A LITERATURE REVIEW AND POWER POINT PRESENTATION

ON DELIBERATE SELF-HARM IN ADOLESCENTS

BY

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A Final Project submitted to the

Campus Alberta Applied Psychology: Counselling Initiative

in partial fulfillment of the requirements for the degree of

MASTER OF COUNSELLING

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DEDICATION

This final project is dedicated to my kids, Megan and Jeff, who calmly accepted my frantic phone calls at all hours of the day and night to help me find my lost pages and guide me in the process of creating a power point. I am eternally grateful that they understood how important this academic accomplishment is to me.
CAMPUS ALBERTA APPLIED PSYCHOLOGY:
COUNSELLING INITIATIVE

SUPERVISOR SIGNATURE PAGE

Faculty of Graduate Studies and Research

The undersigned certifies that she or he has read and recommends to the Faculty of
Graduate Studies and Research for acceptance, a final project entitled A Literature
Review and Power Point Presentation on Deliberate Self-Harm in Adolescents submitted
by Judy Kelly in partial fulfillment of the requirements for the degree of Master of
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The undersigned certifies that she or he has read and recommends to the Faculty of Graduate Studies and Research for acceptance, a final project entitled A Literature Review and Power Point Presentation on Deliberate Self-Harm in Adolescents submitted by Judy Kelly in partial fulfillment of the requirements for the degree of Master of Counselling.

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Date September 12, 07
ABSTRACT

Adolescents learn to cope with emotions in various ways. Some respond with tears, depression, or withdrawal as ways of dealing with overwhelming feelings. There are teens, however, who suffer from intense emotions and are unable to react in a healthy manner because they have not been taught to handle their emotions effectively. These adolescents find it difficult to express their pain through words and will often deliberate self-harm (DSH) as a way of providing immediate relief. Deliberate self-harm is becoming more common with adolescents and is prevalent in our schools. School counsellors are confronted on a daily basis with a myriad of academic, emotional and social challenges faced by their students and must provide assistance. The purpose of this literature review is to explore what specific and practical information is available for school counsellors who work with students who deliberately self harm and to develop a power point presentation to be used in the classroom. For school counsellors, in particular, early intervention seems like a reasonable solution when working with students who DSH but this can only be done when they have essential information on DSH. This project provides information for students about DSH through a power point presentation.
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Chapter I - Introduction

School counsellors are confronted on a daily basis with a myriad of academic, emotional and societal challenges faced by their students. One challenge faced by school counsellors is adolescents who engage in deliberate self-harm (DSH). Deliberate self-harm is a term used to describe an individual who deliberately injures or harms himself or herself. Acts of DSH in students has increased recently (Coleman, Yiannakoulias, Schopflocher, Svenson, Rosychuk, & Rowe, 2004). School counsellors work with a diverse population, therefore, the probability that they will work with a student who engages in DSH is higher than many other occupations. Without an understanding of the current problems adolescents face, school counsellors would be ineffective in working with students who DSH. This final project is a comprehensive literature review of DSH as it relates to adolescents and includes a power point presentation to be used by school counsellors to raise awareness of DSH and provide an avenue to open the lines of communication with adolescents.

**Purpose of Review of Literature**

The purpose of this literature review is to explore what is DSH, what are the risk factors and causes of DSH and what specific and practical information is available for school counsellors when working with students. The following sections provide the purpose and rationale for the literature review and power point presentation.

**Rationale for Review of Literature**

Presently, few procedures are in place for school staff when confronted with students who DSH. A life skills program that can be used within the school to inform students about DSH does not exist in the Province of Alberta (Alberta Learning, 2002).
Best (2005a) suggests that school counsellors are often the first mental health professional encountered by students who deliberately self-harm. More mental health programs should be in place for schools and counsellors so that they may feel more confident in working with these students. These programs would include information on DSH, methods on how to reduce school stress, school-based consultation groups, training of counsellors in bereavement and loss, development of liaisons with outside agencies and provision for professional development for school staff in this area.

Purpose of the Power Point Presentation and Presenter Notes

This final project provides a presentation and notes for use within school psychology or health classes to give students a greater understanding and knowledge of deliberate self-harm and suggestions on what to do if they encounter someone who DSH. It is not unusual for teachers to have limited knowledge of DSH; therefore, working with students who DSH can be very challenging. To effectively respond to adolescents who DSH, counsellors need to be better equipped at anticipating and predicting incidents that lead to DSH (Best, 2005b). The power point presentation and presenter notes, therefore, are for use by a school counsellor in a single class presentation.

Rationale for Power Point Presentation and Presenter Notes

Information on DSH is important for the reason that the counselling field is constantly shifting and school counsellors need to stay current in their knowledge of DSH in order to be relevant. Fox and Hawton (2004) report from a school study where 15 per cent of adolescents had thoughts of harming themselves. Derouin and Bravender (2004) report an increase in adolescent engagement in DSH, which reinforces the need for some form of intervention for these students. Programs on DSH are needed to provide
information for students in school health programs. A proactive approach may encourage students who are contemplating self-harm to approach someone for help. Students, whose friend, may confess to harming themselves also needs support. Teachers are likely to welcome the support when they become the confidante of a student who deliberately self-harms (Best, 2005a). The conceptual framework developed from the literature review on DSH forms the foundation of the power point presentation and notes, which is planned for use in a school psychology and/or health class.

The information gleaned from the literature review will be the basis for the majority of information presented in the power point. Writing the power point presentation from an educator’s perspective and using simple language will aid in the development of a positive teaching tool for the classroom.
Chapter II - Methodology

The extensive literature review focuses on what DSH is, risk factors for adolescents who DSH, and specific and practical information available for school counsellors. This review will target studies involving two groups, adolescents who engage in DSH with non-suicidal tendencies and counsellors in school systems who work with these adolescents.

Methodology for the review of literature was conducted using Mertens (1998) process. Counsellors often request more practical information to assist them in their work with students who engage in DSH. Teachers and counsellors are exposed to incidents of DSH behavior through self-disclosure from students, and disclosure from friends of students who deliberate-self-harm. Practical and applicable information and guidelines will support counsellors and students in this specific area.

Data Source

this literature review were publications from 1990 – 2006. In addition, information
drawn from a presentation on DSH offered to school counsellors through the Alberta
Teachers Association Guidance Council was reviewed (During, 2006).

In order to develop a focused and appropriate search, the age of the population
was defined. For this project the focus was on early adolescents, 13 years through 19
years of age, as these were acceptable school ages. Key phrases such as “DSH”,
“cutting”, “parasuicide”, “emos”, “attempted suicide”, “self-injurious behavior”, “self-
harm” and “self-mutilation” were used to search for articles.

Once papers were identified, further screening focused on DSH without suicide
ideation. Due to the difficulty of identifying literature separate from non-suicide self-
injury and deliberate self-harm these studies are included in the literature review.
Information was organized by: (a) definitions of DSH; (b) causes or reasons why
adolescents engage in DSH; (c) acts of DSH; and (d) information specifically available
for school counsellors on assessing and working with students who engage in these
behaviors; and (e) limitations of the study.

Research from various sources, including both qualitative and quantitative studies
was reviewed in order to find links between DSH behavior, risk factors and interventions
for adolescents who DSH. Risk factors were specifically chosen for review to help
educate school counsellors as to the “why” of DSH and how they can help students who
DSH and the people who care about them. Reviewed literature involved studies that
occurred in a variety of settings such as schools and hospitals (including emergency room
evaluation as well as in-patient psychiatric wards).
Power Point Presentation Methodology

The power presentation and presenter notes were developed from the literature review, in-service training and professional practice. The in-service training was presented by Sally During (2006) to high school counsellors. My professional practice includes thirty years of teaching at the junior high and high school level. I am currently a school counsellor at the junior high level in a position that I have held for five years.

As a junior high school counsellor, students have disclosed to me their need to DSH and through my counselling sessions with these brave souls I have gathered what I believe to be important information that should be shared with the student body. I have chatted with kids, staff and “surfed” the internet on being “emo” as it is a relatively new phenomenon with students and counsellors. From these counselling sessions, chats and informal researching, an outline of the important areas to cover in a student presentation were developed.

This presentation includes the following sections: (a) what do teens report doing; (b) definitions; (c) who engages in DSH; (d) why students might engage in DSH; (e) physical and psychological feelings related to acts of DSH; (f) DSH and suicide; (g) students who DSH for connection with peer groups; (h) how can we help; (i) peer group interventions; (j) distraction methods; and (k) prevention and resources. The presentation, including a preamble, power point and class discussion, will be 50 minutes in length to fit the approximate length of one class period.

The power point presentation is written in simple and clear language at an approximate Grade 5 reading level. Each slide is written so that it presents enough information to accommodate the various learning styles of students. Students will be
given a list of resources at the end of the class as well as time set aside for students who may need personal clarification on any of the topics or to arrange contact with a counsellor. The presenter notes accompany each slide and provide the script for the counsellor.

The power point presentation was piloted with several groups of people. Good presentations run smoothly and engage the audience. First, the timing and pacing of the material was developed by practicing a couple of times on my own as well as practice runs with a couple of guidance counsellors at the high school. My colleagues provided feedback on the subject matter, length of power point, quotes, pictures and how the words appeared on the screen. A second presentation was to a number of staff involved in the development and implementation of the health curriculum, physical education, character education and counselling at the junior high school for feedback on subject matter and how the power point could be used in the school. I spent some time with a member of the administration team at the junior high school and at a high school discussing the power point and both administrators suggested that the power point would be something the entire staff would benefit from being more aware of what was happening in the lives of their students.

The final group used to provide feedback was a group of ten students, male and female from junior high school. They were requested to focus on the mechanics of the power point (color, transitions etc.). The interesting thing was that I was unsure if they even focused on the mechanics of the power point because at the end of the presentation the students were engaged in the content of the presentation as was evidenced by a number of questions about DSH! The overall comment from the students was that the
power point would be an asset to the curriculum. As a result of the feedback from the piloting of the power point with the various groups, I am confident that the power point presentation and presenter notes will provide a valuable teaching tool to be used within the classroom.

In summary, this project will provide a greater understanding of DSH in adolescents. The review of literature will provide an overview of the research conducted in this area while the power point presentation will provide an opportunity to raise awareness of DSH and provide an avenue to open the lines of communication for adolescents.
Chapter III – Review of Literature

Defining Deliberate Self-Harm

Deliberate self-harm is a complex behavior and often results from a variety of factors or emotions. Students are faced with many stressors on a daily basis such as: the family unit breaking up, drugs and alcohol addictions, runaways, homelessness, learning disabilities, school stress, bullying, sexual and physical abuse, date abuse, and poor relationships with friends, family and boy/girlfriends (Derouin & Bravender, 2004). For many adolescents DSH is a way to cope with these stresses. Students who DSH should always be taken seriously, since harming oneself may indicate the existence of a range of serious problems. Adolescents need support in the school environment.

Most teens that engage in DSH successfully participate in school activities and social events, and can appear to be outgoing, high-achievers who are well liked (Best, 2005b; During, 2006). These students are frequently able to hide their DSH injuries for months or years. Studies have shown at least 10% of adolescents who self-harm are likely to do so again within the same year (Best, 2005b; Hawton, Fagg & Simkin, 1996; Kerfoot, 1996).

Dogra, Stretch & Evans, 1999). This paper will focus on adolescents who DSH without suicidal tendencies.

Although eating disorders, drugs and alcohol abuse have been referred to as DSH behaviors, these issues are beyond the scope and have not been included in this paper as they are somewhat more indirect, and are therefore otherwise classified (Best, 2005a; Laye-Gindhu & Schonert-Reichl, 2004). Another area that is not defined as DSH is when the primary purpose of the behavior is sexual gratification, body decoration or spiritual enlightenment (Baszis, 2006). For this paper the term “DSH”, refers to self-harm as the deliberate and voluntary physical self-injury, which is non-life threatening and is not intended for suicidal ideation (Laye-Gindhu & Schonert-Reichl).

*Acts of Deliberate Self-Harm*

Acts of DSH and severity of the acts can vary. It is not uncommon for adolescents who DSH to use more than one method. The following paragraphs will review the literature on the acts of DSH.

In a Canadian study, Laye-Gindhu and Schonert-Reichl (2004) researched the prevalence of DSH and examined why adolescents engaged in such activity (n=424). The sample attended a public high school in Canada with a mean age of 15 years and more females than males. DSH behaviors reported by the adolescents were cutting, hitting or biting, abusing pills, eating disordered behavior, reckless behavior and bone breaking.

Hawton, Hall, Simkin, Bale, Bond, Codd and Stewart (2003) report methods of DSH in adolescents (12-18 years) included self-poisoning (88.7%), self-injury (7.5%) and a combination of poisoning and self-injury (3.8%)(n=1840). DSH injuries were more
common in adolescent males than females with the opposite for self-poisoning. The largest increase in substance use was that of paracetamol. The increase was due to the increasing availability of these drugs.

Allen (1995) described clients who engaged in DSH behaviors such as cutting, stabbing, use of caustic substances on the skin, self-inflicted cuts, scratches and overuse of prescribed or other medications to make themselves feel sick or poisoned. Ayton, Rasool and Cotrell (2003) analyzed routine computer records of adolescents (under the age of 18) who presented at the Accident and Emergency room from October 1996 to November 1998. Clinical categories used as a selection process were overdose in relation to DSH, cutting, and illicit drug and alcohol poisoning. The analysis system identified 730 young people (58% females and 42% males). The most common method of DSH within the female population was poisoning while with males who DSH the most common method was using illicit substances and alcohol. These findings were supported through two separate studies which reported adolescents engaged in DSH by self-poisoning as an overdose involving pharmaceutical drugs (Ayton, Rasool & Cotrell, 2003; Hawton et al., 1999).

During (2006), describes DSH behaviors as cutting, scratching, burning, hitting or abrading the skin, punching the wall, drinking bleach, scrubbing the skin with cleaning agents, picking at warts and wounds, refusing medication, binge drinking, sniffing glue, jumping from a moving car, overdosing, sewing pieces of material to the skin, self-administered piercing/tattoos, scorching skin with aerosols, swallowing objects as ways of hurting themselves. Other methods of DSH include: self-battery (hitting with the intention of breaking bones), jumping from a height, hanging, ingestion of a non-
Ingestible substance or objects and electrocution (Best, 2005a; Hawton, Rodham & Evans, 2006).

Best (2005a) interviewed thirty-two individuals from various educational settings. Information was compiled into the following topics: description of incidents of DSH; prevalence of DSH; teachers’ awareness of DSH; teachers’ reactions to DSH; links between schools and other care agencies; and training and support for teachers dealing with DSH. Acts of DSH reported by the participants were: cutting, scratching, burning, punching the wall, drinking bleach, picking at wounds, refusing medication, sniffing glue and petrol, jumping from a moving car, ingesting paracetamol drugs, sewing pieces of material into the skin swallowing objects and scrubbing the skin with cleaning agents.

Nadkarni et al. (2003) provide a description of children and adolescents presenting to emergency departments after engaging in an episode of DSH, reasons for engaging in DSH behaviors and contacts with professionals. The project was one year in length and 100 children qualified as engaging in DSH behavior. Ninety-one percent of the children reported DSH through self-poisoning by the ingestion of pharmaceutical drugs and nine percent of the children reported cutting the wrists.

In summary, acts of DSH have many characteristics. DSH can look like cutting, burning or branding with hot objects, scalding, banging or scratching the body, breaking bones, hair pulling, hitting the body with objects, swallowing poisonous substances, picking at one’s skin and even sticking needles into the body. Awareness of the variety and nature of DSH acts will lead to a greater knowledge and understanding for school counsellors.
**Frequency of DSH in Adolescents**

DSH was initially recognized as a significant problem during the late 1960 and 1970’s (Hawton, Rodham & Evans, 2006). Rates have increased dramatically. DSH has become one of the major health concerns of adolescents (Coleman et al., 2004). Hawton, Fagg, Simkin, Bale and Bond (2000) in their study of 1840 adolescents who presented at the general hospital, reported an increase in the number of adolescent DSH patients from 1985 through to 1995. Hawton et al., (2003) also reported an increase in the number of persons and episodes of DSH among adolescents from 1991 and 1997 with females reporting 11.1% in 1990-1992 and 17.8% for 1997-1999. This study also discovered a higher prevalence of DSH behavior during school days.

Repetition (repeating an act of DSH) is common in adolescents. Walsh (2006) noted that adolescents reported engaging in acts of DSH 20-30 times during a year. Strong (1998) found that the rate of repetition varied with adolescents she interviewed. There were teens who reported cutting on a daily basis as well as others who reported sporadic DSH over a three-year period.

Hawton et al. (2003) completed an 11 year study of adolescents 12-18 years of age, who presented at the general hospital following an act of self-poisoning or self-injury (n=1840, 73.1% female). The aim of the study was to determine if patterns of repetition of DSH had changed, examine trends in substance used in self-poisoning and to investigate characteristics of adolescents who DSH. There was an overall increase of 28.1% in the number of adolescents and acts of DSH in the 11-year study. Males who DSH reported an increase of 27.7% and females an increase of 28.3 %. Repetition, (repeating an act of DSH) also increased in both males and females, although statistically
more significant with the females. Most repetitions took place within the year of the initial act of DSH. The increase in acts of DSH especially in males parallels the increase in suicide rate in recent years.

Ayton, Rasool and Cotrell (2003) analyzed routine computer records of adolescents (under the age of 18) who presented at the Accident and Emergency room from October 1996 to November 1998. The results showed low numbers of adolescents who DSH, as only adolescents who needed hospital treatment were recorded. Superficial cuts, which did not require medical interventions, were not included in the routine records. It is important to note that research based on surveys, and hospital records may not accurately reflect the frequency of DSH behavior because students who DSH usually refrain from going to emergency rooms unless the act of DSH requires medical attention (Ayton, Rasool & Cotrell, 2003; Hawton et al., 2000; Hawton, Rodham & Evans, 2006).

Adolescents respond differently to the stresses in their lives. Responses such as crying, anger, sadness, or yelling are normal and the individual will usually gain relief from their emotions. For desperate teens, not being able to express their emotions in a more positive way can lead to DSH. Although, researchers have noted an increase in the acts of DSH among adolescents, the problem may be more widespread because not all adolescents who DSH report to hospital where the majority of research has been conducted in the past. School counsellors who recognize the warning signs of DSH may be able to help the students who do not report to hospitals.

*Warning Signs of DSH*

Although DSH is an underestimated and poorly understood occurrence with adolescents, Baszis (2006) states that there are obvious warning signs such as cuts or
scars on wrists or forearms. Less conspicuous sites of DSH might include cuts, burns, and scars on legs, feet or abdomen. Adolescents may bite or scratch these areas. Another warning sign may be bloodstains on clothing or an adolescent who wears long pants and shirts in very warm weather. Hawton, Rodham and Evans (2006) also include the following changes in adolescent behaviors as warning signs associated with DSH: changes in eating or sleeping habits, increased isolation from friends or family, mood changes, decrease in academic grades, and increased talk about DSH or abusing drugs or alcohol.

Often, teachers or counsellors may notice things like unexplained cuts or burns on the wrist or arms of students. They may observe that the student is quieter within the classroom or appears lethargic, or the student may exhibit fits of crying or anger outbursts (Onacki, 2005).

DSH can be difficult to diagnose. Recognizing the acts themselves, the ways students cover up acts of DSH, the signs of stress, and being aware of changes in personality and emotional states are “red flags” when identifying students who may be engaging in acts of DSH.

Risk Factors

For counsellors to effectively respond to adolescents who DSH they need to be better equipped at anticipating and predicting incidents that lead to DSH (Best, 2005b). Onacki (2005) points out the importance of school counsellors in developing a positive rapport with students thereby establishing a safe environment to evaluate individual, family and social factors that may contribute to a student engaging in acts of DSH.
Having a clear understanding of risk factors allows the student and counsellor to work together to decide future referrals if needed.

There are multiple precipitating factors that lead to acts of DSH. Adolescents are a unique population. During (2006) suggests that adolescent’s coping strategies in dealing with emotional pain can be somewhat stunted. It is not unusual for counsellors, parents and other mental health workers to believe acts of DSH are used to draw attention to one’s self and manipulate parents, peers or educators (Hurry, 2000; Onacki, 2005). Skegg (2005), notes that contrary to popular belief for adolescents, DSH is viewed as a “cry of pain” and not as a help-seeking act. Another common belief is that adolescents who DSH have suicidal ideation. Laye-Gindhu and Schonert-Reichl (2004) report that adolescents clearly differentiate between suicidal and nonsuicidal behavior. Adolescents who attempt suicide are quite often victims of DSH. Self-harm is the strongest predictor of suicide in the general population (Blenkiron, House & Milnes, 2000). This is not to say that all or even a high proportion of those who deliberately self-harm will go on to attempt suicide (Laye-Gindhu & Schonert-Reichl).

**Individual Factors**

*Psychological Concerns*

It is common for adolescents to feel vulnerable as they struggle with difficult and stressful developmental challenges. Adolescence is a time of physiological and psychological change. Physical changes can be embarrassing and adolescents may struggle with low self-esteem, feelings of worthlessness, depression and anxiety. In the majority of instances adolescents make their way into young adulthood with little
difficulty. However, there are adolescents who struggle and use DSH as a means for handling emotion turmoil.

In a study of 5293 school-aged adolescents, Hawton, Rodham and Evans (2006) established factors that increase the risk of adolescent who DSH. The large representation of various schools allowed the researchers to compile a broader range of school types for sex, size, status (state, grammar and independent), single sex and coeducational, ethnic minorities, educational attainment (test scores) and socioeconomic deprivation (proportion of students who met the criteria for free school meals). The survey results were considered reliable because the survey consisted of a self-report, anonymous questionnaire that had been piloted in other settings. Hawton, Rodham and Evans (2006) noted that adolescents who DSH, most often experience individual risk factors such as depression/anxiety, poor communication skills, low self-esteem, feelings of hopelessness and/or drug and alcohol abuse.

Impulsivity contributes to an increased risk of DSH in females (Hawton, Rodham & Evans, 2006). However, the authors pointed out that impulsivity might be the result of inadequate skills in problem solving. If an adolescent is unable to make appropriate decisions when confronted with extreme emotional pain they may engage in DSH to produce relief.

Engaging in acts of DSH as a way of responding to emotional distress is also supported by Machoian (2001) in her study of adolescents girls. Machoian focused on DSH in the form of cutting in adolescent girls. The three girls interviewed for the paper had been participants of an earlier project examining suicidal and self-injurious behaviors. The inquiry was guided by a single question, “what do adolescent girls know
about why they DSH?” The research was conducted at a private psychiatric hospital on an unlocked, voluntary adolescent residential unit. Participants had consecutive admissions to the unit and were not suicidal. The interviews were audio taped and transcribed for accuracy.

Deliberate self-harm for the girls emphasized the act as being a way to cope with their emotional pain and to gain a response from someone. In their effort to verbalize their emotional stress the girls found that there was no response from their parents, but the act of DSH solicited a response. In these cases the act of DSH had become a relational strategy, in sense a way to “ask” for help. The adolescent girls were placed at a greater risk for emotional instability when no one listened to them. Ignoring adolescent girls or not taking them seriously until they engage in an act of DSH may create a situation that actually increases acts of DSH.

When adolescent girls use DSH as a form of communication it can lead to them being labeled as manipulative (Machoian, 2001). In actuality, DSH is a form of manipulation but it is used as a desperate attempt to obtain some form of intervention to alleviate emotional stress created from family alcoholism, sexual and physical abuse, depression and violence. Machoian notes when DSH is used to obtain help it should be identified as an act of “self-preservation”.

Laye-Gindhu and Schonert-Reichl (2004) report individual reasons for DSH were depression, feeling all alone, self-dislike, low self-esteem, distraction and feeling the need to hurt oneself, anxiety, stress and loneliness. The adolescents in this study often showed inappropriate responses to emotional distress, demonstrate antisocial behaviors, experience anger control difficulties and negative self-esteem.
In a quantitative school-based study Ross and Heath (2003) set out to determine if adolescents who DSH generated increased feelings of hostility or anxiety prior to an act of DSH compared to students who did not DSH. Two schools were involved in the study. School One was comprised of an ethnically diverse population from lower middle class homes. School One provided 31 students who DSH and 30 non-DSH students from ages 12-16 years for the study. School Two consisted primarily of Caucasian students from upper middle class homes. School Two provided 31 students who DSH and 30 non-DSH from ages 14-16 years for the study. More females than males participated in the study. Both groups completed the Hostility and Direction of Hostility Questionnaire (measures trait hostility) (Caine, Foulds & Hope, 1967) and The Beck Anxiety Inventory (measures anxiety) (Beck & Steer, 1993).

Results of the study indicated that adolescents felt both anxiety and hostility prior to engaging in DSH, with males reporting more acting out behaviors as an expression of hostility than females. Individual reasons reported by adolescents who DSH were: get out feelings of frustration, reduce emotional pain, expression of anger towards others, reduce tension, punishment for being bad, release from worries, to relax and to hurt oneself because they deserved it.

Kerfoot (1996) associated acts of DSH with risk factors intrinsic to the adolescent such as feelings of hopelessness and depression and behavior problems and supported these feelings as strong indicators for DSH behavior. Adolescents who DSH, may also appear to meet the criteria of depression and will often report feelings of loneliness, sadness, and poor problem-solving skills (Kerfoot). When an adolescent has the inability
to work through personal issues, many of these young people who self-harm are likely to repeat within the same year (Hawton, Fagg & Simkin, 1996; Kerfoot, 1996).

Filmore and Dell (2005) identified poor personal health and developmental disabilities as individual risk factors for adolescents who DSH. They also noted that being able to discern problems that adolescents may face on a daily basis contributes to ways in which interventions and support could be provided to adolescents who DSH. Adolescents who DSH are experiencing extreme stress in their lives. These individuals are not engaging in DSH behaviors as a way to get attention or experiencing any mental illness. They are reacting from their emotions to the events that have occurred in their lives. Besides those factors that are intrinsic to the adolescent, there are many other contributing factors that lead adolescents to DSH.

**Gender**

Males and females face different sets of challenges and pressures during adolescence and as they approach adulthood. Disparities in the way males and females are raised can affect how they view or interact in the world. The complexity in accurately assessing gender differences in DSH behavior may occur from variation in how males and females who DSH are identified, acts of DSH and whether or not they seek treatment (Hawton, Rodham & Evans, 2006).

Deliberate self-harm injuries are more common in females than males (Hawton et. al, 2003; Skegg, 2005). Skegg attributes the higher rate for females to other risk factors such as depression, eating disorders and boyfriend/girlfriend relationships. Hawton et al. found that self-poisoning to be more common for males than females.
In a school-based study of 5293 adolescents, with the average age being fifteen-sixteen years of age, Hawton, Rodham and Evans (2006) also report higher incidences of DSH by females (11.2%) in contrast to males (3.2%). This particular study was also used as part of a collaborative study with five centers in Europe and one center in Australia on determining gender ratios on DSH. In all participating countries, females outnumbered males in reporting acts of DSH.

In a Canadian study, Laye-Gindhu and Schonert-Reichl (2005) researched the prevalence of DSH in a public high school (n=424, mean age of 15 years). Females (53%) were more likely to engage in DSH than males (28%).

Hawton et al. (2000) also note a difference between males and females reporting acts of DSH with more females (73.1%) than males (26.9%). Gender distribution found by Nadkarni et al. (2003) also describe more females (82%) than males (18%) reporting to emergency room after engaging in DSH behavior.

Hawton, Rodham and Evans (2006) suggest gender differences may be attributed to various reasons. Depression, which can lead to DSH, is more common in female than male adolescents. Another possibility is the stresses experienced by females’ increases the ideation of DSH. Males have a tendency to react to distress and anger through more aggressive actions such as fighting or engaging in other delinquent behaviors. A further explanation could be that girls engage in acts of DSH as a means of communicating their anguish or to temporarily block out negative feelings, or as a way to relieve tension.

Laye-Gindhu and Schonert-Reichl (2005) reported more males engaged in DSH in order to influence others or out of boredom, whereas females reported feelings of deep despair as the motivating factor in engaging in DSH behaviors. These gender differences
support the research that females direct their emotions and feelings inward and males are more likely to turn their feelings outward.

As previously mentioned, more females than males report DSH behaviors. There are a variety of reasons why there is a disparity in the research. Females may be more prone to seek individual help where as males may be far less likely to ask for help with their emotions or to admit their self-harming behaviors are related to DSH. More adolescent females are diagnosed with depression, which again may be the result of more females seeking help for emotional problems than male adolescents. There is a need for further research in this area.

*Ethnicity*

Adolescents who come from other cultures may find it difficult to be accepted into a new community. Families find it difficult when their child “gives up” their cultural beliefs and chooses to dress, talk or engage in typical teen activities. Hawton, Rodham and Evans (2006) suggest that increased incidents of DSH may be related to prejudice and marginalization.

Hawton and James (2005) found that South Asian adolescent females have a greater risk of DSH due to intercultural stresses and family conflicts. Acculturative stress in adolescents is common when adolescents find the demands of “fitting in” surpass their ability to cope with societal demands. Arthur and Collins (2005) also report that the extent in which an adolescent tries to fit in or integrate with dominant groups in society has a direct impact on their mental health.

Goddard and Subotsky (1996) compared two groups of adolescents; one being Caucasian and the other Black. The sample size was 100 adolescents: 64 were White, 20
as Black-Caribbean, two as Black-African and six as Black-other, two Asian and six
other ethnic groups. The groups were combined into three categories; White, Black and
Asian/other, with more females than males in each group. The researchers investigated
referral rates for DSH by ethnicity and characteristics following an act of DSH. The
results indicate that the referral rate for both ethnic groups was in proportion to the
community composition. The data report a similarity in the characteristics of DSH;
school problems, family stressors, family relationships, non-family relationships, and
single parent family with the mother being the at home parent. The only difference found
in the study was that the Black male adolescent group experienced more social stress
(migration and adverse discrimination) than the other two groups. Adolescence is a time
where acceptance into a “peer” group is important. This is no different for the adolescent
from a different culture. For these adolescents cultural identity is challenged in various
ways such as language, leisure, and decision-making. Challenging their cultural beliefs
creates stress and tension for adolescents and their families; this can result in adolescents
internalizing their feelings which could lead to DSH. However, there are inconclusive
findings on ethnicity specific to prevalence rates on adolescents who DSH.

Sexual Orientation

For adolescents discovering their sexual orientation can be puzzling. Due to
societal pressures the process of sexual identity and self-discovery can often be difficult
and it is not unusual for adolescents to feel confused, isolated, lonely, guilty or depressed.
Typically it is these emotions that are difficult for some adolescents to work through and
can contribute to an adolescent engaging in DSH.
Hawton, Rodham and Evans (2006) report in their study of school-aged students (n=5293), that 3% of the adolescents expressed worries about sexual orientation. There is an increased risk for DSH in gay, lesbian, bisexual or transgender (GLBT) adolescents. Although it is quite common for GLBT adolescents to have greater exposure to other risk factors such as depression, substance abuse, physical and emotional changes during puberty. Hawton et al. (2003) found that DSH occurred mostly when the adolescent realized they were not exclusively heterosexual and females who had expressed worries were four times more likely to DSH as compared to males who had similar concerns reporting twice as likely to DSH. Walsh (2006) notes that adolescents who are GLBT and not “out of the closet” are at a greater risk at engaging in DSH behaviors than those GLBT adolescents who are “out” and have a positive support network.

Despite increased knowledge and information about being GLBT, adolescents still have many concerns. Some of these concerns may include; feeling different from peers; feeling guilty about their sexual orientation; worrying about the response from their families and loved ones; being teased and ridiculed by their peers; and being rejected and harassed by others (Hawton & James, 2005; Hawton, Rodham and Evans, 2006; Walsh 2006). School counsellors will need to be attentive to any potential psychosocial ramifications faced by adolescents who are going through the process of accepting their sexual identification and should be ready to offer support and guidance to those who need it.

**Substance Abuse**

Another risk factor for DSH is substance abuse by adolescents. Hawton, Rodham and Evans (2006) report that acts of DSH increased with substance abuse such as alcohol,
drugs and smoking. They report that hard drugs such as cocaine and heroin was a strong predictor for both genders in contributing to acts of DSH.

Laye-Gindhu and Schonert-Reichl (2004) discovered that students who engaged in DSH behaviors also reported being involved with more precarious behaviors such as alcohol and drugs. Filmore and Dell (2005) noted in their research, that the agencies who counselled girls reported that 95% of the girls who DSH also abused alcohol or drugs prior to or after engaging in acts of DSH.

Adolescents have to deal with new issues daily as they shift from childhood to young adulthood. There are many exogenous factors that contribute to how an adolescent feels. Situations that seem less important to adults have the potential to throw adolescents into a multitude of feelings which may be increased stress levels, depression, anger or anxiety. As noted in the research there is no single factor that contributes to the emotional or psychological states in adolescents. Identity issues, substance abuse and gender issues contribute to the confusion of the development of the adolescent. Social issues such as family relationships and personal relationships are also contributing factors to adolescents who DSH.

_Family Relationships_

Families play a critical part in the development of behavior, needs and personality of adolescents. In today’s world it is not unusual for adolescents to be living in a dysfunctional family (Webb, 2002). There are various reasons that create discord within the family unit and researchers have found significant correlations with adolescents engaging in acts of DSH.
Skegg (2005) note an association between adolescents who DSH and the family environment. Adolescents from families separated or divorced were at an elevated risk of DSH, as were adolescents whose mother may be abused, very young or poorly educated. In adolescents under the age of 16 years, the DSH acts usually occurred in the family home as a response to a family argument. Other risk factors noted in the study were low socioeconomic and poverty for adolescents because of a parent losing their job or unemployment.

Hawton, Rodham, and Evans (2006), however, found that females living in a single parent home had no increased risk of DSH whereas males on the other hand were at greater risk for DSH if they; lived in a single parent home or with a parent and step-parent. It is suggested that for males the increased risk factor is dependent on living apart from their biological father.

Nadkarni et al. (2003) collected and analyzed the data of 100 children, 16 years and under, who presented at the emergency department with deliberate self-harm. Just over half (54%) of the participants, lived with one or both parents, five (5%) lived with extended family or friends, and 18% were living in a group home under a care order. The majority of adolescents presented to the emergency room with one or both parents, however, a large number of adolescents reported alone indicating social isolation or reflecting family problems.

Laye-Gindhu and Schonert-Reichl (2004) also note that adolescents who DSH more often come from single-parent homes or have a parent with a disability or a parent with a serious illness. Taking care of a parent with a disability or a serious illness often creates emotional distress for the adolescent. In response to this stress adolescents may
respond inappropriately by engaging in acts of DSH. Also, noted by Laye-Gindhu and Schonert-Reichl was a connection for both sexes as having increased levels of DSH if the adolescent had an awareness of peers who DSH, self-harm or suicide by family members. Family conflict such as unreasonable expectations, parents divorcing or separation, and constant arguing between the adolescent also contributed to adolescents engaging in DSH.

Ayton, Rasool and Cotrell (2003) found a connection between adults in the family who may have affective disorders, substance disorders and antisocial behaviors and DSH in adolescents because of the high psychiatric morbidity in the parents. Family instability and lack of parental support is another significant risk factor to DSH, as it creates an abnormally stressful environment for the adolescent. Concurrent with these findings, Machoian (2001), note that all three female participants were exposed to family instability and lack of parental support because of alcoholism by one or both parents in their home. Two of the girls also experienced family violence and sexual abuse.

Kerfoot (1996) reported the findings of 100 children under the age of 16 years who were admitted to the hospital following an act of DSH. The researcher found a strong association between adolescents who DSH and family dysfunction. Parental problems such as; criminality, reliance on welfare benefits, disruption in the family unit when a child is taken into custody or placed in “care,” separation or divorce and, negative mother-adolescent relationships can be linked to adolescents who engage in DSH behaviors.

Filmore and Dell (2005) report that of the 178 surveys sent out, 43 agencies returned surveys (24%) and of those surveys, only eight agencies (18%) were specifically
related to adolescent girls. Family disruption was prevalent with the agencies reporting that 36% of the girls were living with their family and the rest living in foster care, residential facilities or group homes. It was also reported by Filmore and Dell that 8% of the girls lived on the street or with friends. Risk factors reported by adolescent girls to the agencies varied. Agencies reported that 90% of the girls reported family violence, which included emotional, physical and sexual abuse and neglect. In addition, agencies reported that 62% their clientele as having actively engaged in acts of physical aggression and violence directed towards parents and siblings.

The most relevant concern of adolescents reported by Hawton et al. (2003) was problems with family members, usually parents. It appeared that at age 14 years, 80% (n=1583) of males and females reported family problems with the percentage of concerns decreasing with age.

Bereavement or loss of a family member or a close friend also contributes to adolescents engaging in acts of DSH (Best 2005a; Hawton et al. 2003; Hawton, Rodham & Evans 2006; Reder, Lucey & Fredman, 2004). As with most adolescents, feelings of being misunderstood are paramount thereby making it difficult for them to seek comfort and advice. Left without support and overwhelming feelings of loss, places adolescents at risk for DSH, as a way of dealing with their emotions.

Abuse

Abuse in families can take many forms, such as sexual, physical, emotional, verbal or a combination of these forms. Teenagers can be victimized by someone they know and trust: a parent, a relative, family friend, or a sibling. For many adolescents, the
effects of abuse remain from childhood through adolescents and often into adulthood. DSH can be a result of abuse.

Children and adolescents who experience emotional, physical and sexual abuse increase the risk of an adolescent DSH (Skegg, 2005). Factors most often reported by young people to counsellors or friends often include physical and sexual abuse (During 2006).

Filmore and Dell (2005) report that within the five agencies they studied, 91% of the girls (up to age 12 years) lived with family abuse (emotional, physical, sexual, neglect), while girls aged 12-17 years reported 95% of living with family abuse (emotional, physical, sexual, neglect). The girls also reported they had been sexually abused (32%) or sexually exploited (29%) by a stranger. The agencies that worked with adolescents girls reported that (80%) of the girls had been or were presently involved in abusive or violent dating relationships.

Hawton, Rodham and Evans (2006) establish that adolescents who had been sexually or physically abused are at a greater risk of DSH. Evidence in the research noted that males who had been sexually abused were at a greater risk to DSH than females who had been sexually abused. Adolescents who had experienced physical abuse were four times more likely to DSH as compared to their peers.

Strong (1998) writes that there are many roots to cutting but the most single and common factor related to DSH is that of childhood sexual abuse. The feelings of fear, pain and excitement created by sexual abuse has serious and lasting consequences to the child’s emotional, neurological and physiological development. The over stimulation of the immature brain creates havoc with the body’s emotional-response system which most
often leads to problems with impulse control and DSH. Deliberate self-harm is a way of marking boundaries to achieve the illusion of power and control. Ironically, as DSH behavior increases, it actually intensifies feelings of disempowerment, amplifies feelings of being alone and helplessness.

There are a number of risk factors as to what motivates adolescents to engage in acts of DSH such as sexual or physical abuse. When adolescents have been abused they experience intense and distressing emotions, which most often leads to feelings of powerlessness and in several instances may experience feelings of “numbness”. If the adolescent does not have the ability to understand or manage these painful emotions, they are at risk of DSH.

Families are often the initial force in providing adolescents with a sense of belonging and self-identity. If families are not a source of support and comfort and are unable to offer an environment of protection and security then teens are at risk for lower self-esteem and mental health problems. Having an understanding of the various relationships in the lives of adolescents and how these relationships affect the teen facilitate in understanding any potential factors that relate to an adolescent engaging in DSH behaviors.

Social Factors

Relationship Factors

The teen years are often the most difficult time for adolescents. There are a number of issues that can potentially become stressful in the life of a teen such as dating, friendships, parents, and school. Relationships are the interactions adolescents have every day with, parents, peers, boyfriend/girlfriends, teachers, coaches and siblings. These
relationships might be close, supportive, or stressful. In the most cases some stress is natural and can have a positive purpose, and can provide a strong incentive to make better choices. When stressors are chronic and the adolescent’s response to stress is self-defeating, the adolescent may engage in acts of DSH.

Deliberate self-harm is one of the most common reasons why adolescents present at hospitals (Crouch & Wright, 2004; Reder, Lucey & Fredman, 2004). Souter and Kraemer (2004) report precipitating factors that lead to DSH in adolescents are usually multiple influences rather than a single cause. Case notes of all referrals to the Department of Child and Adolescent Psychiatry at Whittington Hospital in London, UK, were reviewed and adolescents most often reported problems with boyfriend/girlfriend and peer relationships. Although each story is different, Souter and Kraemer report that the primary cause of a DSH episode is the result of a relationship crisis, which is beyond the control of the adolescent. The act itself therefore should be defined as a way for the adolescent to find a solution to the interpersonal crisis. In the majority of cases, when an adolescent loses hope, this is the point he or she may DSH.

Hawton, Rodham, and Evans (2006) noted that peers play an important connection with adolescents. In their study of 5293 school aged adolescents, Hawton, Rodham and Evans established factors that increase the risk of adolescents who DSH. The average age was 15-16 years with the research reporting 784 adolescents engaging in acts of DSH. They found that personal characteristics and experiences vary with individuals. The results suggest that negative aspects of peer relationships such as breaking up with boyfriends/girlfriends, and friendships ending, increase the chances of an adolescent engaging in DSH.
Filmore and Dell (2005) in conjunction with the Canadian Center on Substance Abuse and the Elizabeth Fry Society investigated the knowledge, experiences and practices of service providers about adolescents who DSH (n= 43) reported that 18% of the adolescent girls lack healthy peer relationships.

One of the foci of school counselling is assisting in the development of school culture and healthy peer relationships. These days’ schools are a much-diversified environment with many cultures and the development of “social groups.” One of the groups most prevalent in high schools is that of “emos.”

There is no single definition of “emo,” and the term that could be considered slang, is derived from adolescents making reference to emotional (emo) feelings as they relate to their life at this moment in time. Individuals share poetry, musical lyrics, phrases and thoughts about who they are, and the importance of “belonging” to this group. Walsh (2006) refers to a “new generation” of adolescents who DSH at the middle and high school level, and tends to describe them as what is not wrong with them. This group denies any history of sexual or physical abuse; they present with normal attitudes about body image, and do not report experiences of dissociation resulting from trauma. Psychologically they appear healthier and have strengths and support within their families, peers and friends, and school.

School

The school environment plays a large part in the life of an adolescent. One of the best indicators of success for a student in school is whether he or she feels connected to the school by establishing relationships with teachers and peers. However, there are students who have difficulty being in school for various reasons; teased incessantly,
laughed at, shoved around, or bullied at school, academic underachievement, or feeling overwhelmed by the pressure to achieve high marks. For some adolescents, their reaction to these stresses may lead them to engage in acts of DSH.

In their previously mentioned study of 5293 school-aged adolescents, Hawton, Rodham and Evans (2006) established school factors that increase the risk of adolescent DSH. One of the factors most noted, by adolescents who DSH was that of bullying in schools. There was a significant correlation between acts of DSH and adolescents who were being bullied. Compared to students who had not been bullied, males were three times more likely to engage in acts of DSH where as female victims of bullying were two times more likely to engage in acts of DSH.

Having difficulties with schoolwork was also sited by Hawton, Rodham and Evans (2006). The researchers note that the methodology was unable to develop a more specific hypothesis as to how schoolwork contributed to adolescents engaging in acts of DSH. The researchers could not concur if struggling with schoolwork was a stressor contributing to DSH, or if the student disengaged from school because they DSH. Other difficulties sited as school related risk factors were poor school attendance, a negative attitude about school and experiencing behavior or discipline problems while in school.

All relationships have an effect in the life of an adolescent. The effect can be positive or negative and has a direct correlation on how an adolescent feels about who they are. The difficult aspect of relationships is that in most cases the adolescent has no control over how the other person or people will respond. As a result, relationships can contribute to emotions such as stress, depression, and loss of self-esteem or self-
confidence. These emotions leave the adolescent susceptible to engaging in acts of DSH (Ayton, Rasool & Cotrell 2003; Hawton, Rodham & Evans 2006).

**Summary of DSH Risk Factors**

There are numerous reasons why adolescents DSH. This behavior is not limited by gender, race, education, sexual identity, or socio-economics (Hawton et al., 2003; Ross & Heath, 2002). DSH is often difficult to monitor because of the secretive nature of DSH. The current literature is inconclusive on any one specific factor which contributes to DSH, however research purports that DSH often results from a combination of external and internal problems (Webb, 2002). Reasons why adolescents engage in acts of DSH vary from adolescent to adolescent. In reviewing the literature it has become clear that there are multiplicity risk factors related to DSH.

Individual factors supported by the literature include reduced communication and poor problem-solving skills. These inabilities often lend to the development of an unhealthy means of coping with feelings of anxiety, depression or hopelessness thereby escalating the probability of the adolescent engaging in acts of DSH as a coping mechanism (Souter & Kraemer, 2004). Poor decision making skills contribute to feelings of low self-worth and may increase acts of impulsive behaviors, these feelings may eventually lead to DSH (Mclaughlin & Miller, 1996; Rodham, Hawton, & Evans, 2004).

DSH is particularly common in adolescents especially females (Ayton, Rasool & Cotrell, 2003; Best, 2005a; Hawton et al., 2004; Laye-Gindhu & Schonert-Reichl, 2004). The number of female participants has outnumbered the males in the literature reviewed for this project (Anderson, 2004; Crawford, Geraghty, Street & Simonoff, 2003; Laye-Gindhu & Schonert-Reichl, 2004; McLaughlin & Peter, 1996).
Another risk factor for adolescents is cultural differences and backgrounds. These factors may lead to rejection in the community or at school, again creating a sense of loneliness for the adolescent thereby increasing at risk behaviors such as DSH.

Family factors, supported by the literature are a history of physical, emotional and sexual abuse. This abuse is often from someone they know, a sibling, parent or family friend (Evans, Hawton & Rodham, 2004; Laye-Gindhu & Schonert-Reichl, 2004). The family dynamics tend to discourage expression of anger or sharing of feelings by the adolescent and yet the parent may display out of control behavior resorting to violence or yelling. These behaviors are quite often the result of one or both parents having a substance abuse problems involving alcohol or drugs.

Difficult parental relationships such as arguments with family members, separation and divorce have been identified as risk factors for adolescent who DSH. Adolescents have reported how important it was for them to be heard and have their emotional conflicts taken seriously (Machoian, 2001). A sense of loss in the family is a common risk factor for adolescents who DSH. The loss may be the death or suicide of a family member or close friend. Another loss may be feelings of rejection in the family unit this may occur due to acculturalization, sexual orientation, or family disruption (living in residential treatment facilities, group homes or on the street).

Research shows an overlap of risk factors with family issues and social issues. For this paper they are separated to distinguish factors that affect the adolescent from within the home and from the adolescent’s social world.

An important risk factor for adolescents who DSH is their inability to develop healthy social relationships with peers, family members and boyfriend/girlfriends.
Deliberate Self-Harm (Rodman, Hawton, & Evans, 2004; Skegg, 2005). As a result of this inability to build healthy relationships it is not unusual for adolescents to develop feelings of isolation and loneliness, which increases their risk of DSH. School stresses such as overachievement in school, exam pressures and bullying, are common social pressures for adolescents who DSH. Researchers have shown that bullying occurs in most schools. Unfortunately, it is often accepted as common school behavior. By trivializing this behavior creates an environment where students who are bullied often develop severe stress and emotional problems and in extreme cases commit suicide (Coloroso, 2004).

Adolescents experience a whole host of emotions during this time in their lives. Those who DSH describe feelings of anger, tension, and despair which bottles up inside until they feel like exploding (similar to taking the cork out of a bottle of champagne). DSH helps to relieve these feelings in adolescents who DSH.

**Cycle of Self Harm**

Most people have difficulty understanding why anyone would deliberately cause him/herself bodily harm. There are a large number of individuals in today’s society who DSH (Allen, 1995; Skegg, 2005; Webb, 2002). Levels of DSH are higher in adolescents, in many societies, than they were three or four decades ago (Hawton, Rodham & Evans, 2006). When people hear about DSH, or discover someone close to them or someone they know, uses razorblades, knives, cigarettes or needles to cut their bodies and draw blood they often react in horror, disgust, anger, or bewilderment. Their reactions are very normal to the situation and often reflect on how “taboo” the topic of DSH is. It is definitely a topic that one doesn’t usually discuss. Simply put, society is unable to attach
an appropriate meaning to acts of DSH and therefore try to connect it with suicidal behavior (Strong, 1998). DSH is not an act of suicide.

For some, physical pain is often easier to deal with than emotional pain. Self injuries to the body often provide the adolescent an outlet for emotional pain that may have been caused by any of the factors in the previous section.

Adolescence is a stressful time for almost all teens, even those who are apparently well adjusted. Most teens experience multiple levels of emotions due to physical, emotional, intellectual and social change (During, 2006). Teens that DSH follow the same sequence of events and various emotional states prior to, during and after harming themselves (Hawton, Rodman & Evans 2006).

The cycle of self harm begins with self-harm precipitated by a negative emotional experience (Negative Emotions) such as anger, loss, tension, anxiety, or panic (see Figure 1). Negative Emotions are defined as anything that makes an individual want to harm themselves. This in turn creates Tension that is defined as the inability to control emotions. As a result of the inability to cope with these emotions, the adolescent engages in a Deliberate Self-Harm Act. As Hawton, Rodman and Evans (2006) have noted that when an adolescent inflicts pain, as in the act of DSH, the body physically responds by producing endorphins. This stage is the Release/Positive Effect. These endorphins are how body produces relief from pain by creating a sense of peace. This is one of the reasons why DSH can become addictive. During the next stage, Negative Effects, the adolescent is often overwhelmed with feelings of shame and guilt because of engaging in DSH and the cycle begins again. The complete sequence of events is illustrated in Figure 1 (adapted from Hawton, Rodham & Evans).
Figure 1. Cycle of Deliberate Self-Harm

**Negative Emotions**
Sadness, anger. Anything that makes an individual want to harm themselves.

**Tension**
Inability to control one’s emotions.

**Deliberate Self-harm Act**
Cutting, burning, etc. Anything causing physical pain.

**Release/Positive Effect**
Endorphins released. Tension and negative feelings dispelled.

**Negative Effects**
Feelings of shame and guilt for DSH.
There is a reported reduction in the negative emotions during and after the self-harming episode (Laye-Gindhu & Schonert-Reichl, 2004; Reder, Lucey & Fredman, 2004). Although every story is different, the common factor is that the adolescent involved in a crisis feels that they have no control. Self-harm can then be understood as a solution to the crisis (Souter & Kraemwe, 2004). Some young people identify the act of self-harm as focusing on transferring the emotional pain they are experiencing onto something manageable: physical pain (Mitchell & Stowell, 2002).

DSH is often regarded as a problematic concept. It is may be unclear whether individuals who harm themselves do so with a conscious intent to do physical harm, or if in fact the act itself is “deliberate” or an impulsive action (Best, 2005a; Fox & Hawton, 2004). However, DSH provides only a temporary relief from stressful events in the adolescents’ life. DSH is used more as a coping strategy or a way of communicating how much distress they are experiencing in their lives. Developing appropriate coping strategies can only happen if the adolescent discloses their DSH behavior and are willing to make changes. Since adolescents spend the majority of their day at school, school environments, school programs and school counsellors are in a prime position to help the student who DSH.

Adolescent DSH and Schools

Adolescents spend a significant proportion of their time at school. With the exception of family, for the majority of students, school is one of the most important social settings they participate in. Therefore it is not surprising that students face school related problems such as bullying, academic pressures, learning disabilities, or peer
relationships. Students also bring to school their problems relating to family relationships. For many, school may be their only “safe and caring environment”. With students coming to school with several problems and concerns, school counsellors often become the most visible and reachable person students can go to for help. For many adolescents, the school counsellor becomes the initial contact for support, intervention and prevention in their quest for help.

The Role of the School

Laye-Gindhu and Schonert-Reichl (2004) in their research with adolescents suggests that school programs should promote self-esteem and resilience in students and guide students in developing more appropriate coping strategies when dealing with life’s problems even if they transpire outside of school or earlier in their lives. Since adolescents are at school for the majority of their day, schools should consider developing appropriate preventive initiatives that for use in the school curriculum or other programs offered to students.

Evans, Hawton and Rodman, (2004) discovered that adolescents who DSH showed less ability to focus or cope with problems and exhibited more avoidant behaviors. The study investigated whether adolescents who DSH or had thoughts of DSH differed from other adolescents in terms of their needs and specifically questioned communication and coping strategies. The ramifications of this study are important for developing prevention strategies, clinical care of adolescents at risk, and the development of educational programs on emotional health and coping with stress. At the present time, Alberta Learning does not provide any specific program of study about DSH in the school curriculum.
Deliberate self-harm is a complex behavior that often results from a variety of factors and emotions, which reinforces the need for some form of intervention for these students. Curriculum on DSH is needed to provide information for students in school health programs. A proactive approach may encourage students who are contemplating self-harm to approach someone for help. Students, whose friend, may confess to harming themselves also needs support. Teachers are likely to welcome the support when they become the confidante of a student who deliberately self-harms (Best, 2005a). Parents of adolescents who DSH need skills, knowledge and information to understand and help their child.

Teachers, coaches, school counsellors and peers are in the best position to detect any physical scars from the effects of DSH (Lukomski & Folmer, 2004). The American School Counsellor Association (2003) released a position statement indicating that school counsellors need to provide comprehensive programs that prevent and at minimum intervene with, behaviors that place students at risk. DSH could be placed in this category of “at risk behaviors”.

Filmore and Dell (2005) noted the importance of raising community awareness. Ways of increasing awareness include viewing DSH as a health issue and not just as a phase of teenage development, increasing educational opportunities about DSH for adolescent girls by developing education workshops for parents and adolescents, providing training on DSH to service providers that include a wide range of adolescent settings, and increasing the number of supports and resources available to adolescent girls.
Given the possibility that the majority of adolescents who DSH are more likely to talk to friends than family members or school counsellors integrating a “peer support program” in schools may provide a viable way of helping adolescents (Best 2005a; Fox & Hawton, 2004; Hawton, Rodman, & Evans 2006). As difficult as it is for some individuals to understand the behavior of students who DSH, it is important for the school to provide a safe and caring environment for these students. The professional development of staff, development of resiliency opportunities and implementing programs for the entire student body in DSH will be the best approaches for achieving positive programming for DSH and the school.

Understanding DSH and being able to speak openly to students, staff, and parents is essential. School programs, which include the opportunity to teach and speak with students, staff and parents, will assist in awareness and understanding of DSH and the issues that surround this behavior. The power point presentation for students developed in this final project is a valuable learning resource that could be integrated into the curriculum (see section on Power Point Presentation and Presenter Notes at the end of this project).

School Programs

An integrated program for students who DSH is as important as teaching drug and alcohol abuse, dangers of smoking, and safe sex (Walsh, 2006). Anyone who DSH struggles to cope with their emotions and needs support and guidance. Hawton et al. (2003) suggests that support of adolescents who DSH should be an essential part of health education in schools through the development of wellness curriculum. This section will overview curriculum developed by Alberta Learning for Alberta schools.
Health and Life Skills Program of Studies

In Alberta, the aim of the Health and Life Skills curriculum for Kindergarten to Grade 9 is to aid students in making well-informed, healthy choices and to develop behaviors that contribute to the well being of the individual and others (Alberta Learning, 2004). These skills are developed by teaching students how their habits, behaviors, interactions with others and decision-making relates to choosing and developing a healthy lifestyle and planning for the future.

The Health and Life Skills curriculum (Alberta Learning, 2004) stresses that students need a safe and caring school environment in which they receive accurate information, explore their ideas and issues when making personal choices, and practice these healthy choices. The expectation is that students will make responsible and informed choices in maintaining personal health and safety for themselves. Another expectation of the program is the development of appropriate relationship choices; students are expected to develop skills promoting positive interpersonal skills in responsibility, respect and caring in the maintenance of healthy interactions. Life learning choices will help students develop skills and use resources to explore various life roles and career opportunities.

The recommended resources and lessons suggested for the section on wellness emphasize: developing active living, positive health habits, growth and change, body image, nutrition, abuse awareness and substance abuse. The material shifts to applying proactive strategies for making individual healthy choices, developing resiliency and illness prevention at the middle school level and higher. These topics are to provide a basis for making personal decisions regarding smoking, substance abuse, impairment
injury, sexual involvement, abuse prevention and other personal choices. There is no reference to DSH in this provincial curriculum.

Many of the risk factors which contribute to students who DSH are indeed mentioned in the curriculum: relationship problems (family, peers, personal) bullying, school pressures or a myriad of other physical and emotional changes an adolescent experiences throughout their teen years. The curriculum is helpful in developing an awareness of personal skills needed in developing appropriate responses to stress levels. Unfortunately to date, there is no information on DSH in the recommended resource directory and lessons suggested for the curriculum.

Career and Life Management Program of Studies

The Alberta high school curriculum (Alberta Learning, 2004) offers two programs for students, which allow students to explore various themes that will contribute to their well being and that of others. The first course is Career and Life Management (CALM). The CALM program presents student objectives on developing strategies for creating individual well being from a holistic point of view. The program purports that well-being is developed from achieving harmony in one’s emotional, psychological, intellectual, social, spiritual and physical states of life. General and specific outcomes of the CALM program outline fourteen specific outcomes for personal choices – none of which specifically deal with informing students of DSH.

General Psychology 20

The second high school program of studies that explore student development is General Psychology 20 (Alberta Learning, 2004). The main objectives of the General Psychology 20 program is to guide students in developing appropriate skills and
understanding that will make for more effective living in society. The curriculum offers lessons that focus on scientific approaches to understanding human behavior in hopes the information is applicable to the students personal development. Two units; Facing Frustration and Conflict and Emotional Problems of Adolescents, offer no information on DSH, although the topics covered; inferiority thrills and thrill seeking, family conflicts, dating, and assuming the roles of men and women (gender issues) are all risk factors for DSH. One reason for the absence of information on DSH could be that this course was revised in 1985 (Alberta Learning 2004) and the units are generally teacher generated. Teachers may have limited background and training regarding DSH and could be uncomfortable with integrating the information into the program (Best, 2005a; During, 2006).

Assessment and treatment of students who DSH, is a challenge to most mental health workers, let alone school counsellors and teachers (Allen, 1995). In the majority of the cases, the health and psychology classes are taught not by the school counsellor but by the classroom teacher or physical education teacher. When confronted with a student who has engaged in DSH school personnel are often incapable of treating the student because they lack the understanding and knowledge of the behavior (Best, 2005a; Lukomski & Folmer, 2004; Onacki, 2005).

The power point presentation will be a positive teaching tool for students on the topic of DSH (see section on Power Point Presentation and Presenter Notes). It will assist in bridging the “secretive” nature of DSH to a more open forum.
The Role of the School Counsellor

Surprisingly, DSH has received increasing levels of exposure in the media: The Oprah Winfrey Show (McGee, 2005) dedicated a program on DSH and Time Magazine featured an article (Kluger, 2005). It is not unusual to find websites and blogs on the topic of DSH for all ages. Professionals working in mental health and social work and those employed in prisons, psychiatric units or young offender programs may not be surprised by this information on DSH, however for those who work in schools DSH may prove to be unknown territory (Nock & Prinstein, 2004).

School counsellors of adolescents who DSH frequently report they do not have enough knowledge to understand DSH, much less provide meaningful assistance (Best, 2005b; Burns, Dudley, Hazell & Patton, 2005; Webb, 2002). As Best (2005b) points out, the teacher or school counsellor is considered “in loco parentis” and has a professional and legal obligation to respond to students who may have emotional or behavioral issues. Unfortunately, DSH albeit given more exposure, is still somewhat of a “conundrum” for school personnel to work with because they have limited knowledge about DSH in relation to adolescents, unsure attitudes towards adolescents who DSH and little training for working with students who DSH (Best 2005b; Crawford et al. 2003).

Best (2005a) found that the incident of DSH dropped during school holidays, thereby reinforcing the possible association between DSH and pressures students experience at school. The importance of having school counsellors trained in working with students who DSH becomes more important since school is where students spend the majority of their day (Best 2005b; Nadkarni et al., 1999). School counsellors are more likely to discover students who deliberate self-harm through reports of peers, teachers
who have had contact with students who DSH, parental contact, and finally the students
themselves may reveal that they DSH. Hawton, Rodham and Evans (2006) note the
importance of counsellors’ awareness of the problems and pressures adolescents face on a
daily basis and their role in working with students who DSH.

Despite the importance of counsellors working with students who DSH, there is
limited empirical data on how school counsellors or other school personnel respond to
adolescents who DSH (Kress, Drouhard & Costin, 2004; Lukomski & Folmer, 2004;
Onacki, 2005; Walsh, 2006). Limited literature was found that included any empirical
data related to what school counsellors are currently experiencing in schools. Articles
about DSH that were directed to school counsellors related to setting up school protocols
and response teams (Onacki, 2005; Walsh, 2006), information and guidance for school
personnel (Lukomski & Folmer, 2004) and specific information about legal and ethical
challenges counsellors may experience when working with students who DSH (Kress,
Drouhard & Costin, 2004).

School counsellors work with adolescents at varying levels on a daily basis, there
fore, chances that they will engage in counselling with a student who DSH is higher than
most other professions. It is therefore important to educate school counsellors in all
aspects of DSH. Understanding what educators actually know about DSH is a perfect
way to begin this education. In one of the few studies involving schools, Best (2005a)
interviewed individuals from various educational settings (n=32, 13 teachers in schools;
four school counsellors; three teachers; one middle-manager (administrative) and one
case worker from a secure treatment unit for young offenders; one learning support-staff;
four school nurses; one clinical psychologist; one senior tutor; one school chaplain; one
school volunteer worker/counsellor; one social worker in child guidance and two members of child and adolescent mental health workers). Information was compiled into the following topics: description of incidents of DSH; prevalence of DSH; teachers’ awareness of DSH; teachers’ reactions to DSH; links between schools and other care agencies; and training and support for teachers dealing with DSH.

Best (2005a) found that the level of awareness of school personnel varied in the interviews. Many participants were uncertain about staff awareness of DSH, most often it depended on whether serious incidents had come to the attention of the entire staff or if the participant had been exposed to an adolescent who DSH. The secure unit reported that possibly the entire population engaged in DSH, they also pointed out they were cognizant of trying to remove possible items that could be used to DSH. Generally, physical education staff, administrative personnel and counsellors were considered to have increased awareness of DSH behaviors in the school. One participant reported high awareness because DSH is often a topic at staff meetings in their school. Another participant reported regular staff in-service training on DSH after a student committed suicide. Another participant cited a need-to-know basis for information and lists of students who DSH is placed in the staffroom. Overall thoughts were that staff was uncertain about DSH awareness levels and suggested better communication in making staff aware of DSH in their settings.

School personnel also report emotional reactions to DSH (Best, 2005a). Many described feelings of alarm, panic, anxiety and shock, distress, repulsion and frustration. Some school personnel felt frustration because they view acts of DSH as a form of manipulation by the adolescent and working with students who DSH is beyond their
professional knowledge or competence levels. School counsellors working with adolescents who deliberately self-harm report low confidence levels and confess to having little knowledge in what to do when in contact with these cases (Best, 2005b; Nadkarni et al., 2003).

For school staff to effectively work with students who DSH, Walsh, (2006) purports the importance of training for school counsellors. Best (2005a) reports that the participants described their training as being formal, informal and on-the-spot training. The school nurses in the study had previous experience working with adolescents who DSH prior to a school placement however, only a single nurse had attended courses on DSH. Counsellors revealed they had attended courses in related areas such as bereavement and loss but issues relating to DSH were not presented. Several teachers involved with pastoral care, special needs or child protection indicated the topic of DSH was discussed at an in-service. For the majority of participants courses on DSH were non-existent. The exception to this profile was the school where a student had committed suicide, and in this case, an in-service on DSH was regularly provided for all staff.

Counsellors need education on the full range of DSH behaviors since they are often responsible for the initial assessment of the situation (Walsh, 2006). Staff should to be able to differentiate between an act of DSH and suicidal intent and understand the types of DSH injuries. Staff need to be aware that DSH is a complex behavior and treatment is time relevant and not having students attend school throughout the process is unrealistic. Counsellors must to be able to offer support to students who DSH in the school setting.
As mentioned, DSH poses a challenge for schools. Best (2005a) raises questions for counsellors involved in schools such as how to develop implement policy and procedures for responding to DSH. Dealing appropriately with DSH requires awareness and the knowledge to develop professional responses to adolescents who DSH. Confidentiality policies varied with schools, creating a sense of frustration for staff because they were unsure as what their requirements were when counselling students who DSH (Best). The policy with some schools stated that parents would be contacted immediately when a student DSH. This created a conflicting policy on confidentiality. Another school uses the “Gillick” competence test (a term used in medical law to describe a minor who has the ability to consent their own medical treatment, despite being under age) prior to making contact with parents against student wishes. An all girls’ school with a prominent Asian student body rarely reports incidents of DSH to parents because of unsupportive and frequently violent reactions (Best). In a single case of DSH, a teacher gave the student her cell number for emergencies.

Policies and protocols regarding referrals and collaboration with outside agencies were mentioned in the work by Best (2005a). In twenty-two interviews of educational personnel, participants referenced making referrals between the school and an outside source. Sources were diverse: community psychiatric teams, family doctor, anorexic units, private clinics, social service, child and family support workers, youth counselling services drug and alcohol support services. In the majority of cases referrals proved to be helpful. School counsellors consulted with a social worker and found the support beneficial in working with adolescents who DSH. In several incidents, counsellors found that when parents were contacted because their child had engaged in DSH behaviors, the
parents indicated their preference was to have the school counsellors work with their child as opposed to involving the family doctor or an outside support agency.

The one difficulty of collaborating with outside specialists had to do with coordinating school schedules with the adolescent who DSH, and the schedule of the professional. There were a couple of incidents when students had been placed on a waiting list but ended up leaving school before seeing the professional. Without a specific policy on what to do when confronted with an adolescent who DSH, counsellors noted their confusion on which agency to approach for support and supervision. At various schools, counsellors noted that in-school support workers created more problems within the school community due to “clique” behaviors with students. This group of students made it difficult or uncomfortable for other students to approach the workers for help or guidance. A valuable suggestion made by the participants was having two or three agencies available for their particular school that would provide support and supervision when needed when working with adolescents who DSH.

A school may have in place adequate policies and a counsellor dealing with a student who DSH may feel the need to refer the student to an outside agency or another counsellor however this action is not always the best way to help the student. Teachers and counsellors who have developed a relationship with the student are usually in a better position to provide support for the adolescent. The act of DSH is often secretive and students who engage in this behavior may feel betrayed being referred. That is not to say a referral may not be in the best interest of the student, but a “knee-jerk” reaction is less likely to occur if counsellors are aware of the facts about DSH (Best, 2005a; Hawton et al., 2000). It has been suggested that since school counsellors are often the first mental
health professional the student who is deliberately self-harming encounters, the following information should be in place for schools and counsellors so that they may feel more confident in working with students who DSH: more mental health programs about DSH, a school based consultation group, supervision, training counsellors in bereavement and loss, development of liaisons with outside agencies and provision for professional development for school staff in the area of DSH (Best, 2005a; Hawton et al., 2000; Hawton et al., 2003).

Another challenge for school counsellors is determining and receiving pedagogical training needed to develop school-based interventions for use with students who DSH. School counsellors provide intervention and prevention programs through individual, group and academic work to students in and out of the classroom. Their role is diversified, with school counsellors promoting personal and social development, encouraging self-esteem, and guiding the development of individual responsibility, decision-making and social skills. Within the Calgary Board of Education (CBE) school counsellors have noted an increase in the number of students disclosing DSH. As school counsellors it can be very difficult to understand adolescents for whom DSH is not something that they avoid or find aversive, but is an activity they seek out, as a way of coping with their problems. Very little training on DSH interventions has been available for CBE school staff to date.

A lack of resources and information on DSH for school staff appears to be common in most schools. Staff is ill prepared to respond effectively to adolescents who DSH. Educating staff with knowledge and interventions, creating a closer liaison between schools and outside agencies, developing peer support and supervision from counsellors
and teachers and incorporating information into the school curriculum can only help when working with students who DSH. The next section will present specific methods or interventions that can be utilized by school counsellors and teachers.

**Interventions**

There are few studies on the effectiveness of psychological treatment for adolescents who DSH. Psychological treatment therapies such as; problem-solving therapy and crisis intervention, cognitive behaviour therapy, family therapy, dialectical behavior therapy, group therapy, or medication have been suggested in treating adolescents who DSH (Allen, 1995; Fox & Hawton, 2004; Hawton, Rodham & Evans, 2006; Lukomski & Folmer, 2004; Walsh, 2006). Although the literature varies on what type of therapeutic approach is recommended for working with adolescents who DSH; the importance of having a trained professional involved in the treatment process is critical (Allen, 1995; Walsh, 2006).

It is not unusual for school counsellors to come into contact with students with DSH behaviors or who have mental health issues (Best, 2005b; Evans, Hawton, Rodham, 2004; Onacki, 2005). The school is in a unique position to recognize the problems related to DSH and to facilitate connections to outside professionals for help in working through the problems and challenges created by DSH. It is possible that some school counsellors have basic training in some aspects of psychological treatments; however, their role in the school is not of a clinician or psychologist.

Researchers support the importance of including educational programs, which develop resiliency, problem-solving skills, and productive coping behaviors (Allen, 1995; Best 2005a; Blenkiron, House & Milnes, 2000; Hawton et. al, 2003; Lukomski & Folmer,
2004; Rodham, Hawton & Evans, 2004). When possible, schools should develop curriculum that encourages more positive and constructive coping and problem solving skills (Best 2005a; Laye-Gindhu & Schonert-Reichl, 2004; Webb, 2002).

There are various strategies for assisting adolescents who DSH. Reduction strategies are techniques used as a substitution for DSH. Cognitive strategies are often used to help the adolescent identify alternative methods when feeling the need to DSH. Self-regulation strategies aid the adolescent in identifying emotions that may lead to DSH.

Allen (1995) notes the importance of analyzing the nature and function of the act of DSH. If DSH is used as a way of expressing and communicating distress or anger then it is important that more appropriate and healthy assertive expressions be developed. The development of anger control skills can be practiced and reinforced within the school by working with the school counsellor. If an adolescents chooses to DSH as a way of regulating their emotions such as “to get a buzz” or to “feel in control” or to “feel something” then it has been useful to help the adolescent develop other ways of dealing with unpleasant emotions by using distraction techniques for relation, physical exercise or talking to someone. If DSH is being maintained as a way of receiving some kind of “interaction” from someone then it would be important for the student to be able to contact the school counsellor when DSH is not the immediate issue. The counsellor can provide a safe environment where the student will feel comfortable talking about why they DSH and can help them look at more appropriate problem-solving skills.

Machoian (2001) also notes that for girls to be able to give voice to their feelings there needs to be someone listening. Adolescents may indicate emotional distress in what
adults tend to note as overdramatic responses, however these signals being dangerous or desperate need to be understood as a way in which adolescents convey their emotional distress. Adults who actively and genuinely listen to adolescent girls help create an environment of prevention and intervention for DSH.

Replacing acts of DSH with what is referred to as distraction methods, creates a more affirmative way of coping with the emotions an adolescent may be experiencing (Hawton, Rodham, & Evans, 2006). These distraction methods can be taught in the school curriculum to students as a more healthy way in dealing with the pressures and emotions in their lives. Hawton, Rodham, and Evans note activities involving emotional intensively such as; writing, drawing, talking to a friend or using a helpline, screaming, hitting a pillow, listening to loud music, physical exercise, having a bath, using ice to recreate the painful sensation and it leaves a red mark, or any other activity that distracts the student from DSH at that moment is beneficial. Combining distraction techniques with counseling/therapy may be helpful for the adolescent who DSH.

Another coping skill is the “Five minute rule”. When the student feels the urge to DSH he/she stops and focuses on the next five minutes with the idea of moving away from thoughts of DSH to something else. This strategy has proven to be effective for most adolescents contemplating an act of DSH (Fox & Hawton, 2004; Hawton, Rodham & Evans, 2006; Strong, 1998)

Walsh (2006) uses replacement therapy which incorporates the following nine skills in treating DSH; negative replacement behaviors, mindful breathing skills, visualization techniques, physical exercise, artistic expression, playing or listening to music, communicating with others and diversion techniques. Walsh reports that these
skills work best when the adolescents, select skills that he/she finds relevant, appropriate, and functional. Counsellors can use various techniques to help adolescents develop more appropriate methods of dealing with emotional pain thereby decreasing acts of DSH (Hawton, Rodham & Evan, 2006; Walsh, 2006).

If bullying is a contributing factor for the student who DSH, researchers supports the importance of developing an effective anti-bullying policy within the school to help create a safe and caring environment for student (Coloroso, 2004; Hawton & James, 2005). For a student with a learning disability, an educational or psychological assessment would be helpful in developing an appropriate academic program for the adolescent to help alleviate the pressure of academic performance which often leads to low self-esteem (Hawton & James, 2005).

Best (2005a) also notes the importance of having qualified staff in place to respond appropriately to students who DSH. If qualified staff is not available to students, schools should be prepared to refer the student to an outside agency as an intervention.

Hawton, Rodham and Evans (2006) emphasize that an important part of preventing DSH is developing a supportive environment in the school, which focuses on building self-esteem and developing healthy peer relationships. A school ethos that educates and encourages adolescents to talk and adults to listen and believe, allows staff to intervene when needed and develops a strong network for the student who DSH in the school and in the community.

With an extensive assortment of problems faced by adolescents who DSH, intervention often calls for a variety of treatment strategies. Gaining a thorough understanding of how DSH relates to other aspects in the life of the adolescent helps in
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facilitating strategies for appropriate interventions. Laye-Gindhu and Schonert-Reichl, (2004), highlight the importance of research-based information to develop effective coping strategies for meeting the needs of adolescents who DSH.

The main purpose of the literature review was to explore specific and realistic information about DSH and how this information is made available to school counsellors. The information from this review has clarified what DSH is, expanded on examples of what DSH looks like, indicated the warning signs for those who may be engaging in acts of DSH and described the risk factors that could potentially lead to an adolescent engaging in DSH. Many adolescents choose to DSH as a way of dealing with difficult feelings that tend to build internally. With an increase in the number of adolescents who DSH, school counsellors need to be prepared to work with these students, the information presented from the literature review is important in setting criteria, possible interventions and inclusion of the topic into curriculum to guide students in understanding DSH.

Strengths and Limitations of the Literature Review

As with any research there are strengths and limitations of each study and the interpretation of findings. For most part, past research about adolescents who DSH, was based on information obtained through hospital records, however, reality is that adolescents are not only presenting at hospital but at schools. Research collected from a school’s point of view is important and relevant as it allows school counsellors greater insight on how DSH impacts the educational setting.

Strengths

Leedy and Ormrod (2005), note that using both quantitative and qualitative methodology allows greater insight into research than if the methodology is a single
approach. The qualitative research provides a more holistic and “emergent” focus to help explain the phenomenon of DSH. Although, adolescents from various environments were accessed in respect to variables such as ethnicity, gender and age, the reasons why adolescents engage in acts of DSH were prominently analogous. An added strength in the studies is that the individuals who executed the research were primarily mental health practitioners; thereby the research was developed in a realm of “expertise” which provided a strong background of information about DSH.

Limitations

First, there is the problematic definition of DSH, as a large portion of the literature piggybacks DSH with suicidal ideation (Davis & Anderson, 1999; Kerfoot, 1996; Nadkarini et al., 2003). It becomes clear that the broad terms of self-harm and DSH may be interpreted differently between disciplines and cultures. There is often little differentiation between nonsuicidal self-injury and actual suicide attempts. Some researchers purposely exclude self-laceration/self-cutting (Webb, 2002). There are adolescents who DSH with no intention of suicide. Most often these individuals do not find themselves in the hospital or a clinic, yet these are the students who present to school guidance counsellors. Studies on how DSH impacts school counsellors or how counsellors respond are very limited in this area (Best, 2005a).

Goddard and Subotsky (1996) express limitations of their study focused on the definition of ethnic groups and how individuals were placed in these groups as within the referrals there may have been biases on many levels. Another limitation in the study is a differential as to how the two groups Black and Caucasian access psychiatric services. The suggestions for other research would be to study how DSH is mediated not only by
ethnicity but by ethnicity combined with biological variables, social variables and self-
identity. Teenagers try to define themselves through their clothing, language,
experiences, hairstyles, and peer groups. Therefore it can be said that adolescents attempt
to discover who they are through external, rather than intrinsic motivation. For families
with different ethnic heritage assimilation has proven to be difficult as parents often find
it difficult accepting how their teen is changing. As a result most approaches to
assimilation often produce ethnic separation and marginalization, which is difficult for
immigrant teens. If students can retain a strong sense of their heritage which includes
their language, religion and culture of their parents and try and combine those with their
in-group peer social network, then it may help the teen become better adjusted and
relieve some of the pressures that contribute to DSH.

It has not been possible to consider all of the related issues this topic raises, such
as culture, sexual identity, and gender. The clinical studies provide counsellors with
information describing what DSH might physically look, but even here there is
discrepancy. Gender and socialization pose some difficulties with DSH; is a male getting
angry and punching something until he breaks a knuckle an indication of DSH or is it just
something boys do when they get angry? Best (2005b) questions this type of male
activity as being more or less culturally acceptable. With respect to gender the difficulty
in accurately assessing the differences in DSH behavior may occur due to the variation in
how male and female who DSH are identified, how they injure themselves and whether
or not they seek treatment (Best, 2005b; Kerfoot, 1996; Laye-Gindhu & Schonert-Reichl,
2004)
A limitation of the school-based studies is the impact of school absenteeism on the sample composition. Hawton, Rodham and Evans (2006) report that when conducting any school based study there will inevitably be students excluded from the study due to absenteeism. These students may include out-of-school activities; students who may be sick, and others who are truant. Truant students tend to have increased risk for engaging in DSH or suicidal behaviors (Nadkarini et al., 2003; Onacki, 2005; Walsh, 2006). A few students who may be absent because of illness may very well have psychological problems and may be at risk for DSH. Many researchers with school-based studies have not addressed this which then creates a sample bias, thereby underestimating the true number of adolescents who DSH (Evans, Hawton, & Rodham, 2004).

Many of the studies employ surveys and self-reporting which have difficulty producing empirical evidence, and hence these findings should be replicated to increase their validity (Mertens, 1998). It is particularly difficult to ensure control groups are free of deception. Also, the choice of interview may have ramifications in a couple of areas; adolescents may conceal very personal types of behaviors regarding DSH during the interview process and finding interviewers who have appropriate skills and qualities for conducting an unbiased interview may be problematic. Many of the studies reviewed were not replicated thereby questioning the validity of the studies. Deliberate self-harm specifically related to nonsuicidal and adolescents, is a fairly limited field of study as this behavior has more just recently gained attention in the field of schools and mental health.

Limitations of studies using case notes may be problematic when important information can be recorded inconsistently. Case notes may also be discarded because of
illegibility thereby reducing the accuracy of information in the study (Hawton et. al, 2003; Nadkarni et. al 2003).

Another limitation is the lack of studies that examines the prevalence and characteristics of DSH in schools from the perspective of the school counsellor or other school personnel who may be in contact with students who engage in this behavior. The role of the school counsellor is crucial when working with adolescents who engage in acts of DSH. As Hawton et al. (2004), noted, it is important for counsellors to have as much accurate information as possible about DSH in order to recognize students who may be at risk for DSH behaviors. Best (2005a) points out school personnel need to be engaged in continual training since they are in a unique position to respond to adolescents who DSH on a number of levels. As well, counsellors cannot react appropriately or even create a safe environment if they themselves lack personal confidence when working with adolescents who DSH.

It is difficult to understand why adolescents would engage in acts of DSH. The research on adolescents and DSH, albeit relatively new, raises a number of factors that contribute to the reasons an adolescent might want to self-harm. Onacki (2005) points out that the school is in a unique position to recognize the problem of DSH and to assist in implementing a protocol in order to help students who DSH. Being able to reflect on the research allows for a greater understanding of the “who”, “what”, “where,” and “whys” of DSH. Using this information to educate school counsellors will improve support for adolescents who DSH in our schools.
Mertens (1998) noted that the common outcome for literature reviews is the evolution of new ideas for future studies. As with DSH there are some prominent themes throughout this literature review such as those related to the definition of DSH, gender issues, risk factors, contagion, school counselling, parental factors related to their child who DSH and internet information in relation to DSH.

The first area that needs to be addressed is the development and use of a comprehensive definition of DSH. In many cases DSH and parasuicadal behavior are terms frequently used to define suicidal behaviors, however, the research points out that these terms are also used to describe nonsuicidal behaviors (Hawton & James, 2005; Nadkarini et al., 2003; Souter & Kraemer, 2004). A single definition of DSH must be developed to provide a strong empirical research base needed for future research.

There appears to be a gender issues with the research as the major participants in the studies were predominately female (Rodham et al., 2003; Ross & Heath, 2002) Research investigating the roles and level of physical harm experienced by male adolescent is needed. Further research that investigates why so many females DSH and solutions to reducing this behavior would be useful when working with female adolescents.

Research should also include information around cultural sensitivity that moves away from stereotypes, takes into account family dynamics, belief systems and cultural constraints as they relate to the adolescent. Goddard and Subotsky (1996) suggested further research would be to study how DSH is mediated not only by ethnicity in terms of
color but by ethnicity combined with biological variables, social variables and self-
identity.

Future research of risk factors should continue to focus on the root causes of DSH with the realization that DSH cannot not be treated as a “stand-alone problem”.
Counsellors need to know what happens when adolescents DSH and what are the possible sources of hostility and anxiety in adolescents so they may develop preventative methods (Fillmore & Dell, 2005; Ross & Heath 2003).

Contagion, (when multiple students who know each other DSH within short periods of time) as reported by Walsh (2006) is a common problem in schools with adolescents who DSH; however there is no research specific to this topic. It is most common among females who know each other and are constantly communicating about DSH thereby elicit this behavior in each other. In some cases it is thought that this behavior creates acceptance in a peer group, the act of DSH may be thought of as a way of communicating feelings for attention from peers, and it may also be conceived as a way to “freak” out or shock parents. School counsellors need to have the skills and knowledge to minimize the risk of contagion.

Many researchers have identified the need for providing school counsellors with better education and training of how to respond and work with adolescents who DSH. There is almost no information available that points to the specific ethnicity, gender and culture of adolescents who DSH in schools. School counsellors need practical applicable research-based information to provide programming and interventions with students who DSH with no suicidal ideation. (Best, 2005a; Laye-Gindhu & Schonert-Reichl, 2004; Nadkarini et al., 2003).
There is limited research in the role of parents of adolescents who DSH, and future research should be directed towards this important relationship (Ross & Heath 2003). When a parent discovers their child has DSH it may come as a total shock. Parents are left with feelings of frustration and unsure as to how to proceed to best help their child.

Finally, future research should be directed at the opportunity and impact of the internet to solicit and share information related to DSH for adolescents who have access to the internet. For many adolescents, the internet is their way of connecting with their peers. Whitlock, Powers and Eckenrode (2006) have noted that the internet has particular relevance for adolescents who feel marginalized because it provides a “low-risk” venue for connecting with others who share their perceived or real differences. Message boards, chat rooms or news groups create a forum where adolescents are able to exchange information that may be difficult to express in person without identifying themselves. Two areas of research should incorporate the positive and negative side of using online communication in bringing together adolescents who DSH. Counsellors should be aware of what information is being circulated to students about DSH so that vulnerable students are not connecting to a subculture group that normalize or encourage DSH behaviors.

Finding answers to the “who” and “why” of DSH will require further research. Perhaps the most pressing question is: how can students who DSH and the people who care about them receive the much needed assistance and support?

Conclusion

Students face many stressors on a daily basis: the family unit breaking up, drugs and alcohol addictions, runaways, homelessness, learning disabilities, stress of school,
bullying, sexual and physical abuse, date abuse, and poor relationships with friends, family and boy/girlfriends. For many students, DSH relates to a lack of coping or problem solving skills in being able to work through the trauma(s) in their lives. There is an increase of students who are engaging in acts of DSH. These actions (DSH) often produce confusion, alarm and fear in school staff that has not been exposed to DSH. The response of school counsellors, to adolescents who DSH can be significant in providing the most effective interventions for the student (Ross & Heath, 2002). A major component for effective interventions is for counsellors to be aware of DSH behaviors in their school and to develop a curriculum to inform students of DSH (Best, 2005a; Evans, Hawton, & Rodham, 2004).

For school counsellors, in particular, programs should be established that provide presentations to students in school health programs. A proactive approach may encourage students who are contemplating DSH to feel confident to approach someone for help. Also, students whose friend might have confessed they DSH will need support for helping their friend. Teachers too, seem likely to welcome the support as they may become the confidante of a student who DSH. The power point presentation and presenter notes developed through this final project is an important starting point for schools and school counsellors.

The role of the counsellor has many facets; there is a need to educate students on adaptability, and the development of positive coping skills. Teaching students it is okay to ask for help when they are floundering and providing a safe environment for students to relieve their burdens is a priority for building resiliency in adolescents. Through encouragement and education counsellors have the opportunity to dispel myths and
breakdown the stereotypes regarding DSH which can only benefit the lives of the students they come into contact with in schools.
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Deliberate Self-Harm
Deliberate Self-harm (DSH) is Common Among Adolescents

Someone you know or someone you are close to, may be contemplating deliberately harming themselves….

…or you may be thinking about deliberate self-harm.
7-14 % of adolescents

DSH

Young People and self-harm
DSH Can be Difficult to Understand

It is a subject, which until most recently was considered as “taboo”.

DSH is generally a “secretive” activity.

Adolescents don’t want to be stigmatized so they hide their scars.
“To harm other people is understandable in our culture but to willingly harm yourself is thought of as perverted.”
Gaining an understanding of DSH is the first step in helping yourself or others
Deliberate self-harm is when a person deliberately injures or harms themselves.

- Self-mutilation
- Self-injury
- Self-injurious behavior
- Self-inflicted violence
- Deliberate cutting
- Self-abuse
- Cutting
Who Engages In DSH?

- There is no portrait of someone who DSH.
- DSH is not limited by gender, race, education, age, sexual orientation, socio-economics or religion.
Characteristics of Individuals Who DSH:

- 11-25 years old
- female
- live residential settings or on the streets
- lesbian, gay, bisexual and transgender
- adolescents with learning disabilities.
EMO

- short for emotional.
- a young sub-set of Goths.
- use cutting as a form of exhibitionism.
- cutting is often symbolic in many lyrics of Emo music.

- Contagion
What Does DSH Look Like?

- Cutting
- Scalding
- Banging or scratching the body
- Breaking bones
- Hair pulling (tricholillomania)
- Hitting (with hammer or other object)
- Swallowing poisonous substances or objects
- Picking at one’s skin
- Needle sticking
- Burning (or branding with hot objects)
Why Do Adolescents Engage In DSH?

DSH may give temporary relief and a sense of control when the individual is trying to cope with painful and difficult feelings.
Adolescents Report That Engaging in DSH Provides Them With a Way To:

- Relieve intense feelings of pressure and anxiety
- Provides them with a sense of being real – to feel something
- Externalize emotional pain
“I felt a warm sense of relief, as though all the bad things about me were flowing out of me and it made me feel alive, real”
Adolescents Link DSH To:

- Being bullied
- Stress and worry
- Feeling isolated
- Arguments with family or friends
- Parents divorcing
- Unwanted pregnancy
- Losing someone close through death or leaving
Adolescents Link DSH To:

- Abuse - physical, sexual, or emotional
- Break-up of a relationship
- Suicide of someone close
- Problems to do with sexuality
- Problems with race, culture or religion
- Feelings of rejection
- Overwhelming feelings of sadness
- Low self-esteem
**Negative Emotions**
Sadness, anger. Anything that makes an individual want to harm themselves.

**Tension**
Inability to control one’s emotions.

**Deliberate Self-harm Act**
Cutting, burning, etc. Anything causing physical pain.

**Release/Positive Effect**
Endorphins released. Tension and negative feelings dispelled.

**Negative Effects**
Feelings of shame and guilt for DSH.

**CYCLE OF DSH**
When an adolescent feels overwhelmed by emotions and feels he or she can no longer cope, DSH may be their way of escaping these feelings.
“Don’t get me wrong, not in a heartbeat do I think that self-harm is a good or positive thing, or anything besides a heart-breaking desperate act that saddens me every time I hear about it. But there’s a reason why people do it”
Adolescents report

- Breaks emotional numbness
- Is an attempt to manipulate
- Self Loathing
- Is a way to self-sooth when they have no other way to calm their emotions
- DSH is done to manage and control pain
“I hurt myself for different reasons, depending on my state of mind. I do it sometimes as a way to get relief from the pain I am feeling inside. Other times I do because at the time I feel I deserve to be punished, or I am angry at myself, but really I think someone else. Other times I do it to "shout out" to the world that I need help and here is the proof. I am a incest survivor, so I think that it's some of the pain that I have had to live with trying to escape my body”
“Some people do it for attention... that doesn’t mean they should be ignored. There are plenty of ways to get attention, why cause yourself pain? And if someone’s crying for help, you should give it, not stand and judge the way they’re asking for it.”
Stereotypes Of DSH

- Stop adolescents from getting help
- Increase negative reactions

We Know DSH Isn’t About

- “Attention seeking”
- A particular youth subculture
- Suicide
“People often link self-harm to suicide but for me it was something very different; it was my alternative to suicide; my way of coping even though sometimes I wished that my world would end”
How would I know if someone was deliberate self-harming?
Signs of DSH

- Unexplained cuts, burns or injuries
- Covering his/her body when it's warm
- Avoiding activities which involve showing themselves
- Increasing secretive behavior
- Wanting to be alone
- Withdrawn
Asking for Help

- who do I ask?
- “one time thing”
- afraid that the only coping strategy available will be taken away
- can cope on my own
- rejection or not taken seriously
- no one would understand or have the ability to help
Asking for Help

- Fear I will be labeled
- Confidentiality
- Actions not serious enough to seek help
- Negative feelings about myself
- Negative experiences make it difficult to trust
- Worry my “secret” will become public
How Can I Help?

- Personal reaction is important...

Try not to be:

- Judgmental
- Angry
- Condescending
- Name Calling
How Can I Help?

- Maintain control
- Remain supportive
- Express their feelings
- Be open and honest
- Encourage person to get help – offer to go with them
- Help with problem solving
“The one thing that always helps is if I’m feeling really bad is to be around someone that I trust. I may look bad and not be very talkative – but just being around someone who doesn’t question my odd behavior and lets me be around them without talking or expectations helps.”
What Should I Do If I DSH?

- Disclosure is difficult
- Acknowledging DSH is a problem
- You’re not bad or stupid
- Find someone you trust to tell
- Don’t feel pressure to answer questions
- Take someone with you for support
Disclosure

- Talk to someone
- Instant messaging (MSN)
- Write a note
- Show injuries to open conversation
- Get help to identify feelings
- Understand your feelings
If you feel the need to DSH, **stop** and focus on getting through the next 5 minutes.

ask yourself what is making me feel this way right now......
Distraction Methods

- Anger and frustration
- Need to feel
- Sooth or comforting oneself
- See blood.
Dealing With Anger or Frustration

Try:

- Vent by screaming, punching a pillow
- Rip something apart
- Exercise
- Making noise
- Writing negative feelings on a piece of paper and ripping it up
If You DSH As a Way of Feeling
Something Try:

- Holding ice where you might cut
- Have a cold shower
- Chew something with a strong taste
- Snapping a rubber band hard on your wrist
“...Sometimes I will do a lot of physical exercise that is really intense-- I focus it on the area that I want to DSH. Like if I am preoccupied with wanting to DSH my legs, I run up a steep hill because I can feel both pain and heat in my legs. I hold onto ice-cubes for as long as I can because I feel pain and heat in my entire arm. I also try to make sure that I am not alone by being with a friend that is aware of the situation or just by being out in a public place. Sometimes I walk around Wal-Mart in the middle of the night if I have to.”
If DSH is used as a way to calm or soothe yourself, try:

- Taking a bubble bath
- Deep breathing exercises
- Write in a journal
- Call a friend
- Draw – doing something creative
If DSH Involves You Having To See Blood Try:

- Drawing or scribbling on a large piece of paper with a red crayon
- Draw a line with red ink where you would usually cut
“I’ve tried so many distraction techniques – from holding an ice-cube, elastic band flicking on the writs, writing down my thoughts, hitting, listening to music, writing down pros and cons. But the most helpful to my recovery was the five minute rule, where if you feel like you want to self-harm you wait for 5 minutes before you do, then see if you can go another 5 minutes, and so on till eventually the urge is over.”
Recovery

- Feelings change
- Problems go away
- DSH patterns change
Caring for Yourself

- Eat well
- Drink sensibly or avoid alcohol
- Exercise
- Develop your skills in an area you are good at
- Seek help when you need it
- Make a list of people you trust as a “support network”
- Set realistic and practical goals
I NEED A HAPPY MEAL
(sniff, sniff)
“I do a lot of things... some sound really stupid. I do practical things like eat healthy and get needed rest. Sometimes I write poems, stories, or sketch because they take a lot of concentration and also express the emotions...”
CALL SOMEONE

- Distress Centre: 266-1605
- East Side Family Centre: 299-9696
- Family Doctor
- School Counsellor
- Teen Hot line: 264-TEEN (8336)
- Kids Help Phone: 1 800 668-6868
- Wood’s Youth & Family Crisis Centre: 299-9699
- Canadian Mental Health Association: www.canadian-health-network.ca
- Mobile Response Team: 266-1605
- 2-1-1 Resources in the Community
References

- Slide #1: internet@elmundo.es
- Slide # 5, 7 & 14: www.selfharm.org.uk
- Slide 8: www.thеспoof.com/sitepics/pdi/11206-5215sa.jpg
- Slide 13: www.edinatoolkit.com/.../depression_2.jpg
- Slide # 17: web.salvationarmy.org.uk/aloive/images/engage
- Slide #31: www.s4c.co.uk
- Slide # 41: www.mathlearningcenter.org
- Slide # 2,15, 22, 24, 27, 30, 38, 47, 52, 53, 54: The Truth About Self Harm: www.camelotfoundation.org.uk
- Self Injury: Types. Causes and Treatments
- Resisting the Urge to Cut: http://www.kidshealth.org/teen/your_mind/mental_health/resisting_cutting.html
- Rethink: http://www.rethink.org/information/about/selfharm7.html