekly as a volunteer for callers and online chatters, yet not once in my 24-year teaching career in the public school system had I come across the topic of cutting either through professional development, in Ministry prescribed curriculum, and/or in informal discussions in staffrooms. I felt unprepared when talking with callers and wanted to learn more about this issue and more importantly, how to help those who were harming themselves. Cutting seemed to be the most prevalent type of self-harm that was being disclosed on the crisis lines. Given how prevalent cutting appears to be, I have specifically chosen this type of self-harm for this thesis topic.

### **Structure of Thesis**

This chapter outlined the purpose and relevance for this study, identified and defined key terms and phrases, offered context for the research, and briefly explored the practice of cutting in the context of schools. The first essay in this thesis will explain some of the more prevalent theories behind self-harm. The second essay will identify the risks associated with self-harm, specifically cutting, and possible outcomes for someone whose self-harm isn't addressed. The third essay will discuss what can be taken from the above two essays and will suggest possible ways that schools can better serve the needs of youth who self-harm. The third essay will also include the perspectives and understandings of youth who have self-harmed and who participated in research on which support and interventions are most helpful to self-harming youth. In the final chapter of this thesis I will summarize the main findings from the research reviewed, and summarize the implications for schools, counsellors, youth workers, health-care workers, and parents or care givers. The limitations of this research will be identified, areas that require further research, and what can be done individually to influence healthy outcomes.

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## CHAPTER 2: THEORIES BEHIND SELF-HARM

Research suggests there are many motives for engaging in self-harm (Horne & Csipke, 2009). Some of these may be to release, convey, or control distress, block memories, manage dissociation, self-punish or express self-hatred, symbolize inner pain externally, or prompt a caring response from others (Horne & Csipke, 2009). Other theories suggest that self-harm can be associated with victimization by peers, parental emotional neglect, insecure attachment, childhood sexual abuse, anxiety, depression, poor school achievement, low self-esteem, drug use, body dissatisfaction, dissociative symptoms and mental illness (Bjarehed & Lundh, Brodsky, Cloitre, & Dulit; Gratz, Conrad & Roemer; Hawton, Rodham & Evans, Klonsky, Oltmanns, & Turkheimer; Laukkanen et al.; Ross & Heath, van der Kolk; Perry, & Herman; Zlotnick et al., as cited in Jutengren et al., 2009). Not all adolescents who cut fit the same profile, thus identifying the underlying reasons for cutting in each individual is important for knowing what treatment is suitable (Gregory & Mustata, 2012).

In this essay, I will explore various theories that explain why some people may turn to self-harm as a coping mechanism. I will include psychological, biological, developmental, and learning perspectives. I will also provide examples of research that support the theories. An explanation for what keeps many youth in a cycle of self-harm once they begin will also be included. I will end the essay with an exploration of how self-harm is newly incorporated in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) (American Psychiatric Association, 2013).

### **Why People Self-Harm**

#### **Psychological Models**

The four-function model (FFM) of self-harm is based on the assumption that reinforcement of self-harm is either positive or negative and self-harm involves intrapersonal or interpersonal contingencies (Nock & Prinstein, 2004, 2005). The first function is automatic negative reinforcement in which self-harm serves to remove or enables one to escape from an unwanted affective or cognitive state (Nock & Cha, 2009). This is the function most often supported by research participants in virtually all studies in this area (Nock & Cha, 2009). Automatic positive reinforcement is the second function in which self-harm serves to generate feeling (Nock & Cha, 2009). Some people report feeling numbness or anhedonia and thus engage in self-harm to feel something (Nock & Cha, 2009). The third function of self-harm is social positive reinforcement whereby self-harm is done to get attention or access resources in the environment (Nock & Cha, 2009). The fourth function of self-harm is social negative reinforcement in which self-harm removes an interpersonal demand (Nock & Cha, 2009).

Within this model, a distinction is made between functions and purposes. The function of behaviour refers to the analysis of the antecedents and consequences believed to cause or maintain behaviour (Nock & Cha, 2009). Other theorists may use the word function more loosely while referring to a proposed purpose of the behaviour, without considering the antecedents or consequences (Nock & Cha, 2009).

A theory that supports the first function of FFM, automatic negative reinforcement, is the Experiential Avoidance Model (EAM) (Chapman, Gratz, & Brown, 2006). EAM is a theory of self-harm that proposes that self-harm primarily is a negatively reinforced strategy for reducing or ending unwanted emotional arousal (Chapman et al., 2006). This theory was developed to apply across various populations who self-harm, such as those with depression, personality disorders, or post-traumatic stress disorder (PTSD) in the absence of suicidal intent (Chapman et

al., 2006). According to the EAM, self-harm is maintained and strengthened through escape conditioning and negative reinforcement (Chapman et al., 2006). In essence, a person experiences unpleasant emotions and wishes to escape—self-harm reduces or ends the unpleasant emotions, thereby negatively reinforcing self-harm (Chapman et al., 2006).

Chapman et al. (2006) define deliberate self-harm (DSH) as the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent. By definition, this would include cutting. Two disorders that are often associated with DSH are borderline personality disorder (BPD) and PTSD with prevalence rates as high as 48-79% and 50% respectively (Chapman et al., 2006). For BPD, DSH is believed to reduce or end difficult emotions (Chapman et al., 2006). Avoiding certain emotions is believed to be a factor in developing and maintaining PTSD (Chapman et al., 2006). DSH is also associated with depression. Depression is believed to be associated with experiential avoidance and the non-acceptance of certain emotional responses (Chapman et al., 2006). Gratz and Chapman (2009) posit that in the moment, self-harm meets some basic human needs, such as to feel safe, protected, comfortable, or to release emotional pain. They add that people frequently say that self-harm often makes them feel better, calmer, and more at peace with themselves.

Findings from a variety of self-report and psycho-physiological studies consistently support the notion that self-harm is indeed associated with relief or escape from unpleasant emotions and distressing thoughts or memories (Chapman et al., 2006). This is consistent for people with BPD, PTSD, depression or adolescents who engage in self-harm (Chapman et al., 2006). In a school-based survey of youth in seven countries that investigated the reasons youth gave for self-harm, the most cited reason was to get relief from a bad state of mind and wanting to die (Scoliers et al., 2009). Hawton and James (as cited in Scoliers et. al., 2009) believe that

although adolescents who self-harm may claim they ‘wish to die’ the motivation is most often a reflection of their distress and a wish to escape from troubling situations. Bancroft, Skrimshire, and Simkins (as cited in Scoliers et al., 2009) propose that adults who self-harm may explain their behaviour as a ‘wish to die’ as a way of gaining social acceptability following the event, and because it elicits sympathy and understanding of their pain as it relates to their self-harm. Scoliers et al. (2009) state a limitation of their research is that it is unclear to what extent adolescents who stated they wanted to die actually believed that death would have resulted from their self-harm.

A study that tested the experiential avoidance model (Chapman et al., 2006) and the moderating effect of emotion regulation skills involved 880 high school students in Sweden (Jutengren et al., 2009). Jutengren et al. examined the relationship between peer victimization and harsh parenting on self-harm. They predicted that adolescents’ high levels of distress involving harassment and bullying and harsh parenting would lead to a high risk of engaging in self-harm (Jutengren et al., 2009). They also predicted that there would be a predictive effect of interpersonal distress on self-harm for adolescents who showed low degrees of adaptive-integrative emotion regulation skills coupled with high degrees of emotion dysregulation and impulsivity (Jutengren et al., 2009). Their results showed that peer victimization was predictive of self-harm ( $\beta = .18, p = .006$ ), but harsh parenting was not ( $\beta = .03, p = .539$ ) (Jutengren et al., 2009). They noted that harsh parenting led to a greater risk of self-harm in girls, but not statistically significant (Jutengren et al., 2009). Their results also did not show any moderating effect involving integrative emotion regulation, emotion dysregulation, or impulsivity (Jutengren et al., 2009). They speculated this to be because their measure of emotion regulation only involved anger and not other emotions such as fear, sadness, and embarrassment (Jutengren et

al., 2009). Their definition of emotion regulation reflected the adolescents' ability to understand and constructively respond to recent interactions with people who provoked strong emotions in them (Jutengren et al., 2009). They hypothesized that constructive problem solving may work with minor interpersonal problems, but may be less effective when adolescents are victims of bullying or harassment (Jutengren et al., 2009). The authors concluded that this study is important because it used a non-clinical sample of adolescents and showed that peer victimization has a predictive effect on self-harm in general populations of adolescents (Jutengren et al., 2009). They concluded that individual factors alone are not sufficient to explain deliberate self-harm—circumstances within the social environment also need to be examined (Jutengren et al., 2009). This may be particularly relevant given the pervasiveness of bullying (Mishna, Cook, Gadalla, Daciuk, & Solomon, 2010). Cyber bullying is also prevalent—a 2010 study that involved 2186 middle and high school students in Toronto found that 49.5% of students indicated that they had been bullied online and 33.7% of them indicated that they had bullied others online (Mishna et al., 2010).

### **Biological Models**

The most commonly accepted biological model for understanding self-harm involves the role of opioids. Endorphins are one form of endogenous opioids that are produced in the body during strenuous exercise, excitement, pain, and orgasm (Koneru, Satyanarayana, & Rizwan, 2009). Endorphins work as natural pain relievers and provide a sense of power and control (Koneru et al., 2009). This model suggests people who self-harm may have chronically lower levels of endogenous opioids (Sher & Stanley, 2009). Self-harm may serve to restore endogenous opioids to normal levels (Sher & Stanley, 2009). Opioid deficiency could stem from chronic and severe childhood trauma such as abuse and neglect and previous research shows



there is a correlation between childhood trauma and self-harm (Sher & Stanley, 2009). The opioid hypothesis proposes that self-harm induces endogenous opioids, which create analgesia (the inability to feel pain) and relieve emotional distress (Chapman et al., 2006). If this theory is correct for understanding repetitive self-harm, then treatment with a long-acting opioid antagonist could block the release of endogenous opioids brought about by self-harm (Sher & Stanley, 2009). Naloxone and naltrexone hydrochloride (NTX) are opioid antagonists (Sandman, 2009). They have been found to be useful for some who engage in self-harm (Sandman, Touchette, Lenjavi, Marion, & Chicz-DeMet; Symons, Thompson, & Rodriguez, as cited in Sher & Stanley, 2009).

Gratz and Chapman (2009) describe self-harm as an impulsive and aggressive behaviour. They add that people who self-harm most often do so when upset. Serotonin is a neurotransmitter that regulates mood, aggression, and more (Gratz & Chapman, 2009). It has been proposed that a major effect of serotonin problems is irritability, and the lower one's serotonin activity is the more likely one will be impulsive and aggressive in response to their irritability (Gratz & Chapman, 2009). Some research has suggested that people who self-harm might have less serotonin being transmitted from one neuron to another, which suggests that those with less serotonin activity may be at-risk for self-harm (Gratz & Chapman, 2009).

A study explored the relation between peripheral serotonin levels and mother-child interaction patterns involving 21 typical and 20 self-harming adolescents, where cutting was the most preferred method of self-harm reported (Crowell et al., 2008). The researchers hypothesised that families of youth who self-harmed would show higher levels of negative affect and lower levels of positive affect compared to families with youth who did not self-harm, and peripheral serotonin levels would correlate with more positive affect and less negative affect

within the dyads. They also explored whether the interaction between negative affect and peripheral serotonin was related to self-harm beyond the effects of negative affect and peripheral serotonin alone. They found higher levels of negative affect and lower levels of positive affect and cohesiveness among families with adolescents who self-harmed. They also noted that peripheral serotonin correlated with the expression of positive affect within dyads. Serotonin levels were significantly lower among youth who self-harmed than in the control group. The researchers acknowledged that interaction patterns within a family could influence serotonin levels over time and more longitudinal research is needed. Their most significant finding was that serotonin levels interacted with negativity and conflict within dyads to explain 64% of the difference among youth who self-harmed versus those who did not. This research is consistent with a Biological Vulnerability X Environmental Risk model of self-harm (Crowell et al., 2008).

### **Developmental Models**

Disorganized attachment was significantly overrepresented in the developmental histories of people who self-harm with a history of disorganization increasing the chances of performing self-harm by three times (Yates, as cited in Yates, 2009). Yates (2009) posits childhood abuse or neglect can cause or increase negative representations of the self, others, and of the self in relation to others, which can lead to self-harm. She explains the person can view her or himself as bad, see others as unsafe, and relationships as dangerous, hence, self-harm may serve to punish or self-soothe. The self-punishment hypothesis proposes that self-harm verifies an individual's belief that she or he is a bad person who deserves to be punished, thereby lowering their emotional arousal (Chapman et al., 2006). Or, it may be that self-punishment may diminish the desire of others to punish the individual, and thus acts to protect the person from others' unwanted behaviours, which may then lower a person's anxiety (Chapman et al., 2006).

Youth who experienced sensitive care and secure attachment can access affective and cognitive information (Yates, 2009). They have a sense of safety and resilience that allows them to know what they feel and feel what they know (Yates, 2009). Yates posits it is possible that childhood maltreatment may interfere with a person's ability to integrate affect and cognition, whereby dissociation between thinking and feeling may occur. She explains dissociation may become a coping method for some. When children have less ability to acknowledge and express their emotions in ways that lower their distress, they may continue to attempt to regulate the intensity of their emotions through other means (Way, Yelsma, Van Meter, & Black-Pond, 2007). It has been proposed that maltreatment may disrupt a child's development to use language to express emotions and instead emotions are expressed through behaviour, sensation, and somatization (Yates, 2009). Dissociation and somatization may give way to self-harm (Yates, 2009).

In support of this theory, a recent study investigated the expressive language of adolescents who cut through 100 narratives chosen at random that were posted on a cutting website, [www.psyke.org](http://www.psyke.org) (Gregory & Mustata, 2012). The researchers defined magical thinking as poor differentiation between the real and the symbolic based on the work of Piaget (Piaget, as cited in Gregory & Mustata, 2012). They hypothesized that magical thinking would appear in most narratives and would be associated with poor interpersonal functioning, reported past abuse, and relief of negative emotions (Gregory & Mustata, 2012). Furthermore, the purpose of cutting would be to see blood and feel pain (Gregory & Mustata, 2012). Two university faculty members and a medical student independently rated the narratives and the researchers reported that inter-rater reliability for magical thinking was excellent (Gregory & Mustata, 2012). They found that magical thinking occurred in 66 narratives of the 100 selected and was associated with

cutting which served as a way to see blood, feel pain, and relieve distress (Gregory & Mustata, 2012). Blood replaced negative emotions, and emotional pain becoming physical pain (Gregory & Mustata, 2012). Their analyses caused them to propose three subgroups within their sample of the 66 adolescents who cut and displayed magical thinking. The first was a relatively high functioning subgroup with good verbal skills who cut for pleasure and because others did so (Gregory & Mustata, 2012). The second was a lower functioning subgroup marked by magical thinking, and who cut to deal with negative emotions (Gregory & Mustata, 2012). The third was also a lower functioning subgroup with reported histories of trauma, loss, and suicidality, that used cutting to alleviate dissociation (Gregory & Mustata, 2012).

A developmental perspective also recognizes the potential that chronic childhood trauma may alter biological systems, which in turn can contribute to the potential for self-harm (Yates, 2009). One system to be affected is the endogenous opioid system (EOS) as discussed prior. As well, higher levels of cortisol have been found in children subjected to ongoing trauma and anxiety (Music, 2011 as cited in Carter & Grenyer, 2012). Cortisol has been named “the stress hormone” because it is typically secreted in higher levels in the body’s response to stress—higher and prolonged levels of cortisol can affect cognitive functioning (Scott, 2014, par. 3). Higher levels of cortisol may explain the connection between abuse and expressive language deficits (Carter & Grenyer, 2012).

In a single case study, the cortisol levels of a woman who engaged in self-harm was measured over an 86-day period to understand the relationship between cortisol levels and self-harm (Sachsse, Von der Heyde, & Huether, 2002). High levels of cortisol coincided with high ratings of negative emotions and preceded episodes of self-harm (Sachsse et al., 2002). Following self-harm, cortisol levels decreased significantly and stayed low for a few days

following (Sachsse et al., 2002). While generalization is not possible given the extremely small sample size, this case study may begin to explain how self-harm can reduce levels of distress by lowering the cortisol levels in some people.

Beyond studies that involve clinical populations, a study involving suburban, upper-middle-class high school students on the west and east coasts of the United States predicted that perceived parental criticism would be positively associated with self-harm (Yates et al., 2008). The researchers hypothesized that this association would be due to feelings of alienation towards parents (Yates et al., 2008). Their findings supported their hypothesis that perceived parental criticism statistically predicted self-harm and that students' reported sense of alienation towards their parents was a salient process for understanding this association (Yates et al., 2008). The researchers concluded that this study reflects the need to better understand self-harm beyond the individual, as other systems such as family systems are involved. Self-harm is "thriving in seemingly pristine and protected communities" (Yates et al., 2008, p. 61) and the reasons behind self-harm in these communities reach beyond the adolescent to include family systems, and perhaps broader systems such as peers and media (Yates et al., 2008). Parents, teachers and clinicians often mistakenly do not realize self-harm stems from multivariate interactions between youths and their environments (Yates et al., 2008). As such, Yates et al., (2008) believe that when working with youth who self-harm, psychoeducation is needed for parents and others to understand the numerous psychosocial systems that influence adolescent behaviour. Crowell et al. (2008) propose that characteristics of youth who self-harm as well as their families should be assessed with the belief that decreasing negativity and conflict may reduce self-harming behaviours among many vulnerable youth.

In addition to poor attachment, chronic childhood trauma, and perceived parental criticism, other researchers speculate mental health issues can often be explained by disconnection and social isolation in an increasingly individualistic Western society (Eckersley & Dear, 2002; Myers, 2000; Seligman, 1990; Twenge, as cited in Twenge, 2011). Twenge posits that the cultural shift to individualism and an emphasis on personal needs has weakened relationships and increased expectations. She proposes this may have led to more anxiety and depression. Another possible theory is that between the early 1990s and the late 2000s, self-esteem, self-evaluations, and narcissism among American youth have increased (Gentile, Twenge, & Campbell, 2010; Stewart & Bernhardt, 2010; Twenge, Campbell, & Gentile, in press; Twenge & Foster, as cited in Twenge, 2011). Twenge explains that while these traits are usually negatively associated with anxiety and depression, they may have produced unintended results. Narcissists often become depressed after they become estranged from others due to their self-centredness (Miller, Campbell, & Pilkonis, as cited in Twenge, 2011).

### **Social Contagion**

Self-harm has entered popular culture during the last 20 years, and as a result self-harm may be losing some of its unacceptability and instead gaining tolerance among youth (Alfonso & Dedrick, 2014). Cutting has entered popular culture through movies, songs, and celebrities (Shapiro, 2008). Movies such as *Girl Interrupted*, *28 Days*, and *Secret Cutting* (Shapiro, 2008) have introduced many youth to self-harm and or cutting. A variety of television shows such as *Degrassi*, *Interventions*, *Grey's Anatomy*, and *Seventh Heaven* show the physical and emotional aspects of self-harm in manners that may highlight its usefulness as an emotional outlet for youth at risk of this behaviour (Whitlock, Purington, & Gershkovick, 2009). Self-harm has become so

prevalent that there are even jokes about it, such as “I wish my grass were Emo so it would cut itself” (Purington & Whitlock, 2010).

Cutting entered young adult (YA) fiction in the early 1990s (Miskec & McGee, 2007). The overall perception of the cutter depicted in YA literature has shifted. Earlier novels portrayed the cutter as someone who came from neglectful homes and had ongoing trauma (Miskec & McGee, 2007). They cut because it was the first expression of their wanting to die (Miskec & McGee, 2007). The next trend was for the characters’ trauma to be better explained and showed how cutting served as a means to gain a sense of relief and reduce their pain so that they could go on living (Miskec & McGee, 2007). The latest trend is shown in futuristic novels where cutting extends beyond the personal to the social—cutting is a source of power and a means of resisting society’s ability to exert control (Miskec & McGee, 2007). In essence, there has been a shift in YA literature where self-harm is now portrayed from a cultural rather than a psychological perspective (Miskec & McGee, 2007). This may reflect a shift in understanding how the forces underlying self-harm have moved beyond the individual as Yates et al. (2008) suggest to include family, peers, and media.

The Internet is reshaping how youth socialize and connect with their peers and strangers (Whitlock, Powers, & Eckenrode, 2006). Most students experience technology as an integral aspect of their daily lives (Fitton, Ahmedani, Harold, & Shifflet, 2013). Numerous Internet sites promote the use of self-harm—a simple search results in over 500 message board sites for self-harm (Whitlock, Lader, & Conterio, 2007). Entering “self-harm” on YouTube brings up about 120,000 results.<sup>1</sup> Twenty years ago, self-harm was largely unknown and most often done in

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<sup>1</sup> As of 10/30/14.

private (Whitlock et al., 2007). While self-harm may still be a foreign idea to the parents of many of today's youth, it is not to most contemporary adolescents (Whitlock et al., 2009).

Social learning theory suggests that people copy the behaviours of others (Bandura, as cited in Whitlock et al., 2009). Media is a powerful motivator of behaviour because when viewers closely identify with those they are observing, their later behaviours can be affected (Whitlock et al., 2009). Disinhibition theory proposes that behaviours become more prevalent because witnessing another perform a behaviour lessens the viewer's inhibition to try it (Freedman as cited in Whitlock et al., 2009). This is especially relevant if one is undecided about performing a behaviour but witnesses another complete it successfully (Whitlock et al., 2009). Script theory posits that people are more likely to repeat a behaviour if the behaviour has been successful (Abelson, as cited in Whitlock et al., 2009). Both disinhibition theory and script theory suggest that when self-harm is shown to be painless, common, and effective, inhibition may be reduced and scripts that support its use are accepted (Whitlock et al., 2009).

### **What Maintains Self-Harm**

It is possible that self-harm can develop into a dangerous cycle due to four factors (Chapman et al., 2006). Chronically avoiding unpleasant emotions may have a paradoxical effect, increasing distress and thereby escalating the likelihood of self-harm (Chapman et al., 2006). As well, avoidance of unwanted emotions may maintain these emotions, as the person doesn't learn to deal with them or manage them effectively (Chapman et al., 2006). A person who engages in self-harm may adopt a rule that they will feel better after they harm, which reduces their likelihood to learn from the unpleasant consequences of self-harm (Chapman et al., 2006). It is also possible that self-harm over time might be associated with few negative consequences as the individual gets use to the behaviour (Chapman et al., 2006).



### DSM-5

Nonsuicidal self-injury (NSSI) is included in a new section in the DSM-5 titled “Conditions for Further Study” (American Psychiatric Association, 2013, p. 803). Presently, insufficient research doesn’t warrant NSSI as an official mental disorder, and further research is welcomed (American Psychiatric Association, 2013). In the DSM-4, “self-mutilating behaviour” was included as one possible symptom for borderline personality disorder (BPD) (American Psychiatric Association, 2000). This proposed diagnosis in the DSM-5 reflects what the research is showing—that NSSI can occur independent of BPD, such as with individuals experiencing depression or a non-diagnosable psychopathology (Stetka & Correll, 2013). Most studies discover that less than 50% of people who self-harm meet the criteria for BPD (Gratz & Chapman, 2009). This can be an important distinction as an incorrect assumption or diagnosis can lead to inappropriate treatment (Gratz & Chapman, 2009).

The proposed criteria for NSSI in the DSM-5 include the following. In the last year the individual has on five or more days engaged in self-inflicted damage to his or her body without suicidal intent and with the belief that the damage will be minor or moderate. There is an expectation for the self-injury to provide one or more of the following: relief from a negative feeling or cognitive state, resolve an interpersonal problem, and/or create a positive feeling state. The behaviour must also be associated with at least one of the following: interpersonal difficulties or negative feelings or thoughts, a preoccupation with the self-injury behaviour that is difficult to control, and self-injury as a recurring thought. The self-harm is not socially sanctioned such as body piercing or tattooing and can be more than scab picking or nail biting. The behaviour or its consequences causes clinical distress or interferes in interpersonal,

academic functioning or other important areas. The behaviour is not better explained by a medical condition or mental disorder (American Psychiatric Association, 2013).

### **Closing**

In this chapter I identified several theories and supporting research around self-harm as a coping behaviour. Psychological, biological, developmental, and learning theories were explained. It is possible that for any given individual, more than one theory may simultaneously explain how self-harm can be a strategy for dealing with intrapersonal or external stressors unique to that individual—it is unlikely that there is only one mechanism underlying self-harm (McKenzie & Gross, 2014), suggesting that the factors that result in self-harm are multifaceted (Purington & Whitlock, 2010). How self-harm is incorporated in the DSM-5 was also included.

In the next essay I will look at the risks associated with self-harm and possible long-term outcomes. I will also explore the connection between self-harm and suicide.

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## CHAPTER 3: RISKS OF SELF-HARM AND ASSOCIATION WITH SUICIDE

Adolescence is characterized by physical, psychological, and social changes that require the ability to cope (Bjarehed, Wangby-Lundh, & Lundh, 2012). The outcome of this period depends on the way that these changes and the challenges that arise because of them are resolved (Bjarehed et al., 2012). Youth who are struggling psychologically, as indicated by self-harm, may need professional support to enter adulthood psychologically healthy.

Gratz and Chapman (2009) explain that some people may self-harm regularly without being preoccupied it and do not experience a tolerance or withdrawal. They also explain others may self-harm only a few times and then stop. There is a belief that the frequency of self-harm declines during late adolescence into young adulthood, which explains why most research on self-harm focuses on adolescents (Moran et al., 2011; Butler & Malone, 2013). Findings suggest that most adolescent self-harm behaviour resolves spontaneously (Moran et al., 2011). Moran et al., (2011) used a stratified, random sample of 1943 adolescents from 44 schools in Australia between 1992 and 2008. Using data pertaining to self-harm from questionnaires and telephone interviews, they followed the participants from a mean age of 15.9 years through to a mean age of 29.0 years. Of the 149 youth who reported self-harming in adolescence, 122 reported no further use of self-harming in young adulthood. Moral et al. (2011) also highlighted that adolescent symptoms of depression and anxiety were clearly associated with self-harm in young adulthood and that these mental health problems may not resolve without treatment. For this reason they believe that early detection and treatment of mental health problems, such as depression and anxiety, in adolescence might be an important component of suicide prevention in young adults.

In this chapter, I will identify possible outcomes of self-harm if left untreated, myths surrounding self-harm, and how self-harm may develop into an addiction for some youth. I will also explore the association between self-harm and suicide.

### **Short and Long-Term Outcomes**

Self-harm can result in severe injury including life threatening blood loss or infection, scars, and disfigurement from healed injuries (Purington & Booker, n.d.). It is possible to harm one's self more than what was intended—cutting deeper or developing an infection (Smith & Segal, 2014). Self-harm can bring about stigma and disapproval from others (Gratz & Chapman, 2009). Keeping cutting a secret from family and friends can be difficult and adds to a sense of isolation (Smith & Segal, 2014).

Self-harm can be an effective coping behaviour in the moment, but it is likely to lower self-esteem and thereby exacerbate symptoms and distress in the long-term (Jacobson & Gould, 2007). Following an episode of self-harm, research suggests that individuals feel relief as well as shame, guilt, disgust, and disappointment (Laye-Gindhu & Schonert-Reichl, 2005; Smith & Segal, 2014). These feelings of shame and guilt about one's self can be long lasting (Butler & Malone, 2013).

The ability to cope in a healthy manner involves being able to manage stress and deal effectively with problems (Gratz & Chapman, 2009). Healthy coping skills enable individuals to reduce, manage, or accept unpleasant emotions in ways that preserve their sense of competence and self-respect (Gratz & Chapman, 2009). Because self-harm can provide short-term relief, it can keep youth from learning more effective strategies for feeling better (Smith & Segal, 2014) or the self-harm might be done at the expense of good coping strategies that are eventually forgotten from lack of use (Gratz & Chapman, 2009).



### **Anxiety, Depression, and Alcohol Misuse**

Historically, anxiety in children and youth was largely unnoticed by both the general public and mental health professionals yet anxiety disorders are now regarded as the most frequent type of mental disorder in children and adolescents (Rapee, Wignall, Hudson, & Schniering, 2000). These disorders can cause significant personal suffering and interfere substantially with family cohesion, making friends, academic success, career opportunities, and self-esteem (Rapee et al., 2000). Left untreated, the long-term prospects for anxious children and youth is not good (Rapee et al., 2000). Rapee et al. (2000) explains that while a number of children and youth will reduce their anxiety over time, a large proportion are likely to continue to have anxiety disorders and develop other problems such as depression, drug and alcohol misuse, and suicidal ideation.

Many youth who self-harm have mental health problems that might not resolve without support (Moran et al., 2011). In one community sample of adolescents for whom cutting was the most common method of self-harm, students who reported self-harm also reported significantly more symptoms of anxiety and depression compared to those who did not self-harm (Ross & Heath, 2002). “Cross sectional surveys of young people have consistently found an association between mental distress and self-harm, and depression and anxiety predict later suicide attempts in young people” (Moran et al., 2011, p. 241). Most people with substantial emotional pain need support to work through their feelings, heal from past events, and learn better ways to cope (Carr-Gregg, 2006). This may explain why youth who engage in a self-harm as a coping mechanism and don’t learn other effective strategies are, as Smith and Segal (2014) point out, at risk for developing major depression, drug and alcohol addiction, and suicide.

Studies that involved about a 1,000 students, ages 13-15, in a small Swedish town found that psychological difficulties such as depression and conduct problems were significant risk factors for developing self-harm, but for girls, self-harm was also a risk factor for increased psychological difficulties (Lundh, Wangby-Lundh, & Bjarehed; Lundh, Wangby-Lundh, Paaske, Ingesson, & Bjarehed, as cited in Bjarehed et al., 2012).

A study involving over 30,000 mainly 15 and 16 year-old students in seven European countries found that increased severity of self-harm was associated with depression, anxiety, as well as impulsivity, low self-esteem and a prevalence of stressful life events (Madge et al., 2011). Madge et al. found that these patterns were consistent across gender and country. They concluded that both psychological characteristics and stressful life events significantly increase risk for self-harm. These are important findings for how self-harm is treated and ideally prevented, and will be further addressed in chapter four.

A 2014 published study followed 39,014 individuals who self-harmed between the ages of 15 and 34 with a median follow-up of 7.5 years (Bergen et al., 2014). At the time of follow-up they found that 2695 individuals (6.9%) had died and that 307 (11.4%) of these deaths were alcohol related. Compared to the general population rates, they found that rates of alcohol-related death were eight times greater in males and 11 times greater in females. Alcohol related death was associated with unemployed/sick/disabled status, alcohol use during self-harm, referral to drug/alcohol services, and a lack of psychosocial assessment following self-harm (Bergen et al., 2014). They concluded that all persons who present at hospitals for self-harm should be assessed for alcohol problems in order to receive appropriate interventions. While some studies show clinical significance, this study showed only statistical significance.

### **Myths and Stigma**

As stated, many youth who engage in self-harm try to keep their behaviours a secret from family and friends (Smith & Segal, 2014). This likely leaves many people alone in trying to deal with their behaviour. Self-harm is prone to misinformation because it is a shocking, confusing, and frightening behaviour to those who aren't struggling with it, as well as to some who are (Gratz & Chapman, 2009). Response to another's self-harm is likely to be "flight" (Best, 2005), which seemingly would make it difficult for others to truly understand another's self-harm. Myths about self-harm lead to more confusion and misunderstandings about the behaviour, which can further add to the distress experienced by those who self-harm (Gratz & Chapman, 2009). Gratz and Chapman (2009) identify several myths that include: self-harm is the same as a suicide attempt, self-harm is superficial and not dangerous, self-harm is manipulative, if a person self-harms, he or she has BPD, self-harm is a female problem, self-harm is crazy, sick, and irrational, a person must resolve his or her underlying problems before he or she can stop self-harming, and if underlying issues are resolved, then self-harm will end. They explain some youth (but certainly not all) can develop an addiction to this coping mechanism if underlying issues aren't addressed.

While there is an association between self-harm and suicide, there are far more instances of self-harm than suicide attempts (Klonsky, May, & Glenn, 2013). Medical personnel who interpret self-harm as a suicide attempt can respond inappropriately and add to a person's sense of feeling misunderstood and isolated (Gratz & Chapman, 2009). While wounds may not always be severe, that doesn't mean that a person is not suffering (Smith & Segal, 2014). Gratz and Chapman further counter the numerous myths surrounding self-harm. They explain that as people begin to rely on self-harm as a coping method, tolerance for self-harm can develop, which in turn may result in more harmful cutting. This can be especially problematic if someone is

self-harming while dissociating, which makes it more difficult to know how much harm is being done.

Gratz and Chapman (2009) suggest that seeing self-harm as a manipulative behaviour may interfere with individuals receiving the help they need. People typically self-harm in private without seeking attention due to shame and fear (Smith & Segal, 2014)—influencing others isn't a primary purpose of self-harm (Gratz & Chapman, 2009).

Originally, self-harm was viewed as a symptom of borderline personality disorder (BPD), however self-harm has also been identified in numerous clinical samples without BPD (Butler & Malone, 2013). While it is true that self-harm is a common symptom of BPD, that is not to say that all self-harm stems from BPD (Gratz & Chapman, 2009). Many people who self-harm don't have BPD or any psychiatric disorder (Gratz & Chapman, 2009).

Historically, self-harm has been seen as a female behaviour, yet research is showing that males and females self-harm for many of the same reasons and some studies indicate at the same rates (Gratz & Chapman, 2009). The belief that this is a female specific behaviour may make it more difficult for males to tell others about their self-harm (Gratz & Chapman, 2009).

Gratz and Chapman (2009) recognize that while self-harm is more dangerous than other coping behaviours, it is very effective in the short-term in reducing distress, and therefore not irrational or crazy. Labeling people who self-harm as crazy is neither accurate nor helpful (Smith & Segal, 2014).

Gratz and Chapman (2009) also believe that stopping self-harm before trying to work through other problems puts someone in a better place psychologically to then focus on resolving other problems, as less energy is spent on self-harm. Over time, self-harm can become addictive, thus, even if other problems are resolved, stopping self-harm can be difficult (Gratz & Chapman,

2009). In addition to treating the underlying causes of self-harm, they suggest several alternative coping strategies to deal with urges to self-harm. These include accepting urges will happen, using distraction, creating other strong sensations, becoming active with another activity, practicing mindfulness and ‘surfing’ the urge, and doing something physical such as intense exercise or tensing and then relaxing muscles.

### **Process Addiction**

Addiction can be defined as an overwhelming involvement with any activity that is harmful to the addicted person, society, or both (Alexander, 2008). This definition encompasses more than drugs and alcohol but includes process addictions—addictions to an activity. Compulsivity, loss of control, and continued use of the substance or behaviour despite negative consequences are accepted elements of an addiction (American Psychiatric Association, 2000). Compulsions are behaviours that are precipitated by a desire to prevent or reduce distress (American Psychiatric Association, 2000). Loss of control refers to the “persistent desire or unsuccessful attempts to cut down or control substance use” (American Psychiatric Association, 2000, p. 197). Researchers have found that many people who self-harm have strong urges to self-harm coupled with a loss of control (Buser & Buser, 2013). As well, many who self-harm continue to do so despite negative consequences (Buser & Buser, 2013).

Tolerance can be understood as a diminished effect with continued use (American Psychiatric Association, 2000). Empirical research supports the notion that for some people who engage in self-harm, their self-harm progressively becomes more intense and frequent to experience the same outcome (Buser & Buser, 2013). It is believed that self-harm may trigger the release of endorphins due to the pain from cutting, and over time people may develop a

tolerance to these endorphins resulting in the need for more frequent and intense self-harm (Yates, as cited in Buser & Buser, 2013).

Brown and Kimball (2013) asked self-selected university students about their experience, or story, regarding self-harming behaviour. This was a small phenomenological study involving 11 participants who had attempted to stop self-harming either on their own or with professional help, and who weren't currently in crisis or suicidal (Brown & Kimball, 2013). The median length of time the participants had been self-harming was 8.64 years. The median age at onset was 14.09. The primary method of self-harm was cutting (Brown & Kimball, 2013). Semi-structured interviews over the course of a week followed by data analysis resulted in three major categories: self-harm is misunderstood, reasons why self-harm is used as a coping mechanism, and advice to professionals.

A theme within the misunderstanding of self-harm is that self-harm is an addiction (Brown & Kimball, 2013). Six of the 11 participants either named their self-harm an addiction or compared it with the high drug users experience—"a reliable fix for overwhelming feelings" (Brown & Kimball, 2013, p. 199). Furthermore, what started out as experimental use led to increased use to receive the same results (Brown & Kimball, 2013), suggesting they developed a tolerance for their self-harm. Both frequency and intensity increased, with participants noting that they had a difficult time stopping despite negotiating with themselves to stop (Brown & Kimball, 2013), indicating a loss of control. This led to guilt and a repeated cycle of self-harm to manage their guilt (Brown & Kimball, 2013).

### **Association with Suicide**

Self-harm is defined in this thesis as the intentional damage of body tissue without suicidal intent and for purposes not socially sanctioned. Distinguishing self-injury (or self-harm)

from a suicide attempt is important as the two behaviours are very different and have different motivations (Dorko Mueller, 2009-2010). Dorko Mueller (2009-2010) explains that self-injury is a coping mechanism for survival while suicide is an attempt to die.

As explained, part of the difficulty in discussing self-harm is the numerous terms and definitions found in the literature. Without a universally agreed upon term or definition, interpreting the research on similar phenomena can be difficult (Gregory & Mustata, 2012). The terms self-harm and non-suicidal self-injury (NSSI) can reflect different views about the relationship between self-harm and suicide. The research about the link between self-harm or self-injury and suicide can seem conflicting, with opposing views (and different terminology) being upheld by differing research.

NSSI has become a common term in the United States as researchers acknowledge that not all youth who self-harm meet the criteria for a psychiatric illness or wish to die (Kapur, Cooper, O'Connor, & Hawton, 2013). NSSI is “the direct deliberate destruction of one’s own body tissue in the absence of intent to die,” (Butler & Malone, 2013, p. 324). Studies have shown that NSSI can be present with those with mood and anxiety disorders, eating disorders, substance misuse, conduct disorder, and PTSD (Butler & Malone, 2013). Thus NSSI may prevent some youth from being inappropriately labeled with a personality disorder—hence its new inclusion in the DSM-5 as a condition for further study (Kapur et al., 2013).

Klonsky, May, and Glen (2013) distinguish important differences between NSSI and attempted suicide. These include that NSSI is more prevalent, frequent, and the methods are also typically different. Previous research has shown that NSSI can be performed dozens or even hundreds of times, whereas suicide attempts are typically performed only once or twice (Klonsky, May, & Glenn, 2013). While Purington and Booker (n.d.) suggested that self-harm

can result in severe injury including life threatening blood loss or infection, scars, and disfigurement, Klonsky, May, and Glen (2013) suggest the contrary—that NSSI rarely causes severe or fatal injuries (Klonsky, May, & Glenn, 2013). As well, NSSI primarily involves cutting and burning, whereas attempted suicide typically involves self-poisoning (Klonsky, May, & Glenn, 2013).

NSSI can be interpreted as a sign of psychological pain, which can increase risk for suicide (American Psychiatric Association, 2013) without suggesting that NSSI and suicide attempts are the same (Butler & Malone, 2013). NSSI is indicative of maladaptive coping to regulate distress and endure life, whereas an attempted suicide reflects a desire to escape and end one's life (Butler & Malone, 2013). Research findings suggest that there are common risk factors predisposing people to both self-harm or suicide attempts (Butler & Malone, 2013). However, it is important to remember that NSSI does not necessarily indicate a less lethal attempt at suicide (Butler & Malone, 2013). With more psychopathology and environmental problems, more frequent and chronic self-harm and eventual suicide attempts are seen (Butler & Malone, 2013). Those who attempt suicide compared to those who self-harm score higher on anxiety, depression, and suicide ideation measurements (Butler & Malone, 2013).

In contrast to many North American researchers, European researchers typically use the term self-harm as it refers to self-injury regardless of whether suicidal intent is present or not (Ougrin, 2012). Kapur et al. (2013) argue it is likely that several motivations may be at play during an episode of self-harm, motivations may change from one episode to the next, and the underlying motivations may not be entirely understood by those who have self-harmed. Kapur et al. (2013) highlight that self-harm *without suicidal intent* is related to an increased risk of more self-harm and suicide compared with the general population. Kapur et al., ask whose view—the



doctor's or the patient's—should establish whether the self-harm is NSSI or not. For these reasons, Kapur et al. (2013) believe the term NSSI is problematic in that those given this label will be given lower priority and receive poorer treatment than other persons seen by front-line clinical staff. Kapur et al. (2013) recommend that clinicians always assess for the presence or absence of suicidal intent for current and past episodes of self-harm.

A consistent association has been found between self-harm and mental distress, and anxiety and depression foretell later attempts at suicide amongst adolescents and young adults (Moral et al., 2011). While Gratz and Chapman (2009) refute that self-harm is the same as an attempt at suicide, they do not say that someone who self-harms cannot *also* be suicidal. Non-suicidal self-injury (NSSI) has been found to be the strongest predictor of future attempts at suicide in adolescents with depression who are being treated under randomized, controlled trial conditions (Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, as cited in Butler & Malone, 2013).

Repeated self-harm is especially common in those who cut (Hawton et al., 2012). Hawton et al. used data on 5,205 youth, aged 18 and younger who presented at three hospitals in England following self-harm between 2000 and 2005, including a follow-up period for repeated self-harm to the end of 2007, and then national death information on the same youth to the end of 2010. They found a strong association between self-harm and suicide in adolescents as suicide was the cause of 25 out of 51 deaths following non-fatal self-harm. Twelve of these 25 youth who completed suicides did not show repeated evidence of self-harm. They concluded that this finding again highlights the need for all youth who are treated following self-harm to have a full psychosocial assessment.

Thus regardless of the terminology chosen, it would seem prudent to always consider suicidal ideation when working with a student who self-harms. This would be no different than considering a suicide risk assessment if it becomes known that a student is depressed, with or without signs of self-harm. Dorko Mueller (2009-2010) advises educators to always err on the side of caution and to refer students to the school counsellor for follow-up. More about the relationship between self-harm and suicide as it pertains to the role of school counsellors will be discussed in chapter four.

### **Closing**

In this chapter, I have identified unintended outcomes of self-harm that include infections, scars, feelings of isolation, guilt, shame, and low self-esteem, the loss of healthy alternative coping behaviours, the connection between self-harm anxiety, depression and alcohol misuse, and how self-harm doesn't solve one's problems. I also identified numerous myths that shroud self-harm and their possible effects on those who self-harm. I also explained how self-harm might become an addiction for some individuals, and the differing opinions researchers argue about the connection between self-harm and suicide.

In the next chapter, I will explore how self-harm is a relevant topic for schools to address through school policies, especially how it may or may not relate to suicide, and how teachers and other front-line workers can respond when approached by or knowing of a student who is cutting. I will also include the voices of youth as heard in various studies regarding what they want and do not want in response to their self-harm.

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## CHAPTER 4: CUTTING AND THE ROLE OF SCHOOLS

The purpose of this chapter is to highlight the many challenges school staff may encounter in responding to cutting among their students. I will begin with a discussion of how prevention is an approach schools could consider to handle student anxiety as it relates to self-harm. This will be followed by a description—supported by research—of how cutting is often not yet fully recognized or understood by most teachers and counsellors as evidenced by common responses to cutting and a lack of school policies. Ideas for how to better ensure that teachers and counsellors are prepared emotionally and professionally both at an individual and school-based level will also be included. I will also share opinions of youth who have cut, collected through studies on how they would like to be helped and what they believe is unhelpful.

### **Prevention**

As previously explained, self-harm in adolescence is associated with numerous mental health problems such as depression and anxiety, and these mental health issues are worthy of early intervention (Moran et al., 2011). “Prevention, wherever possible, is better than cure” (Best, 2006). Prevention strategies should be directed at all youth (Shapiro, 2008). If self-harm is associated with low self-esteem, lack of self-confidence, and excessive anxiety, then schools need to consider how they can promote positive self-concepts and provide their students with necessary skills to effectively handle challenges (Best, 2006). A health education program that includes coping skills, interpersonal communication, goal setting, anger management, and advocacy skills can enable students to model and practice social skills that are necessary for making healthy and safe decisions (Shapiro, 2008).

### **School Climate**

Schools are obliged to create a safe and secure environments that foster resilience for their students (Lieberman, Toste, & Heath, 2009). Wells and Axe (2013) state that schools must create trusting relationships between students and adults to ensure comfortable communication. They suggest universal prevention strategies include access to mental health services, connecting with families, creating positive relationship between teachers and students as well as between peers, and using curriculum that addresses problem solving and coping skills. They believe these strategies create a strong school community and may reduce self-harm among students. This echoes Lieberman and colleagues (2009) belief that a sense of belonging empowers students and is a strategy for preventing self-harm and other risky behaviours among youth. Lieberman and colleagues (2009) recommend that schools create a sense of connectedness for students by establishing an environment where students are able to express themselves, discuss problems and concerns, connect with peers and staff in a safe space, and find resources if needed.

Self-efficacy can be defined as a subjective belief in being able to cope with new and difficult demands by one's own competencies, and is a core prevention criterion of mental health (Jerusalem & Klein Hessling, 2009). Jerusalem and Klein Hessling (2009) posit that school is an important setting for providing resources for mental health since experiences at school contribute to personality development in childhood and adolescence. They reviewed two school intervention projects in Germany that were aimed at promoting students self-efficacy. They concluded that social self-efficacy can be enhanced by creating a positive class climate where students support each other and teachers are aware of the individual needs of their students.

A study examined associations between classroom climate and student mental health in elementary school, and whether students who had emotional and behavioural problems in Grade



2 were more vulnerable to the effects of a poor classroom climate in Grade 6 (Somersalo, Solantaus, & Almqvist, 2002). The results showed associations between poor Grade 6 classroom climate and an increase in emotional and behavioural problems in boys and girls. As well, the girls who struggled in Grade 2 were notably vulnerable to a poor classroom climate in Grade 6. The researchers concluded that their findings aligned with earlier research that found that classroom climate and emotional and behavioural problems in students are in a dynamic relationship, and schools should pay attention to atmospheric aspects for the mental health of their students.

### **Mental Health Programs**

The FRIENDS program was created for schools as a universal approach for preventing the onset of anxiety in school-aged populations (FRIENDS; Batter, Lowry-Webster, & Turner; Barret & May as cited in Maggin & Johnson, 2014). Prevention strategies aim to develop students' coping strategies and resiliency to manage anxiety and are especially relevant for students who are not yet identified or who experience high, though nonclinical levels of anxiety (Maggin & Johnson, 2014). Using the principles of cognitive behavioural therapy, the program is delivered over 10 weekly 60-minute lessons. While Maggin and Johnson (2014) challenge that FRIENDS is an evidence-based program, they do recommend that schools develop a clear plan for supporting students who show an elevated risk for anxiety. The researchers suggest a systemic approach to intervention can make use of the FRIENDS program to ensure that all students receive some support for handling anxiety and that it's integration can be a part of screening, intervening and monitoring the progress of treatment for students who show elevated risks for anxiety.

Childhood anxiety is the most common risk factor for adolescent depression (Barrett, 2013). Symptoms of anxiety and depression overlap in childhood and adulthood and left untreated, childhood anxiety can lead to depression in adolescence (Barret, Farrell, Ollendick, & Dadds as cited in Barrett, 2013). Given that anxiety disorders are the most common mental health concern in children (Heather et al., 2009) it would seem to be important for elementary schools to take an active role in helping young learners manage their anxiety. Specifically, the FRIENDS curriculum creates opportunities for children and youth to have their fears and worries normalized (Heather, Lynn, & Yvonne, 2009). The program encourages parents to become involved and suggests they facilitate practising the skills as a family to improve the likelihood their children will learn effective resilience coping skills and use them as they relate to family, community or school friends (Barrett, 2013).

In many school districts in Canada and elsewhere, school counsellors have finite availability (Heather et al., 2009). Maggin and Johnson (2014) suggest that teachers be trained to deliver the program as the most efficient way to implement it. In doing so, the FRIENDS program can be an efficient and effective way to lessen anxiety as well as to train and sensitize teachers to the psychosocial needs of students (Heather et al., 2009). Given that the FRIENDS program is sponsored by the BC Ministry of Education, perhaps school policies could ensure that this program is universally delivered as a preventative and screening measure for student anxiety.

The Signs of Suicide (SOS) Middle School Program may detect at-risk students (Lieberman et al., 2009). It is a school-based program for middle and high school students that includes an educational video and tool to screen for depression and also includes a resource on self-harm that has suggestions for school counsellors, teachers, and parents (Lieberman et al., 2009). The program attempts to increase teen awareness of depressive and suicidal symptoms,

and how they can get help for themselves or friends whether through adults or crisis lines (Lieberman et al., 2009). Ideally, help would be provided early enough through this program to prevent any possible suicidal ideation that may subsequently develop if depression is left unchecked.

### **Common Responses to Self-Harm**

A series of 34 interviews involving teachers, learning support staff, counsellors, school nurses, and others in support and clinical roles in the United Kingdom included reactions of teachers to self-harm in 15 of the interviews (Best, 2005). The interviews occurred between March 2003 and June 2004 and typically lasted just under an hour (Best, 2006). Most responses involved the emotions that were triggered in teachers. “Statements referred to *feelings of alarm, panic, anxiety and shock*, and of being *scared, distressed, upset, taken aback, fazed, freaked out, repulsed, bewildered, frustrated, sorry and mystified*” (Best, 2006, p. 168, emphasis in original). Some teachers commented on how scary and upsetting encountering self-harm can be for the first time, especially cutting (Best, 2005). One counsellor believed that the reactions to cutting are more extreme than those to an overdose (Best, 2006). Another counsellor suggested that the link many teachers assume between cutting and suicide is what arouses their anxiety (Best, 2006).

For one teacher, a student’s cutting triggered reminders of what she experienced in her own youth, resulting in feeling the student’s cutting was a problem too big for her to cope with and a felt need to pass it on to another as soon as possible (Best, 2006). The emotions of teachers who support students who self-harm can be overwhelming (Best, 2006). For this reason, it is necessary for school staff to monitor their responses to ensure that negative reactions are not being conveyed if a student discloses self-harm (Toste & Heath, 2010). Perhaps

becoming aware and knowledgeable of self-harm is one way to lessen or prevent a variety of unpleasant emotions and a 'flight' response from being triggered.

### **Developing Awareness, Knowledge, and Basic Skills**

An Australian study involving 501 secondary school teachers and other staff revealed that 80.4% of staff had never received any education in self-harm, that 81.8% reported they would welcome it, and 73.6% reported they required education in self-harm (Berger, Hasking, & Reupert, 2014). Furthermore, only 22.9% of school mental health workers had received any education in self-harm, and 75.4% believed they needed professional development in self-harm (Berger et al., 2014). Qualitative data showed that teachers and support staff were empathic and wanted to be able to help students who self-harmed, but a lack of knowledge and resources was noted (Berger et al., 2014). It was also demonstrated that the more knowledgeable and confident staff was to respond to students who self-harmed increased staff communication with these students (Berger et al., 2014).

Thus, it is important that schools first become aware of self-harm and then be equipped to deal with it, similar to how teachers have been better prepared to respond to child abuse and bullying (Best, 2006). Similarly, the current and growing awareness of self-harm can be compared to the recognition of eating disorders that developed in the 1970s and 1980s (White Kress, Gibson, & Reynolds, 2004). As public and professional awareness increased, many people began to find help for what was at the time thought of as rare conditions (Conterio, Lader, & Bloom, as cited in White Kress et al., 2004).

Schools have to better recognize cutting among students (Best, 2005). Being able to recognize that a student is engaging in self-harm is critical to providing an appropriate response and effective support (Toste & Heath, 2010). Beyond visible scars and new cuts, other warning

signs are wearing long sleeves or bulky clothes at all times—even when it is inappropriate—refusing to participate in activities that involve revealing skin or refusing to change for physical education, and alluding to self-harm through creative writing, journals, or art work (Nixon & Heath; Walsh as cited in Toste & Heath, 2010).

School staff are often asked to deliver school-based mental health lessons and to refer students in need of additional support (Reinke, Stormont, Herman, Puri, & Goel as cited in Berger et al., 2014). In essence, schools become gatekeepers for those students who require further help. In respect to cutting, positive attitudes and confidence to respond to self-harm in a school setting would seem to be important elements of whether teachers and support staff can respond effectively for students in need (Berger et al., 2014).

It is possible for schools to develop policies around cutting to increase awareness and knowledge of this topic for teachers and front-line workers and after doing so, provide them with professional development to develop the skills for how to effectively respond when they become aware of or approached by a student who is cutting. As the Australian study (Berger et al., 2014) demonstrated, communication increased between staff and students when staff felt knowledgeable and confident. Hence, it seems likely through awareness, knowledge, school policies, and skill development teachers will be better prepared for dealing with cutting and thus more likely to feel confident to respond in a helpful manner.

Most self-harm does not occur on school property, thus it is arguable that the initial response to self-harm should come from family doctors and others who relate to the youth and their family (Best, 2005). However, schools do have an active role in caring for their students and are expected both professionally and legally to respond to students who have personal, social, emotional, or behavioural problems (Best, 2005). Frequently, school counsellors become

aware of students' cutting prior to families and others outside of school (White Kress, Gibson, & Reynolds, 2004). This awareness can come from many sources that includes observations or physical indicators of self-harm, information that is reported by the student, teachers, and parents, as well as students reporting of a friend's self-harm (White Kress et al., 2004) known as "peer flagging" (Wells, Axe, & College, 2013).

The same series of interviews involving 34 teachers and others in support and clinical roles in the United Kingdom revealed that many parents prefer schools to take charge of the problem rather than initiate reaction through family doctors and support (Best, 2005). This is another reason for expanding teachers' awareness, knowledge, and skills necessary for them to respond effectively and cope (Best, 2005).

Developing an awareness of self-harm needs to be contextualized for the reasons why people self-harm (Best, 2005). Factual material provided in context for why people self-harm can help staff appreciate that there are acceptable forms of self-harm such as over-work, lack of sleep, and to some extent the use of alcohol, where the line is then blurred between those who "self-harm" and those don't (Best, 2005). Turp (2002) has coined the acronym *cashas* for culturally acceptable self-harming activities, which include a range of behaviours such as body-contact sports, sleep deprivation, tattooing, body-piercing, use of tobacco, alcohol and other 'recreational drugs,' as well as overwork. Recognizing that most people self-harm in one form or another, coupled with an understanding that cutting is in fact one form of caring for one self (albeit not ideal) may help teachers and staff assume a non-judgmental approach (Best, 2006). Providing school staff members with information based on current research, along with photographs and quotes from youth who self-harm leads to better understanding of why youth may self-harm (Shapiro, 2008).

**Initial Response**

From a therapeutic perspective, a panicked response is counter-productive (Best, 2006). Labeling students as “cutters” leads to unhelpful scrutiny or monitoring that may further increase anxiety and subsequent cutting (Best, 2006). Youth are unlikely to seek help from teachers for self-harm (Fortune et al., as cited in Berger et al., 2014) possibly due to anticipated negative reactions teachers may have and a fear that parents will be contacted (Patterson et al., as cited in Berger et al., 2014).

While recognizing that teachers may lack mental health training and are not expected to act as counsellors to their students (Koller, Osterlind, Paris, & Weston as cited in Berger et al., 2014), professional development can prepare teachers and other school staff with the knowledge and required skills to respond effectively to self-harm (Berger, et al., 2014). More helpful and understanding responses are likely when teachers are aware and knowledgeable (Best, 2006). Respectful attitudes towards students to self-harm are likely the most important aspect for students to seek help from teachers, which in turn maximizes their chances for early intervention (Berger et al., 2014).

Listening to and talking with youth, giving information and resources are ordinary strategies for most adults and need not be exclusive to professional counsellors (Berger, Hasking, & Martin, 2013). Combining an open-minded response with active listening will enhance teachers’ ability to respond empathically and supportively (Best, 2005). Education for staff in the aetiology of cutting as one form of self-harm coupled with training in basic counselling skills, such as active listening, and a clear understanding of a school’s policy and procedures for responding to self-harm are needed (Best, 2006).

Regular in-service on mental health issues and basic counselling skills could consider self-harm alongside other issues such as grief, bullying, and abuse (Best, 2005). School counsellors or other agencies such as Child and Youth Mental Health could provide professional development on mental health issues and active listening skills. Cross, Matthieu, Cerel, and Knox (as cited in Berger et. al, 2014) suggest that professional development could focus on developing skills involving active listening, clarifying questions, asking about intentions to self-injure, motivation to get help, and how to refer. The quality of the response teachers and support staff could give to students would be enhanced while also providing a needed source of emotional support to staff (Best, 2005). Professional development would allow teachers to discuss their experiences, problem-solve their challenges, and instil confidence in their ability to respond effectively (Berger et al., 2014).

While many may find self-harm difficult to understand or think about, creating trust, respect, and sensitivity may be much simpler (Woldorf, 2005). Gathering information directly from youth in a nonjudgmental manner may convey respect while also avoiding assumptions about what the self-harm signifies (Woldorf, 2005). A calm and nonjudgmental response to an adolescent conveys that his or her thoughts and feelings are acknowledged (White Kress et al., 2004). A calm approach also will not reinforce the behaviour (Shapiro, 2008). This approach can form the basis of a trusting relationship (Shapiro, 2008).

Toste and Heath (2010) recommend that school staff show acceptance for the student despite not necessarily accepting the behaviour, to let the student know that there are people who care about him or her, to understand that cutting is the student's way of coping, to use the student's language for his or her self-harm, to convey a willingness to listen respectfully, and to have a non-judgmental compassion for the student's experience. Toste and Heather (2010) stress



that staff not be overly reactive to avoid alienating the student and damaging rapport, not respond with panic or other negative emotions and to not look away, not try to stop the cutting with threats or ultimatums, not show excessive interest in the cutting, not let the student relive the experience of cutting as this can be a trigger, not talk about the student's cutting in front of the class or around peers, and not promise confidentiality. An example of a best practice response from a teacher to a student's cutting is provided in the Appendix.

### **Counsellor Involvement and School Policies**

A study that involved 470 school counsellors in North America revealed that 92% of counsellors reported working with a student who engaged in self-harm (Duggan, Heath, Toste, & Ross, 2011). The majority of counsellors (63%) indicated that their respective school districts were without protocols for responding to self-harm and 20% were unaware if their school had a policy in place. As well, the majority of counsellors rated their knowledge of self-harm as moderate involving causes, symptoms, and treatment (Duggan et al., 2011). These findings suggest counsellors' needs for formal training and education with respect to self-harm, along with effective school policies to provide important guidelines and procedures (Duggan et al., 2011). Inadequate training in self-harm can mean that counsellors are not only unprepared to help youth who self-harm but also less able to be an effective school contact or support teachers and other staff who encounter students who self-harm (Duggan et al., 2011). Ultimately, school staff must convey awareness, understanding, and compassion in order to have open communication with students and increase their chances for accessing support (Toste & Heath, 2010).

Following the initial response to the disclosure or identification of self-harm, Toste and Heath (2010) recommend a school counsellor (or nurse) meet with the student to determine

immediate risk, intervention planning, or referral. Questions that include the intent, and the emotions at the time of the cutting such as “Could you say more about this?”; “What were you thinking or feeling prior?” can help differentiate self-harm from suicidal behaviour (White Kress et al., 2004). School counsellors should consider assessing for depression, helplessness, and hopelessness; suicidal ideation, plan and intent, preparation and available means, and past attempts; social support; family history of suicide; and recent stressors (White Kress et al., 2004). From this assessment, counsellors could then determine if the student needs to be referred to outside mental health services (Toste & Heath, 2010).

A response protocol explains the school’s procedures for how to respond to incidents or reports of self-harm. It needs to be created and agreed upon by all involved—administrators, counsellors and teachers (Toste & Heath, 2010) as this will likely increase its use. Specific procedures for the role of teachers, counsellors and administration, for reporting when a student is or suspected of self-harming and whom to report to, all need to be included and understood (Toste & Heath, 2010). It should also include policies for guiding the primary assessment and when a student needs to be referred to outside mental health agencies (Toste & Heath, 2010). Consideration for when to contact parents must also be included and agreed upon by all (Toste & Heath, 2010).

Toste and Heath (2010) recommend that if the assessment shows low risk for suicide and no serious mental health concerns, then parental contact may not be required, however a follow-up assessment should occur to ensure that the level of risk has not changed (Toste & Heath, 2010). Asking the student if his or her parents are aware of the cutting, or if the student is willing to discuss it with his or her parents can be useful to establish open communication to create additional support from home (Toste & Heath, 2010).

### **Opinions of Youth**

Students in a sample of 41 secondary schools in England completed an anonymous, self-report questionnaire that included the question, “What do you think could be done to help prevent young people from feeling that they want to harm themselves?” (Fortune, Sinclair, & Hawton, 2008). Written responses of 2,954 students ages 15-16 were analyzed. Eleven broad categories of responses were identified involving the causes and possible ways of preventing self-harm among adolescents. The most common theme was the need for youth to have someone to talk to about their problems, with over 28% suggesting this as one way to prevent others from feeling the need to self-harm (Fortune et al., 2008). The second most common theme was the role families have in either contributing to or preventing adolescent distress, with the belief that parents could be educated more about self-harm so that they could discuss this with their children (Fortune et al., 2008). The third most common theme was the need for recreational activities and centres followed by the need for friendships and peer interactions (Fortune et al., 2008). School was the fifth common theme that included pressure due to exams and assessments, the role of teachers in terms of wanting them to be more available to students, for teachers to be aware of warning signs, and to look out for troubled students, to have a school counsellor available to talk to on any given day, and the negative effects of bullying along with the wish for schools to have more effective bullying policies (Fortune et al., 2008). Eleven percent of the respondents identified as having a history of self-harm, and 28% were friends of peers who had engaged in self-harm. The authors concluded that family, friends, and school are the most important sources of support in preventing self-harm, highlighting the need for school counsellors and school-based mental health programmes (Fortune et al., 2008).

In an Australian study involving 2637 students aged 12-18 years, students were asked what they thought teachers (and parents) can do to help students who self-harm (Berger et al., 2013). The authors felt that understanding the role of teachers from a youth perspective may be meaningful in terms of intervention with the intent to reduce unhelpful reactions and increase a willingness among youth to seek help. Several themes emerged, including reducing stigma and maintaining confidentiality, reducing academic stress and bullying, educating students about the consequences of self-harm, similar to education about drugs, alcohol and sex, and for schools to research self-harm from a self-harmer's perspective (Berger et al., 2013).

In a small qualitative study, Hill and Dallos (2011) explored the stories of adolescents who self-harmed to fully understand their experiences. Six adolescents ranging in age from 13 to 18 years old participated and all were either currently self-harming or had done so within the last six months, mainly by cutting (Hill & Dallos, 2011). Hill and Dallos found that the pleas for professionals, peers, and parents to understand them better was the most important message that the adolescents conveyed in their stories. They felt misunderstood because others didn't understand their reasons for self-harm, as well as a broader sense of not feeling understood or listened to (Hill & Dallos, 2011).

A 2008 study investigated the views of 96 young women with a history of self-harm (Ryan, Heath, Fischer, & Young, 2008). Participants were recruited from three online support forums for those wanting support to manage or reduce their self-harm, and lived primarily in the United States, England, and Canada, as well as Singapore, New Zealand, and several European countries. Participants expressed a desired to be listened to without judgment, to be able to talk out their emotions, to have their depression acknowledged before it got worse, and to have others understand that self-harm is a symptom of a bigger and more complex set of problems (Ryan,

Heath, Fischer, & Young, 2008). Interactions that they viewed as harmful included parents forcing them to talk about it when they didn't wish to, being shouted at as a way to discourage future self-harm, and body searches to check for self-harm (Ryan et al., 2008). From this study, the researchers identified the need for school-based services to better meet the mental health needs of students who are struggling with self-harm by school counsellors building rapport and increasing their understanding of the emotional needs instead of focusing on the self-harm for their students (Ryan et al., 2008).

A United Kingdom study that involved in-depth interviews with young people who had been involved in a cycle of self-harm revealed similar results (Bywaters & Rolfe, 2002). Many of those interviewed said that feeling understood, being listened to, and not being judged were how others had been helpful to them (Bywaters & Rolfe, 2002). Participants wanted friends, families, and others to respond to their distress behind the self-injury, and to see “beyond the scars” (Bywaters & Rolfe, 2002, p. iii). Participants identified professionals who tried to understand and were respectful as being helpful in contrast to those who were disrespectful, dismissive, patronizing, and judgmental (Bywaters & Rolfe, 2002).

### **Closing**

In this chapter, I have identified the need for schools to foster resilience and coping skills amongst students as one way to prevent students from turning to self-harm. Beyond specific programs that address anxiety, depression, suicide, and self-harm, creating a school culture where students feel safe, connected, are welcome to discuss their problems, and have access to further resources if needed may keep many students from beginning self-harm. As well, I highlighted the need for teachers and other front-line workers to increase their awareness and knowledge of self-harm, as well as their basic listening skills in terms of responding effectively

when approached by or becoming aware of a student who is cutting. Research was included that showed that teachers and school counsellors would most often like to be able to help students who self-harm but frequently lack knowledge and understanding, coupled with a lack of school policies. As well, various studies were reviewed that included the perspectives of youth who have self-harmed and how they most often wished to be listened to without judgment so that their problems and feelings can be discussed openly.

In the following and closing chapter, I will summarize the main findings of the research, the implications for school staffs, the limitations of the research, areas that require further research, and what can be done individually to influence healthy responses for those working with youth in school settings.

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## CHAPTER 5: DISCUSSION AND CONCLUSIONS

This chapter will begin with a summary of the research reviewed on self-harm. Implications for school staffs when they become aware of a student who is or may be cutting will then be discussed, with particular attention given to the relationship between self-harm and suicide and the need to assess for suicide. Limitations of this research, including personal biases, will be highlighted as well as gaps in the research and literature. It will close with suggestions for what can be done to increase awareness of cutting and thereby try to ensure that support is provided to students who self-harm.

### **Main Research Findings**

Research with youth has shown that self-harm is a behaviour that is increasing in frequency, with cutting being the most prevalent form (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). It is difficult to know the actual percentages, as it is uncommon for youth to be assessed following episodes of self-harm (Hall & Place, 2010) but studies in Western Canada have shown rates from 15 to 16.9% among high school students (Laye-Gindhu & Schonert-Reichl, 2005; Nixon, Cloutier, & Jansson, 2008).

Numerous models have been developed to explain this growing phenomenon. The most common psychological model is the Experiential Avoidance Model (EAM) that proposes that self-harm is a negatively reinforced strategy for reducing or ending emotional distress (Chapman, Gratz, and Brown, 2006). Self-report and psycho-physiological studies support the theory that self-harm offers relief from unpleasant emotions, thoughts, or memories (Chapman et al., 2006).

An accepted biological model focuses on the role of endorphins—natural pain relievers. This theory proposes that people who self-harm may have lower levels of endorphins and the act

of self-harming may bring this form of endogenous opioids to normal levels (Sher & Stanley, 2009). It is possible that an opioid deficiency could stem from childhood trauma such as abuse and neglect (Sher & Stanley, 2009).

A developmental model considers the overrepresentation of disorganized attachment among those who self-harm, whereby a history of disorganized attachment can as much as triple the likelihood of self-harming (Yates, as cited in Yates, 2009). This theory proposes that a person with disorganized attachment may view her or himself negatively, along with others and relationships. Chapman and colleagues (2006) explain that self-harm acts as self-punishment, which justifies the belief that self-punishment is deserved. The self-harm lowers a person's emotional arousal, or the desire of others to punish them, which can protect the person from others' unwelcomed behaviours, thus lowering a person's anxiety (Chapman et al., 2006).

Social contagion through popular culture may also explain the increase in self-harm as such behaviour has become more accepted among youth (Alfonso & Dedrick, 2014). Cutting in particular has been portrayed in young adult fiction, movies, television shows, songs, and celebrity disclosures. As well, numerous Internet sites promote self-harm (Whitlock, Lader, & Conterio, 2007). Disinhibition theory and script theory posit that inhibition for self-harm may be lowered when it is shown to be common, effective, and pain-free (Whitlock et al., 2007).

Purington and Whitlock (2010) state that the factors leading to self-harm are multifaceted, which supports McKenzie and Gross' (2014) assertion that it is unlikely that there is only one influence beneath self-harm. Thus, for any person it is possible that many theories may simultaneously explain their use of self-harm as a mechanism for coping with intrapersonal or external stressors unique to them.

While some research supports that many individuals who self-harm stop spontaneously (Moran et al., 2011), Chapman and colleagues (2006) explain others may enter into a dangerous cycle after beginning to self-harm. They explain that once an individual begins to self-harm it may have a paradoxical effect whereby it can add to a person's distress and thereby escalate the likelihood of repeated self-harm. They also suggest that unwanted emotions may be maintained if an individual instead tries to avoid these emotions through self-harm rather than learning how to manage them effectively. As well, an individual may adopt a conviction that he or she will feel better after self-harming and thus won't learn from the unpleasant consequences of self-harm (Chapman et al., 2006). Over time these negative consequences may be reduced as the person becomes used to the behaviour. Another possibility why self-harm may be difficult to stop for some is that self-harm may trigger the release of endorphins and with time a tolerance to these endorphins may develop resulting in the need for more frequent and intense self-harm (Yates, as cited in Buser & Buser, 2013).

While self-harm can be an effective coping behaviour in the moment, Jacobson and Gould (2007) propose that it is likely to exacerbate symptoms and distress in the long-term. Research suggests that following an episode of self-harm, individuals feel relief as well as shame, guilt, disgust, and disappointment that can be long lasting (Laye-Gindhu & Schonert-Reichl, 2005; Butler & Malone, 2013). The short-term relief that self-harm provides can prevent youth from learning or using more effective strategies for feeling better (Smith & Segal, 2014; Gratz & Chapman, 2009).

Self-harm is associated with many mental health problems that include anxiety, depression, impulsivity, low self-esteem, and stressful life events (Madge et al., 2011). As previously explained, self-harm may end, but many youth who self-harm may have mental health

problems that might not get resolved without support (Moran et al., 2011). Thus, without learning other coping strategies, youth who self-harm are at risk for developing major depression, drug and alcohol addiction, and committing suicide (Smith & Segal, 2014).

Different researchers may have different opinions on the connection between self-harm and suicide as reflected in the various terms they elect to use. However, research has shown a consistent association between self-harm and mental distress, and anxiety and depression foretell later suicide attempts amongst youth and young adults (Moran et al., 2011). Butler and Malone (2013) use the term non-suicidal self-injury (NSSI) to distinguish between self-harm and a suicide attempt. They maintain that self-harm doesn't necessarily mean a less direct attempt at suicide while also acknowledging that there are common risk factors that make an individual vulnerable to both self-harm or suicide attempts. They further acknowledge that as mental distress and situational problems increase, more self-harm and eventual suicide attempts may also occur.

In contrast, Kapur and colleagues (2013) believe the term NSSI can lead to less effective treatment by hospital front-line workers and a suicide assessment can be overlooked. They highlight that self-harm without suicidal intent is associated with an increased risk for further self-harm and suicide compared to the general population. Hence, they stress that clinicians always need to assess for suicidal intent for current and past episodes of self-harm.

Numerous myths about self-harm may add to the confusion and bewilderment that self-harm can provoke in others. Gratz and Chapman (2009) identify several. These include that self-harm is manipulative, if a person self-harms they have borderline personality disorder, self-harm is a female problem, and self-harm is crazy and irrational. Another myth is that self-harm is superficial and not dangerous. In a sense the very opposite of that belief is the myth that self-

harm is a less lethal suicide. As the research shows, the underlying causes of self-harm can be vast. Thus it would seem to make sense to assess each individual occurrence of self-harm as the motivations and intentions can change and be different from one individual to another.

### **Implications for Schools**

Because self-harm is associated with numerous mental health challenges (Moran et al., 2011) prevention strategies should be aimed at all youth (Shapiro, 2008). Beyond health education programs, Lieberman, Toste, and Heath (2009) recommend creating a school climate where students feel safe, secure, and welcomed to discuss their problems with staff and where they access further resources if needed. Such a school climate may reduce self-harm among students (Wells, Axe, & College, 2013). Studies interviewing youth who have self-harmed have shown that feeling understood, being listened to, and not being judged were helpful as opposed to those who were disrespectful, dismissive, patronizing, and judgmental (Bywaters & Rolfe, 2002).

Without being aware and knowledgeable of self-harm, initial responses to self-harm often include feelings of alarm, panic, anxiety, shock, as well as being frightening, distressed, repulsed, and bewildered (Best, 2005). Assuming that self-harm is a suicide attempt may be what most arouses teacher anxiety (Best, 2006). Best (2005) maintains that schools need to develop awareness and understanding of self-harm so that they are then be able to provide a measured, informed, and systemic response to students who self-harm. He believes that if schools are able to respond effectively, students are more likely to seek and receive help without feeling shame. It would seem this is all the more vital given a student who self-harms is potentially also more vulnerable for suicide.

School policies should be developed to increase awareness and knowledge of self-harm, and professional development can be offered to teachers and support staff to develop skills to respond effectively when they become aware of or approached by a student who is cutting. Basic counselling skills that involve active listening, clarifying questions, asking about intentions to self-harm, motivation to get help, and how to refer would enable staff to respond effectively (Cross, Matthieu, Cerel, & Know as cited in Berger, Hasking, & Reupert, 2014) while also instilling a sense of confidence to do so (Berger et al., 2014).

Following an initial response to a student's disclosure or identification of self-harm, Toste and Heath (2010) suggest a school counsellor or nurse meet with the youth to assess immediate risk, intervention planning, or referral. This should include assessment for depression and suicide risk, as well as the student's family history of suicide, social support, and recent stressors (White Kress, Gibson, & Reynolds, 2004). This assessment could enable counsellors to determine if the student should be referred to community mental health services (Toste & Heath, 2010). A response protocol outlining the role of teachers, counsellors, and administration for reporting when a student is or suspected of self-harming and whom to report to, and considerations for contacting parents when a student is deemed to be at risk to him or herself should all be included and understood by staff (Toste & Heath, 2010).

### **Limitations of the Research**

A limitation of this thesis is that youth were not interviewed directly to know what their preferences might be for school policies and responses from staff, or how they perceive and make sense of the connection between self-harm and suicide. There may be differences in student perceptions of self-harm based on where they come from. The included research that

examined students' perception of self-harm was from the United Kingdom. How students in Western Canada perceive their school experience as it relates to self-harm may be different.

Another limitation could be the search engines that were used. These included ProQuest, EBSCOhost, and LexisNexis Academic through City University of Seattle, and Summon through the University of British Columbia. The key search words used were cutting, self-harm, deliberate self-harm, self-injury, self-injury behaviour, self-injurious behaviour, self-inflicted injury, superficial self-injury, non-suicidal self-injury, and self-mutilation. These search engines and keywords may not be exhaustive of all the available research in this area.

Other limitations include personal biases. As a teacher, student, and parent, I developed the idea for this thesis based on my personal experiences of encountering self-harm both as a parent and volunteer at a local crisis centre. From my perspective, I concluded that little was being done, at least in the school district where I work, to develop awareness and knowledge of self-harm among school staffs. It is possible that within my district and others, schools may have developed policies and provided professional development to their staffs on this topic without my being aware.

Another personal bias is the belief that schools in many parts of the world, including Canada, are overly concerned about academic performance at the expense of students' emotional well-being. My beliefs are based on personal observations. For example, the academic requirements and competition for youth to enter into the same urban university that I attended is far beyond what was required of me. Perhaps the growing number of tutors that are employed within my community reflect this new standard. How does this culture of academic pressure impact students? Is this pressure another contributing factor of low self-esteem, anxiety or depression that may lead to self-harm? This observation is supported by Levine (2006) who



highlights that anxious parents make anxious children and believes that of all the things parents can be anxious about, academic performance is near the top of the list. Levine further makes the connection between parents' anxiety about school performance and children who become perfectionists. She adds that incessant academic pressure can cause depression, anxiety, and suicide in some children.

I would also like to highlight the term self-harm and its synonyms such as self-injury, non-suicidal self-injury, superficial self-injury and others may be perceived as pejorative by many youth. Perhaps these terms are another barrier that keep many youth silent about their behaviour (as well as adding challenges to the research). As previously explained, many other behaviours may be harmful yet aren't identified as such. These could include, but are not limited to, drinking, working excessively, piercings, tattoos, and even exercise or high risk sports. I believe that when talking to youth about their self-harm, stating the specific behaviour such as "cutting" is more respectful and nonjudgmental.

### **Areas that Require Further Research**

Most of the research on self-harm seems to involve youth or young adults, with significantly less research examining self-harm among adult populations beyond those with clinical mental illness. In order to better understand the long-term course self-harm can take, adult populations should be researched.

As well, more research could involve the motivations and intentions behind the cutting or similar behaviours. How self-harm has been portrayed in young adult literature has shifted, and so too may the reasons for many youth who self-harm today versus 20 years ago. With more understanding, this may help devise better prevention programs as well as ways to help people

who self-harm. More research might also help us understand the efficacy of various treatment approaches.

Another challenge within the research is the numerous terms used to describe self-harm. There isn't a commonly accepted universal term or definition. This concern is highlighted by the DSM-5 proposal to include a non-suicidal self-injury (NSSI) disorder based on data that is collected from Canada and the United States, as these countries use these terms and definitions. Youth around the world may be given a psychiatric diagnosis based on data collected from North America and thus such a diagnosis may be culturally biased (Muehlenkamp, Claes, Havertape, & Plener, 2012).

### **Concluding Thoughts**

A major objective of writing this thesis was to extend awareness and knowledge of self-harm, particularly cutting. A secondary objective was the desire to learn about and do more for youth who cut. Understanding that cutting is a coping behaviour in response to a myriad of potential factors will hopefully reduce the guilt and shame that is experienced by many who cut as well as their families. It is also hoped that many of the myths and stigmas surrounding cutting are exposed and can be challenged when they are encountered. Developing school policies and protocols can be a starting place for collectively making a positive difference to students.

At the micro level, individuals can motivate change by being informed and talking about cutting with colleagues to further reduce myths and stigma while increasing an awareness and knowledge in others. Conversations can also occur with students for the same reasons as well as fostering a sense of acceptance for what they may be struggling with and creating a safe place to contain their problems. At the macro level, talking about cutting with families can further spread awareness and knowledge to a broader audience. Overall, bringing this issue more into the open

and having factual and evidence-based discussions about it will hopefully alleviate much of the pain and suffering for those affected by self-harm, or cutting.

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## APPENDIX

## Sample of Best Practice Teacher Response to Student's Disclosure of Cutting

Student: Mr. Smith, can I talk to you privately?

Mr. Smith: Sure.

Student: I'm feeling stressed about how much work I need to complete before the end of term. This isn't my only class where I've got lots of assignments due.

Mr. Smith: Yes, I can appreciate that. A linear timetable makes it all the more difficult.

Student: I don't know how I am going to get everything done. I'm freaking out about it.

Mr. Smith: I'm glad you're talking to me about it. I'm beginning to get a sense of how stressed and anxious you perhaps are about upcoming due dates?

Student: Yes, I am!

Mr. Smith: How have you been coping so far?

Student: I haven't really. Sometimes I cut.

Mr. Smith: Cut classes or cut yourself?

Student: Myself.

Mr. Smith: Mmmm.

Student: A lot of kids are doing it. It makes me feel okay when I'm doing it and for a little while after.

Mr. Smith: So when you cut, it helps for a bit, but later, I'm sensing you're still feeling highly stressed?

Student: Yeah, and I don't really want to keep cutting, but I just don't know what else to do?

Mr. Smith: So on top of everything else, cutting is also becoming a problem for you?



Student: Yeah.

Mr. Smith: Thank-you for coming to talk to me. I realize this has taken a lot of courage.  
When you're cutting, are you feeling suicidal?

Student: No. It helps me get through difficult times of the day.

Mr. Smith: How would you feel about talking with the school counsellor? I know that she  
can help you with this, or can get you connected with others who can.

Student: Okay. But can you first explain to her what I told you?

Mr. Smith: Sure. And in the meantime, let's figure out a way for you to tackle some of your  
assignments.

Student: Okay. Thanks.