

# SDDFS NOTES

## ON SELF-INFLICTED VIOLENCE (SIV), SELF-INJURY (SI), AND SELF-HARM (SH)

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### SPECIAL POINTS OF INTEREST:

- Dispel the Myths
- A Look at Behavior Patterns and Backgrounds of SI
- How to Help

### INSIDE THIS ISSUE:

- Examining the Scope of the SI Problem 2
- Common Myths about Self Injury 3
- Behavior Patterns and Psychological, Biological, and Physiological Reasons for Self-Injury 4
- Helping Self-Injurers 8
- Concluding Thoughts on Care and Treatment 9
- Resources 10

**Self-injury, defined as the “direct, deliberate destruction or alteration of one’s own body tissue without conscious suicidal intent,”<sup>1</sup> is gaining a greater notice, due in no small measure to the increase in awareness among professionals and an increase in coverage by media.**

## Seriousness of the SIV Problem

According to Dr. Tracy Alderman’s estimate in 1998, “somewhere between 1 and 2 million people are doing SI to themselves.”<sup>2</sup> Another expert in the field, Deb Martinson, estimates that “approximately 1% of the population in the United States has, at one time or another, used self-inflicted physical injury as a means of coping with an overwhelming situation or feeling. The American Self-Harm Information Clearinghouse (ASHIC) strives to increase public awareness of the phenomenon of self-inflicted violence and the unique challenges faced by self-injurers and the people who care about them.”<sup>3</sup>

Other frequency estimates of SI are higher or lower, but all experienced experts in the field indicate that the problem is greater than is being reported, since historically most self-injuries of a serious nature have been looked upon by the medical profession as unsuccessful suicide attempts. Most self-injurers who are reported or discovered are girls, but, because reporting procedures in hospitals

vary greatly and because motivations of self-injurers continue to be misunderstood, many experts feel that the number of male self-injurers is generally under-reported. Some researchers hold that roughly equal numbers of males and females resort to SI as a means of coping with emotional stress.<sup>4</sup>

The problem of SI is not a new one. Since the practice of self-injury is so secretive, no accurate numbers are known; however, an estimated 1%, or nearly 3 million Americans, practice self-injury. The public is slowly beginning to realize that it has always been here, although seldom discussed. Those who injure themselves come

from both sexes, all social classes, all ethnicities, and from all stages of life. Their ages range from early adolescence to age 60 and beyond.<sup>5</sup>

All experts agree that SI is very often related to childhood abuse — sexual, physical or psychological, leaving self-injurers unable to express anger in language or to cope with feelings of self-loathing that frequently accompany abuse.



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Continued from page 1

There are often problems in the home with violence and abuse of various types (alcoholic parents, spouse abuse, incest, or sexual abuse by live-in companions of parents) – dysfunctional family relationships of various kinds, all resulting in poor parenting. Steven Levenkron speculates in *Cutting: Understanding and Overcoming Self-Mutilation*, that “Perhaps the nondissociative cutter is marginally healthier than the dissociative cutter.”<sup>6</sup>

As we know, when a problem exists in society, it invariably exists in our schools also; therefore, SI among students is bringing school officials face to face with a problem that very few teachers, counselors, and administrators knew existed only a few short years ago.

In a December 2003 article in Education Week, Boca Raton High

School Principal Geoff McKee described SI as “a subtle, silent, and private act, that is frightening because it can easily go unnoticed.” McKee said he had not heard of “cutters” until

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**Self-Injury is a subtle, silent, and private act, and that is frightening because it can easily go unnoticed.**

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he assumed the principalship in 1998, when his school nurse told him of the phenomenon. At the time of the article, he had seen at least 20 students who had the problem.<sup>7</sup> It is a credit to McKee’s school that a staff member felt the duty to alert the principal to the problem.

Richard Lieberman of the Los Angeles Unified School District spoke of the overload of referrals his

counselors were experiencing. He also said that a major concern for school officials is that SI tends to spread, especially in the population of students who are already troubled.

“It’s a contagious behavior,”<sup>8</sup> he said, but the fact that self-injurious behavior has a tendency to spread is no reason for educators not to discuss it and to prepare for it. It is a practice that will exist whether it is spoken about or not. It is much better to face the problem than to ignore it to the detriment of our children.

This issue of SDDFS Notes seeks to de-mystify SI and to provide information that can lead to an understanding of the SI problem and then onward to dependable resources where help and additional information might be found.

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## Self Injury and Examining the Scope of the Problem

### What it IS NOT

Knowing what self-injury is NOT is important for educators and parents, as well as those from the medical profession. For example, the act is “not SI if its primary purpose is sexual pleasure, body decoration, spiritual enlightenment via ritual, fitting into a group, or participating in a fad in an attempt to be cool.”<sup>9</sup>

### What it IS

Self-injury, self-harm, self-inflicted violence, parasuicide, delicate cutting, self-abuse, self-mutilation, or the more clinical term, Repetitive Self-Mutilation Syndrome (RMS), are examples of the many terms that describe the behavior. Regardless of the name one chooses to give SI, all experts agree that the act is most often committed in private and is an attempt to alleviate stress or to cope with an emotional crisis. For purposes of this newsletter, the above terms are synonymous.

There are three major categories of self-injury or self-mutilation (a term that self-injurers do not like because it implies that the goal of the act is to change the body,

when most people who harm themselves seek only to help themselves cope with an emotionally intolerable crisis).

- **Psychotic Self-Injury:** the category includes extreme behavior, such as self-amputation of body parts — often as “a response to hallucination or delusion.” This type is easily identifiable and is treatable with drugs and therapy,
- **Organic Self-Injury:** the category most often associated with “autistic disorders, developmental disabilities, or other physiologically induced disorders.” Such behaviors, according to Alderman, are always “influenced by a physical or chemical problem in the body,” and
- **Typical Self-Injury:** the category includes superficial self-injury that is done “to make oneself feel better or to cope with life.” It is not caused by hallucinations, delusions, or physical causes, but because of emotional or psychological reasons.<sup>10</sup>

This newsletter will be addressing the third category, Typical Self-Injury.

According to some research at the American Academy of Child & Adolescent Psychiatry, “Typical Self-Injury” is

the practice of “deliberate, repetitive, impulsive, non-lethal harming of one’s body.” The following list includes some, but not all, means of self-injury, gathered from a couple of sources:

- ✓ Branding;
- ✓ Biting of one’s flesh or nails;
- ✓ Bruising or breaking bones;
- ✓ Burning, often with cigarettes and sometimes with heated objects;
- ✓ Cutting with razor blades, knives, glass, etc.;
- ✓ Excessive or obsessive tattooing;
- ✓ Excessive body piercing;
- ✓ Infecting oneself deliberately;
- ✓ Inserting objects in body openings;
- ✓ Sticking needles into oneself;
- ✓ Picking scabs or interfering with wound healing;
- ✓ Pulling out one’s hair;
- ✓ Punching oneself or objects;
- ✓ Scratching with fingernails; and
- ✓ Many others.



**Experts agree that Self-Injury is most often committed in private and is an attempt to alleviate stress or to cope with an emotional crisis.**

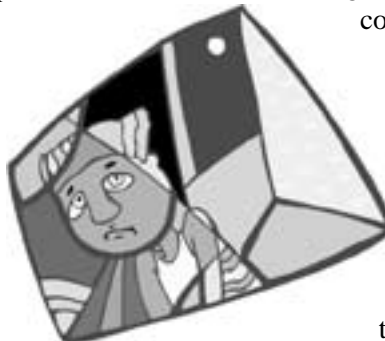
## Common Myths about Self-Injury

Following are some myths associated with SI that need to be dispelled before one can understand the phenomenon. Sources vary in their discussion of these myths of SI, but most listings contain the following:

### **MYTH:**

**SI is usually a failed suicide attempt.**

Although people who self-injure may be at a higher risk of suicide than others, SI has been and still is misidentified as failed suicide attempts in many emergency rooms in America. While some SI is sometimes life threatening because the addictive nature of the practice frequently demands more and more drastic SI behaviors to satisfy the needs of the self-injurer, the purpose of SI is usually just the opposite of suicide. Self-injurers are harming themselves so that they can stay alive and cope, however inappropriately, with the triggering stressful situation – one they must cope with in the only way they know that gives them quick, but temporary, relief. Frequently misunderstood, “Self-injury is a



maladaptive coping mechanism, a way to stay alive.”<sup>11</sup>

### **MYTH:**

**People who SI are insane and should be institutionalized.**

Those involved in SI are not insane, any more than the person who uses alcohol or smokes tobacco to cope with emotional situations is mentally unbalanced. Those who purposely self-injure by cutting, head-banging, or bruising themselves in an effort to cope with an unbearably stressful situation are also satisfying an emotional need – albeit inappropriately.

**Students and others who self-injure need to seek professional help.** School personnel, family, and friends should encourage self-injurers to obtain help, but those who SI need someone they trust to communicate their needs to: a friend, a counselor, a teacher, or another trusted adult. Medical professionals, along with mental health professionals, should always determine the need or advisability to hospitalize a self-injurer.

**MYTH:**

**People who SI are just seeking attention and are just attempting to manipulate others.**

Some may use SI as a means to manipulate others and to seek attention, but most self-injurers do not. Most SI is done in private and wounds are hidden. "Self-injurers may NEED attention, but they are not hurting themselves FOR attention. In fact, most people who self-injure try to hide their wounds and scars"<sup>12</sup> and, almost universally, they are plagued by guilt following incidents of SI.

**MYTH:**

**SI is a teenage girl problem.**

SI occurs in both sexes, all social classes, all ethnicities, and from all stages of life. Although female incidence of SI outnumbers male incidence substantially, the disparity between the sexes may be a function of reporting or seeking treatment for non-life threatening injuries.

HOPE

**MYTH:**

**SI is untreatable and hopeless.**

SI is treatable, and there is hope for those who self-injure.

## Behavior Patterns and Psychological, Biological, and Physiological Reasons for Self-Injury

According to Steven Levenkron, in his book, *Cutting: Understanding and Overcoming Self-Mutilation* the two types of SI are nondissociative and dissociative self-injury. Just because these categories are listed, does not mean they pertain to all self injurers.

### “Nondissociative self-mutilators

[in whom pain, not emotional numbness, is the goal<sup>13</sup>] usually experience a childhood in which they are required to provide nurturing and support for parents or caretakers. If a child experiences this reversal of dependence during formative years, that child perceives that she can only feel anger toward self, but never toward others. This child experiences rage, but cannot express that rage toward anyone but him or herself. Consequently, self-mutilation will later be used as a means to express anger.”<sup>14</sup>



**Disconnection can lead to a sense of ‘mental disintegration’.**

### “Dissociative self-mutilation

occurs when a child feels a lack of warmth or caring, or cruelty by parents or caretakers. A child in this situation feels disconnected in his/her relationships with parents and significant others. Disconnection leads to a sense of ‘mental disintegration.’ In this case, self-mutilative behavior serves to center the person,<sup>15</sup> or to provide him or her with “a powerful distraction around which to organize and stop the mental disintegration. Pain, and his/her own blood, provides a sufficient distraction, and works as a tool” to help “center” the self-injurer.<sup>16</sup>

The difference between the two types, put simply, seems to be that the nondissociative self-injurer hurts himself or herself out of anger, usually self-directed; whereas, the dissociative self-injurer causes himself or herself pain in an effort to focus on the point of the pain in order to defuse the emotional numbness

or detachment from reality he or she feels. The injuries brought on by each dimension may physically be the same, but the motivation for each is dramatically different.

### Clues to Spotting Self-Injurious Behavior Among Youth

Some specific behavioral signs/clues that a student might be self-injuring are listed.

- ✓ Wearing long sleeved shirts and long pants, even on hot, humid days;
- ✓ Unwillingness to wear shorts or “dress out” for physical education (P. E. teachers should especially be made aware of this issue);
- ✓ Frequent appearance of bruises from “accidents”;
- ✓ Frequent appearance of cuts from “cat scratches” (especially on the arm opposite the dominant one);
- ✓ Having the same superficial wound bandaged and re-banded for extended periods, longer than it should take for the injury to heal;
- ✓ Having “accidents” (possibly even at school) when the student is obviously under stress over issues of alienation and loss, such as peer relationship issues, the loss of a friend, a parent’s absence from home (due to separation, divorce, or death), or other reasons that serve to isolate the student.

Insight into indicators for SI and may help to head off self-injurious behavior and mental anguish. If teachers or other adults in our schools see these predictors or triggers among students, it is their duty to report the suspicious situation to a person in authority at that school.

Unfortunately, the stressful conditions among the most at-risk children educators encounter seem never to change. For example, “chaotic family conditions during childhood, physical and emotional neglect, and exposure to physical or sexual abuse have all been found reliable predictors of SI behavior. Those who cannot remember ever feeling ‘special’ or ‘loved’ by anyone as children [frequently are] the least able to control their self-injurious behavior.”<sup>17</sup>

### Some Other Behavioral Predictors and Possible Triggers for SI Include:

- ✓ Loss of a parent by (death or divorce);
- ✓ Family violence;
- ✓ Peer conflict and intimacy problems;
- ✓ Impulse control problems;<sup>18</sup>
- ✓ Parental depression or alcoholism;
- ✓ Childhood physical or sexual abuse;
- ✓ Stormy parental relations;
- ✓ Broken homes;
- ✓ Lack of emotional warmth from parents;
- ✓ Hypercritical parents;
- ✓ Violence at home, often with inhibition of verbal expressions of anger;
- ✓ Perfectionist tendencies;
- ✓ Inability to express emotional needs or experiences;
- ✓ Withdrawal, moodiness, and depression; and
- ✓ Inability to tolerate intense feelings.

### Who Self-Injures and Why? Psychological Characteristics Common in Self-Injurers

According to American Self Harm Clearinghouse, people who practice SI have a diminished ability to express or to regulate emotional responses well, and “there seems to be a biologically-based impulsivity. They tend to be somewhat aggressive and their mood at the time of the injurious acts is likely to be a greatly intensified version of a longstanding underlying mood.”<sup>19</sup> Like a steam pressure cooker, there has to be an appropriate outlet for the pressure or there will most certainly be an inappropriate one.

Some characteristics of self-injurers reveal that, in general, they:

- ✓ Strongly dislike/invalidate themselves;



ON THE EDGE

- ✓ Are hypersensitive to rejection;
  - ✓ Are chronically angry, usually at themselves;
  - ✓ Tend to suppress their anger;
  - ✓ Have high levels of aggressive feelings, which they disapprove of strongly and often suppress or direct inward;
  - ✓ Are lacking in impulse control;
  - ✓ Tend to act in accordance with their mood of the moment;
  - ✓ Tend not to plan for the future;
  - ✓ Are depressed and suicidal/self-destructive;
  - ✓ Suffer chronic anxiety;
  - ✓ Tend toward irritability;
  - ✓ Do not see themselves as skilled at coping;
  - ✓ Do not have a flexible repertoire of coping skills;
  - ✓ Do not think they have much control over how/whether they cope with life;
  - ✓ Tend to be avoidant; and
  - ✓ Do not see themselves as empowered.
- ✓ Affect modulation (distraction from emotional pain, ending feelings of numbness, lessening a desire to suicide, calming overwhelming/intense feelings);
  - ✓ Maintaining control and distracting the self from painful thoughts or memories;
  - ✓ Self-punishment (because they believe they deserve punishment . . . or because they hope that self-punishment will avert worse punishment from some outside source);
  - ✓ Expression of things that cannot be put into words (displaying anger, showing the depth of emotional pain, shocking others, seeking support and help);
  - ✓ Expression of feelings for which they have no label – this phenomenon, called alexithymia (literally ‘no words feeling’), is common in people who self-harm.”<sup>20</sup>



### **Biological Factors: What SI Does for the Self-Injurer**

Clearly, individuals indulge in SI for many reasons – the saddest of these is that the act of self-injury does what the self-injurer wants it to do. SI provides a quick end to the painful emotional situation confronting him or her. This “quick-fix” to complicated problems encourages the addictive component to the practice of SI; since the relief experienced is virtually instantaneous for the self-injurer, he or she seldom advances beyond the act itself, thus ensuring that he or she will not mature past this point in successfully and appropriately dealing with crises.

“Some of the reasons self-injurers have given for their acts include:

Miami-Dade Safe & Drug-Free Schools Coordinator, Paula Swope, and School Social Worker, Yvette Berger, provided additional information and insights into SI and expanded the previous list of factors relating to why teens self-injure:

- ✓ SI focuses the self-injurer on the site of the pain and away from the problem, eliminating the need for the coping skills never learned and compensating for the inability to deal with emotional crisis;
- ✓ SI affords immediate, but temporary, relief from “intense feelings, pressure or anxiety”;
- ✓ SI provides “a way to break their emotional numbness” or to “provide a sense of being real, being alive”;
- ✓ SI is the external, physical expression of interior, emotional agony;
- ✓ SI, even though it is done in private, is a communicative gesture made by those who cannot

communicate their pain in any other way – harming one’s own body, so as to ask for help from others indirectly;

- ✓ SI is often based on self-loathing and self-punishment for “having strong feelings” (forbidden to express as children), or “for a sense that somehow they are bad and undeserving” of the care of others;
- ✓ SI allows the self-injurer “to control and manage pain – unlike the pain experienced through physical or sexual abuse”;
- ✓ SI supplies feelings of euphoria, as the body produces endorphins and other naturally sedating chemicals; and
- ✓ SI serves as a self-nurturing exercise to the individual who, alone in the hell of self-inflicted pain, afterwards attends to his or her own wounds;
- ✓ SI is a way to “draw attention to the need for help, to ask for assistance in an indirect way.”<sup>21</sup>



**SI is often based on self-loathing and self-punishment for “having strong feelings” (forbidden to express as children), or “for a sense that somehow they are bad and undeserving” of the care of others.**

No matter which of the above factors apply, however, SI temporarily relieves the stress of the individual and allows self-injurers to cope with crises in their lives. Since the SI provides instant but temporary relief, the self-injurer does not acquire the skills needed to cope appropriately with emotional situations that trigger self-injury. Because SI relieves the problem so rapidly, the self-injurer fails to develop the capacity or the motivation to learn to solve problems in non-injurious ways. Because SI brings a quick sense of focus and creates a sense of control that was lacking in a time of unrelenting stress, the self-injurer comes to rely on self-inflicted violence as his or her only available means of coping with problems.

#### **Physiological Effects of Self-Injury**

Medical science has made strides in brain chemistry over the past two decades and has found that the effect of

naturally occurring substances in the neurological system offers insight into those afflicted with the pre-disposition toward self-injury. With acts of self-injury, endorphins are released in the body and a sense of well-being and calm ensues, granting the self-injurer temporary respite from his or her stressful episode. “Cutters” or self-injurers, according to tests at the Harvard Medical School, produce more enkaphelin and endorphins than their non-self-injuring counterparts.<sup>22</sup>

It is clear then that biological predisposition, reduction of tension, and lack of experience in dealing with strong emotions are all factors.<sup>23</sup> Additional brain research is being applied to the SI problem, and there should be some answers forthcoming, as more is learned about the brain and its chemistry.

# Helping Self-Injurers

First of all, friends, parents, and educators should become aware of local school-based resources, including student support staff, crisis teams, guidance counselors, social workers, and school psychologists. Likewise, they should realize that there are no short cuts to the journey from causing injury to oneself to being able to translate that pain into language. The process of helping someone to be able to cope successfully with SI triggering emotions takes time, trust, and tolerance.

According to Dr. Sharon Farber, a Board Certified Diplomat in Clinical Social Work, “For most people, to go from the experience of inflicting pain on the body to the experience of articulating the pain into words is a long process that doesn’t happen overnight. It is also one of the reasons that short-term therapies are not that effective.”<sup>24</sup> Those who self-injure lack the skills to communicate the pain and stress of intolerable emotional stress to others. It is extremely important for the self-injurer’s well-being that strong and long-lasting contact be maintained with people the self-injurer trusts. School personnel, especially guidance counselors and teachers, can be invaluable objects of this trust.



## Being Supportive

Anyone who interacts with self-injurers must be supportive and tolerant, but in doing so, one can very easily become confused by the process and upset by the reactions of the self-injurer. One’s emotional reactions to the acts themselves may be a sense of futility, revulsion, guilt, or even hostility. Dr. Laura Gibson, a licensed clinical psychologist, of the University of Vermont offers some general guidelines for those who will be called upon to provide support:

- “Take the self-harm seriously by expressing concern and encouraging the individual to seek professional help.
- Don’t get into a power struggle with the individual—ultimately they need to make the choice to stop the behavior. You cannot force them to stop.
- Don’t blame yourself. The individual who is self-harming initiated this behavior and needs to take responsibility for stopping it.
- If the individual who is self-harming is a child or adolescent, make sure the parent or a trusted adult

has been informed and is seeking professional help for them.

- If the individual who is engaging in self-harm does not want professional help because he or she doesn’t think the behavior is a problem, inform them that a professional is the best person to make this determination. Suggest that a professional is a neutral third party who will not be emotionally invested in the situation and so will be able to make the soundest recommendations.”<sup>25</sup>

According to Jaelline Jaffe, a licensed psychotherapist and the mental and emotional health editor for *Helpguide* at the Center for Healthy Aging, it is difficult to accept that a friend, a student, a sibling, or an offspring is participating in SI. There is a danger that one’s concern for the self-injurer might “come out as frustration” at the prospect of the self-injury. Those who are concerned for the self-injurer must remember not to say or do anything “that can drive the person further away.” He or she already feels alone and rejected, so actions that reinforce those feelings are never appropriate. Following are some suggestions from Jaffe that might prove helpful:

- “Understand that self-harming behavior is an attempt to maintain a certain amount of control, and that it is a way of self-soothing;
- Let her or him know that you care and that you will listen;
- Encourage expression of emotions, including anger;
- Spend time doing enjoyable activities together;
- Offer to help find a therapist or support group;
- Do not tell the person to stop the behavior or make judgmental comments – people who feel worthless and powerless are even more likely to self-injure;
- If you are the parent of a self-injuring child, prepare yourself to address your family’s difficulties with expression of feelings, as this is a common factor in self-injury – this is not about blame, but about a learning process that will help the entire family.”<sup>26</sup>

## Concluding Thoughts on Care and Treatment

It has not been the goal of this newsletter to outline treatments for those who self-injure, partially because the brevity of a newsletter carries with it the danger of only being able to provide partial information. It can safely be said, however, that SI can be treated successfully, and the students who injure themselves can stop the practice with help and understanding. The root causes of deep-seated problems need also to be addressed, and strategies to address those deeper problems must be tailored to the individual case.

Karen Conterio and Wendy Lader, with the S.A.F.E. Alternatives® Program at Linden Oaks Hospital in Naperville, Illinois, pioneers in self-injury treatment since 1985, describe treatment techniques for self-injury patients: "Self-injury treatment options include outpatient therapy, partial (6-12 hours a day) and/or inpatient hospitalization. . . . The effective treatment of self-injury is most often a combination of medication, cognitive/behavioral therapy, and interpersonal therapy, supplemented by other treatment services as needed."<sup>27</sup> They advocate a multi-dimensional approach to the problem of SI.

Researcher Chris Simpson of San Francisco State University also sees progress being made and says that "Those treatment methods that have shown effectiveness in working with this [SI] population include: art therapy, activity therapy, individual counseling, and support groups."

So, even though the jury still appears to be out on a well-defined solution to the very complicated SI



problem, there are some things of which we can be certain. Self-injurers can be treated successfully. They need to be treated by professionals, and it seems equally important that there be a team approach brought to bear on the problems of each of

them. The total group should, of course, include medical and mental health professionals, but it must also include school personnel: teachers, counselors, and administrators, either as individuals or as crisis teams. The self-injuring teen is extremely vulnerable and needs desperately to communicate problems, fears, doubts, apprehensions, and anger to compassionate and caring adults and friends.

Finally, it must always be a given that one of the primary duties of every responsible adult in a school is to intervene on behalf of the child whenever there is danger to that child, whether the adult be a counselor, a principal, a teacher, or a member of the non-instructional staff. Self-injuring students provide a challenge about which many school personnel are neither knowledgeable nor comfortable – even talking about the topic. Unfortunately, the self-injury problem is here with us – in all likelihood to stay. We would do well to equip ourselves with knowledge of the problem, with appreciation of the consequences of self-injury, and with strategies that will allow us to help our students through their episodes of crisis. To that end, we offer this newsletter.

**The self-injuring teen is extremely vulnerable and needs desperately to communicate problems, fears, doubts, apprehensions, and anger to compassionate and caring adults and friends.**

# RESOURCES

- <sup>1</sup> Favazza, Armando, MD. (1996). *Bodies under siege*. John Hopkins University Press. 1987, 1996. p. 225.
- <sup>2</sup> Tracy Alderman, PhD. (March 3, 1998). Self-Injury: Transcript from an online question and answer session at a concerned counseling conference. Retrieved on the world wide web on November 30, 2005 at <http://www.cyc-net.org/reference/refs-self-mutilation-alderman2.html>. For additional information on Concerned Counseling see <http://www.concernedcounseling.com/ccijournal/index.html>.
- <sup>3</sup> Martinson, Deb. (1998) Self-injury: a quick guide to the basics. American self-harm information clearinghouse. Retrieved on the world wide web on December 1, 2005, at <http://selfinjury.org/>.
- <sup>4</sup> Alderman, Tracy. (1997) *The scarred soul: understanding and ending self-inflicted violence*. Oakland: Johns Hopkins University Press. 189.
- <sup>5</sup> Strong, Marilee. (1998) *The bright red scream: self-mutilation and the language of pain*. New York: Penguin Books. 19.
- <sup>6</sup> Levenkron, Steven. (1998) *Cutting: understanding and overcoming self-mutilation*. New York: W. W. Norton and Company. 109.
- <sup>7</sup> Galley, Michelle. (2003) Student self-harm: silent school crisis. *Education Week*, vol. 23, issue 14, pp. 1, 14-15.
- <sup>8</sup> Galley, Michelle. (2003) Student self-harm: silent school crisis. *Education Week*, vol. 23, issue 14, pp. 1, 14-15.
- <sup>9</sup> Martinson, Deb. (1998) Self-injury: a quick guide to the basics. American self-harm information clearinghouse. Retrieved on the world wide web on November 18, 2005, at <http://www.palace.net/~llama/psych/guide.html>.
- <sup>10</sup> Alderman, Tracy. (1997) *The scarred soul: understanding and ending self-inflicted violence*. Oakland: Johns Hopkins University Press. 22.
- <sup>11</sup> Strong, Marilee. (1998) *The bright red scream: self-mutilation and the language of pain*. New York: Penguin Books. 151.
- <sup>12</sup> Fullington, Erica. (2004). Top 10 myths about self-injury. *Youth Noise*. Retrieved on the world wide web on December 2, 2005, at [http://www.youthnoise.com/page.php?page\\_id=1419](http://www.youthnoise.com/page.php?page_id=1419). See also Sutton, Jan. ()
- <sup>13</sup> Levenkron, Steven. (1998) *Cutting: understanding and overcoming self-mutilation*. New York: W. W. Norton and Company. 109.
- <sup>14</sup> Simpson, Chris. (2001). ERIC/CASS Digest. ERIC clearinghouse on elementary and early childhood education. December 2001. Retrieved on the world wide web on December 6, 2005, at <http://www.athealth.com/Consumer/disorders/selfmutilation.html>.
- <sup>15</sup> Simpson, Chris. (2001). ERIC/CASS Digest. ERIC clearinghouse on elementary and early childhood education. December 2001. Retrieved on the world wide web on December 6, 2005, at <http://www.athealth.com/Consumer/disorders/selfmutilation.html>.
- <sup>16</sup> Levenkron, Steven. (1998) *Cutting: understanding and overcoming self-mutilation*. New York: W. W. Norton and Company. 48.
- <sup>17</sup> Mueller, Walt. (1998) *Crying through their cuts: the stark reality of physical self-abuse*. Center for Parent/Youth Understanding. Retrieved on the world wide web on December 2, 2005, at <http://cpyu.org/Page.aspx?id=76714>.
- <sup>18</sup> White-Kress, Victoria E., Gibson, Donna M., Reynolds, Cynthia A. (2004). Adolescents who self-injure; implications and strategies for school counselors. *Professional school counseling*, vol. 7, no. 3, 198.
- <sup>19</sup> American self-harm information clearinghouse (2003). About self-harm. Retrieved on the world wide web on December 1, 2005, at <http://selfinjury.org/>.
- <sup>20</sup> Martinson, Deb. (1998) Self-injury: a quick guide to the basics. American self-harm information clearinghouse. Retrieved on the world wide web on November 18, 2005, at <http://www.palace.net/~llama/psych/guide.html>.
- <sup>21</sup> Jaffe, Jaelline, Ph.D. (2004) Self-Injury: Types, causes and treatment. Helpguide: expert, non-commercial information on mental health. The Center for Healthy Aging. Retrieved on the world wide web on December 6, 2005, at [http://www.helpguide.org/mental/self\\_injury.htm#helping](http://www.helpguide.org/mental/self_injury.htm#helping). Information for this section was also provided by Yvette Berger, Miami-Dade County SDFS Coordinator.
- <sup>22</sup> Strong, Marilee. (1998) *The bright red scream: self-mutilation and the language of pain*. New York: Penguin Books. 106-107.

- <sup>23</sup> Martinson, Deb. (1998) Self-injury: a quick guide to the basics. American self-harm information clearinghouse. Retrieved on the world wide web on November 18, 2005, at <http://www.palace.net/~llama/psych/guide.html>.
- <sup>24</sup> Farber, Sharon, PhD., New York University School of Social Work. (2002). Getting help for self-harm: online conference transcript. Retrieved from the world wide web on December 1, 2005, at [http://www.healthyplace.com/Communities/Self\\_Injury/Site/Transcripts/self\\_harm\\_help.htm](http://www.healthyplace.com/Communities/Self_Injury/Site/Transcripts/self_harm_help.htm).
- <sup>25</sup> Gibson, Laura, PhD. (2004) Self-harm. SIARI Self-injury and related issues. Retrieved on the world wide web on December 2, 2005, at <http://www.siari.co.uk/Fact%20Sheets%20and%20guidelines/Self-harm-fact-sheet.htm>.
- <sup>26</sup> Jaffe, Jaelline, Ph.D. (2004) Self-Injury: Types, causes and treatment. Helpguide: expert, non-commercial information on mental health. The Center for Healthy Aging. Retrieved on the world wide web on December 3, 2005, at [http://www.helpguide.org/mental/self\\_injury.htm#helping](http://www.helpguide.org/mental/self_injury.htm#helping).
- <sup>27</sup> Conterio, Karen, and Lader, Wendy, Ph.D. (1998). SI facts. Self-abuse finally ends alternatives. Retrieved on the world wide web on December 6, 2005, at <http://www.selfinjury.com/sifacts.html>.
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