Self Mutilation

Inward Pain Turned Inside Out

Gail Abraham, RN, BSN, School Nurse, in collaboration with Deb Ilardi, RN, BSN, *School Nurse News* Clinical Editor

Ryann's Story

Ryann had a "permanent pass" to the health office to come whenever she felt she was in "crisis." She would come to seek advice or just sit somewhere quietly. There was very rarely a day that I would see her in anything but a long-sleeve shirt and jeans. We would retreat to a private room where she would tell me how she "was feeling" and slowly, over time, she revealed her cutting secret to me.

I did not feel qualified to counsel Ryann about her cutting, but would listen each time and try to give advice as best as I could. Sometimes we would talk for thirty minutes or more. "Don't get sucked into her stories, she will only manipulate you," my co-worker Lynn would add each time Ryann visited. I remember one evening researching the internet on "cutting behavior," and found myself in a chat room. Was I "too" attached to this student? I think it is hard to stay "detached" when involved in helping a student. Did I take this situation too personally? Would my personal beliefs make it harder to counsel or help another who might be experiencing the same? How good it did make me feel though every time Ryann did seek me out. A nurse's office is a "safe haven" for students in "crisis." I did, however, refer Ryann out to our school social worker. Ryann disliked this very much, stating, "I will go and see her but I won't talk with her." And so the battle began. Each time she was called upon by the social worker, Ryann sat and never spoke a word. It became a cycle — a session with the social worker followed with a visit to the health office; very rarely exhibiting her scars, only occasionally requesting an assessment if she thought one might be infected. Communication between Ryann's parents and myself was good. Desperate to find a "cause" and "reason" Ryann's parents were always grateful for our help and assistance. It became a struggle to find the cure. After all, there is a cure? Isn't there?

Ryann has since graduated from high school. I spoke with her on the telephone the other day. This "up-beat," happy young lady told me that coming to the health office offered a "sense of relief for her so that she could just stop thinking." She says that after her visit to the health office she often felt better because school was just too overwhelming. I asked Ryann how she was doing today and if the "cutting ever goes away." Her response was that "it never goes away, it only makes me miss it."

~ submitted by Lisa Morgan, RN, NYSASN School Nurse of the Year - 2004

Marilee Strong, award-winning journalist and author of "A Bright Red Scream," accurately defines *cutting* as "the deliberate, direct, nonsuicidal destruction or alteration of one's body tissue." "Cutters" are people who repeatedly and systematically cut their skin, burn themselves, and/or break their own bones. It is extremely unlikely that this behavior can be stopped without some type of therapy. Many "cutters" have lived through varying degrees of physical or emotional childhood abuse, with abandonment (real or perceived) being a key component of that abuse. Currently, close to 2,000,000 Americans have been identified as suffering from this psychological disorder of self-mutilation or self-injury. It is not surprising that school nurses are on the front lines of recognizing and referring self-injuring students for help and support. Cutters repeatedly report that, for them, cutting turns chaos into calm, powerlessness into control (Favazza, 1998). For children/adolescents who are unable to verbalize their emotions, cutting becomes their language. It is a language that is written on the body through blood, wounds and scars. The characteristics of self-mutilation, typical descriptions of a cutter, approaches to care, appropriate treatment, and resources for referral are presented here.

Historical Perspective on the Phenomenon of Self-Mutilation

Cutting, popularly referred to as the disease of the 90's, is by no means a new phenomenon. Cutting has been with us for at least 2,000 years, the first published reference to cutting being found in the New Testament Gospel of Mark, in which a man living in a graveyard is described as cutting himself deliberately with stones. There have been numerous historical accounts of self-flagellation to relieve religious guilt. The recent best-selling novel "The DaVinci Code" makes numerous references to this phenomenon. Yet, to this day, cutting remains largely ignored or misdiagnosed by the medical community. Mental health professionals cannot agree on whether cutting is a symptom or a diagnosis in its own right. They cannot even agree on what to call it: self-injury, self-mutilation, self-harm, self-abuse, auto-aggression, self-inflicted violence, or the deceptively innocent sounding "delicate self-cutting."

If you are speaking to students who identify themselves as cutters, they usually will reject the term self-mutilation, preferring the term self-injury. The prominent medical anthropologist Arthur Kleinman, also a psychiatrist, states that people do not "have" diseases. People have stories, and these stories are narratives of their lives, their relationships, and the way they experience an illness. "Cutting" is the recorded story, told in a language of blood.

Reaction to Cutting and Its Significance to Society

When people first hear about cutting, discovering that someone close to them uses knives, razors, glass, etc. to cut themselves, to draw blood, their reaction is often horror, disgust, disbelief, and incomprehension. Marilee Strong (1998) reports that the medical and psychological understanding of cutting is still in the formative stages. She believes that by listening to the tortured stories told by cutters about their lives and the meaning that cutting has for them, we can gain insight into much broader social patterns and problems. These problems include issues from child-rearing to child abuse, from eating disorders to the popular culture trend of tattooing and body piercing. She believes that this activity tells us something about ourselves as a society. The image that we find in broken skin is not a happy one. As the anthropologist Mary Douglas once said, "What is carved in human flesh is an image of our society." Throughout history and across a thousand different cultures and societies skin has been decorated, scarred, hidden or revealed, tattooed, cut, or branded to tell a story and to communicate status in the community as a warrior, a wife, a slave. Skin communicates (Strong, 1998) when verbal communication is difficult.

Students who are cutters need someone in whom to confide, someone who they feel is as comfortable and knowledgeable about their bodies as they are with their minds. The school nurse is a natural first contact. The student who cuts needs a committed, focused, caring, team approach including but not limited to the school nurse, social worker, school psychologist, counselor, outside therapist, and family support. We must become desensitized to the results of the physical acts committed against the body and also to the fact that this damage is self-inflicted. This part is probably the most difficult; if we respond with shock and horror, then students feel that they are horrible, and not worthy of our help. If we react with puzzlement and bewilderment, then they believe we do not understand them. We are the people they have come to for help, and they feel they are hopeless. Cutting remains today a behavior that is unaddressed by both professionals and the public. Self-mutilation is a frightening barrier that keeps us from seeing a person who is lost, in pain, and in desperate need of help (Levenkron, 1998). In our day-to-day role as school nurses, we give

priority for care to the most traumatic, emergent care needs. Someone who is making superficial cuts to their arm and seeking our attention and the attention of their friends does not seem to merit being put high on our emergency list. It is tempting to wonder why they are wasting our time. This behavior should, instead, be seen as a red flag. The "exhibitionist" is the cutter who is not at all secretive about her cutting. She is damaging herself in full view of the world. When others find out they become frightened and angry with her and at the same time express their worry and feelings of helplessness around her. This extreme focus and attention is gratifying in its own way, even though it is what is known as negative attention. The cutter feels more powerful when she is getting all of this attention. This is known as a secondary gain; that is, she is consciously unaware of her own motives. The cutter who exhibits rather than hides her cutting is not a "phony," but has simply discovered that negative attention is better than none at all. She also has discovered feelings of powerfulness derived from experiencing our reactions. They are a sharp contrast to the feelings of helplessness she has, those of a lonely childhood.

Anorexia's Relationship to Cutting Behavior

When anorexia was first being widely reported in the news media in the 1970s, nursing staffs of the large urban hospitals were seeing an influx of adolescent anorexia patients filling up hospital beds on their units. There was a widespread feeling of resentment from the nursing staff regarding these patients, whom they perceived as taking up valuable hospital space when patients with serious, involuntary medical conditions could be using them. As faulty as this thinking turns out to be, it was consistent with societal expectations of the decade. They saw the adolescent anorexic as someone who was just refusing to eat, who was not truly ill, and could change this behavior if she truly wanted to. Instead, these non-eaters appeared to be sabotaging the help that their healthcare professionals were trying to give them. An anorexic patient that this writer worked with for several months at a large metropolitan hospital remained hospitalized for a lengthy period of time primarily for hyperalimentation. She could have actually gotten dressed in street clothes every day but instead chose the hospital gown that was given her every day for 2 months. When I asked her why, she said, "The staff resents me being here and taking up a bed that they think should go to a cancer patient or someone who is really sick. They don't see me as being sick. I wear the gown to remind them that I am sick, too." Thirty years later we are at the same point with the patient who self-mutilates. We must desensitize ourselves to the unusual and unattractive behavior and scars of self-mutilation but not to the patient's emotional distress. This is the first step in seeing the self-mutilator as a person in desperate need of help and human contact, even those who are delicate superficial cutters.

Description of the Cutter

Ashley, 18, had been cutting her upper arms repeatedly at home with a shard of glass she kept clean and hidden in her desk drawer. She would always come to the school nurse the morning after, for good wound care and a dose of caring. Washing and bandaging her always gave us the opportunity to talk privately. This is rare in our busy office. Ashley always knew we would make time for her. From there, she would go straight to her in-school counselor.

> It always amazes us when school nurses feel held back in their practice by privacy laws. The law preserves students' rights, it does not make any judgment on whether a shroud of secrecy is appropriate in any setting. Urge collaboration whenever possible. The more professionals available to help at-risk students, the better able they are to stay in school and learn. These professionals are versed in confidentiality laws in a manner similar to school nurses. Unfortunately, teachers do not receive preparation to handle confidential health information. While some will develop an excellent respect for what it means not to discuss information casually, others with good intention violate a student's right to privacy with frightening ease. Once something is said in the hallway of a busy school, there can be no protection.

One day she walked in, at mid-day, looking frightened and quieter than usual. She had one hand over the other wrist. I was working with a student and the other nurse was on the telephone. Ashley walked right up to me and said, "I need your help now. I did something really bad." I excused myself and took her into the bathroom. She had felt the need to cut herself during school. She went to the girls' lav. She looked through her bookbag for something sharp enough and took apart her pocket pencil sharpener, thinking she could cut superficially with it. Instead, she had laid open all the skin layers of her wrist, and she was frightened.

I was able to care for her physical wound and the school psychologist came to my office to talk with Ashley while I did. Together we helped her understand the need for emergency care. Remarkably, her alcoholic mother was available and able to come for her. She received sutures and emergency psychiatric evaluation that day. The next day, Ashley came to show me her sutured wrist, and assured me she had no plans to attempt that again. But the day after that, when I saw her, she was happy with her wound. She had carefully removed the sutures so that it would heal with a large, disfiguring scar. Her emotional pain would continue for many, many more months despite therapy. Still, she was able to continue to come to school every day, and in June was the first person in her family to graduate from high school.

The cutter seeks relief from mental pain and anguish by self-inflicting physical pain. Favazza (1998) categorizes self-injury into three sub-types: episodic, repetitive, and compulsive. Repetitive self-injurers hurt themselves chronically and develop a fixed identity around cutting. They believe that their symptoms define them, that there is nothing but a huge void inside, and that if they were prevented from cutting, they would fall apart. Both episodic and repetitive cutters hurt themselves for the same reasons: to relieve tension, release anger, regain a sense of control, and put an end to an emotional state of deadness. They may also have a variety of psychological and medical conditions, including posttraumatic stress disorder, depression, dissociative disorders, anorexia, bulimia, and personality disorders, specifically obsessive-compulsive disorder. Recent work on brain chemistry at Duke University has shed some light on why trauma encountered at an early age causes such long-lasting consequences. The young developing brain that has experienced posttraumatic stress shows evidence of permanent "hard wiring" changes to the brain. This is a very intriguing concept that shows how an emotional memory becomes

imbedded and the brain begins to maladapt and "mislearn" how to problem solve and handle stress. This becomes important when considering treatment and long-term outcomes.

What is the prevalence of "cutting" in our society? Currently, short on statistics, it is believed that the percentage of cutters is similar to the number of people with anorexia, that is, one in every 250 girls. This number is based on an informal survey by the Canadian Broadcasting Company. Five hundred school psychologists were asked if they had seen cutters during the year, and they indicated an incidence of two to three cutters per school (Levenkron, 1998). Far more girls than boys are presenting with these symptoms, but boys can also be at risk for cutting. In a study of 20 children and teenagers hospitalized for self-mutilation, University of Kansas Professors Cynthia Simpson and Garry Porter concluded that children who never had stable dependency relationships with their parents were unable to develop their own separate identity in adolescence. The researchers found evidence that at least 16 subjects had been physically abused. In addition, 9 subjects admitted to sexual abuse and the same number had experienced the loss of one or both parents. The researchers viewed self-injury as serving a variety of purposes for these individuals: a cry for help, an outlet for pent-up rage, a means of self punishment, a controllable method for reducing emotional trauma, a form of "body stimulation" for children who had become numb to pain as a result of physical and/or sexual trauma and, for the child who feels invisible, non-existent, a way of validating and verifying that they indeed are alive.

Practical Guidelines

What signs and symptoms will you see as a school nurse?

1. Recurrent cutting or burning of one's skin
2. Students' statement of feeling a sense of tension immediately before the act of cutting
3. Relaxation, gratification, pleasant feelings, and numbness experienced at the same time as physical pain
4. A sense of shame and fear of social stigma, causing the cutter to attempt to hide the scars, blood or other evidence of self-mutilation

The school nurse's role is to recognize the signs and symptoms of cutting. In working with students who have these wounds, use standard first aid in a nonjudgmental, caring fashion that shows that you are concerned for the student's well-being, not disgusted or afraid. It is also part of your role to consult with other caring professionals, such as the student's guidance counselor, school psychologist, social worker, and student assistance counselor (if this service is available in your school system). The support of family members and friends will help this individual over the long run as she works with outside therapy and counseling. The goal is to see her discover her voice, in language rather than cutting, and to develop healthy ways to ask for what she needs in life. All this must be done with utmost understanding of the student's right to privacy —understanding what "need to know" really means, and communicating that to the student and family, improves your ability to help the student overcome the health challenges.

Support From Clinical Partners

Derouin and Bravender (2004) explain their views: Nurses and primary care clinicians are in an excellent position to increase understanding of the complex issues surrounding adolescent self-mutilation. As trusted and reliable health advocates for adolescents and young adults, we can share our knowledge of developmental issues with the families and help to break the cycle of self-mutilation by alerting parents to this current cultural trend. Information can be shared at parent–teacher association meetings, School Board meetings, and other community meetings attended by parents and prominent community members. Nurses can voice concerns to members of government and to the entertainment industry, individually and collectively, about promotion of violence and self-destructive behaviors by the media.

Resources for Students, Families and Staff

Understanding Self-Injury: A Workbook for Adults. Helps sufferers understand self-destructive behaviors and explore alternatives through writing and drawing exercises. To order, send $10.00 for the workbook plus $1.00 for shipping and handling to:

Pittsburgh Action Against Rape
81 South 19th Street
Pittsburgh, PA 15203-1852

The Cutting Edge (a self-injury newsletter)
P.O. Box 20819
Cleveland, OH 44120

S.A.F.E. (Self Abuse Finally Ends)
659 Dundas Street
London, Ontario
Canada N5W 2Z1

SAFE Alternatives at Rock Creek Center: 1-800-DONTCUT. Provides information and referrals; sends out a useful information packet on request.

REFERENCES

Derouin, A. & Bravender, T. (2004). Living on the edge: The current phenomenon of self-mutilation in adolescents. MCN, *The American Journal of Maternal/Child Nursing, 29*(1), 12-18.

Farber, S. (2000). *When the body is the target.* Northvale, NJ: Jason Aronson.

Favazza, A. (1992). *Bodies under siege: Self-mutilation in culture and psychiatry* (2nd ed.). Baltimore, MD: Johns Hopkins University.

Favazza, A. (1998). The coming of age of self-mutilation. *Journal of Nervous Mental Disorders*, 186, 259–256.

Favazza, A. (1999) in: *Harvard Medical School Guide to Suicide Assessment and Intervention.*; pp. 125-145. San Francisco, CA: Jossey-Bass.

Levenkron, S. (1998). *Cutting: Understanding and overcoming self-mutilation.* New York: W. W. Norton.

Strong, M. (1998). *A Bright Red Scream.* New York: Viking Penguin.

ABOUT THE AUTHORS

Gail Abraham, RN, BSN, NCSN is currently a graduate student in the MSN program at the University of Phoenix and a school nurse employed by the Chappaqua Central School District, Chappaqua, NY.

Deb Ilardi, RN, BSN is the Clinical Editor for *School Nurse News* and a practicing school nurse at Cicero-North Syracuse High School, Cicero, NY.