

Self-Injury and Postvention: Responding to the Family in Crisis

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Abstract:

Postvention actions are commonly employed after completed suicides and suicide attempts but can be adapted to assist affected family members in dealing with other types of crisis. The authors adapt a postvention model to be applied to systemically working with families who have a member engaging in self-injurious behavior. Recommendations for counselors who work with youth who self-injure and their families are provided.

Keywords: self-injury; postvention; crisis; families

Article:

Self-injury is defined as “all behaviors involving the deliberate infliction of direct physical harm [that causes tissue damage] to one’s own body without the intent to die as a consequence of the behavior” (Simeon & Favazza, 2001, p. 1) and includes a wide range of behaviors, with cutting and burning being reported as the most frequently seen behaviors (Sutton, 1999; Trepal & Wester, 2006). Researchers within the past few decades have deduced that self-injurious behavior (SIB) has an onset in early adolescence and continues into adulthood (Favazza & Conterio, 1988).

SIB has been found to be increasing in the general population, from 1% in 1971 (Lester, 1971) to 4% within the past decade (Briere & Gil, 1998). Although increases have been noted, little is known about the impact of SIB on a family. Although researchers have not examined the impact of a youth’s SIB on family members, they have studied the impact of suicide attempts. Pehrsson and Boylan (2004) discussed the impact suicide attempts have on surrounding survivors (e.g., family members, peers, teachers). They mentioned that suicide survivors tend to continually search for answers without really finding any, mourn the original family network that has since changed, and may feel isolated from friends and other family members while possibly experiencing their own sense of crisis. However, postvention programs, implemented by counselors and other professionals, for survivors of attempted and/or completed suicide were found to buffer the negative impact (Pehrsson & Boylan, 2004; Rickgarn, 1994).

Although SIB is not synonymous with suicide, it has been mistaken for a suicide attempt in various settings (e.g., Comtois, 2002); thus, similar reactions in family members may be found in those who self-injure. This article is one of the first to adapt a suicide postvention model for counselors to work with a family who has a youth who engages in SIB. The authors will briefly present the impact that SIB has on a youth in general, along with the impact it may have on a family and how counselors may use a postvention model to work with a family from a systemic perspective.

IMPACT OF SIB ON YOUTH

There are various reasons why youth engage in SIB. Researchers and practitioners have suggested some of the reasons youth engage in SIB are to cope with problems in relationships or to deal with past childhood traumas (Crowe, 1997; Levenkron, 1998; Simeon & Favazza, 2001; Tantam & Whittaker, 1992). However, childhood trauma is not the only cause of SIB (Crowe & Bunclark, 2000). Other researchers found that problem-solving skills, coping abilities, and social skills can play a role in whether an individual chooses to self-injure. These

include a lack of distress tolerance, emotion regulation, attempts to stop thoughts, fears, or worries, dealing with stressful events, attempting to end feelings of dissociation or gain a grip on reality, feeling shame, stopping memories from reoccurring, punishment, expression of self-hatred, gaining attention or getting care from others, or SIB as a form of general coping (Alderman, 1997; Favazza, 1996; Favazza & Simeon, 1995; Gratz, 2003; Haines & Williams, 1997; Himber, 1994; Levenkron, 1998; Pattison & Kahan, 1983; Ross & Heath, 2002; Strong, 1998).

Although SIB seems to be a form of coping for an individual, it can have negative outcomes including physical disfigurement from scars, infections from interfering with wound healing or using rusty razor blades or other unhygienic paraphernalia, or social rejection because of multiple scars or marks on one's body. An individual may isolate himself or herself because of his or her embarrassment of cutting or burning his or her skin, or he or she may overdress for an event (e.g., swimming) or season. The individual may also feel guilty for continually engaging in SIB or be afraid of the behavior being discovered, especially when others know and want the youth to stop or may reprimand or label him or her. Regardless, if the individual is hiding the SIB or does not obtain more adaptive coping methods, there may be intense ramifications. Given that SIB is only a temporary, immediate release of the problem or emotion, it may lead to further frustration or intense feelings, or a sense of emptiness may intensify, possibly leading to an increase in frequency or severity of self-injury.

IMPACT ON FAMILY OF SELF-INJURING YOUTH

Very little is known about the reactions of family regarding children who self-injure. The majority of the research that has been conducted on families of adolescents who self-injure has examined the family systemically but has not focused on the reactions of and impact on family members themselves. Researchers who have examined family dynamics have found that self-injuring youth are more likely to come from physically abusive or neglectful homes (Himber, 1994), have experienced physical or sexual abuse (van der Volk, Perry, & Herman, 1991; Zila & Kiselica, 2001), or come from a violent or high-conflict family (Conterio, Lader, & Bloom, 1998). Parental divorce or loss within a family has also been found to be antecedents to self-injury (Paris, 1998; Suyemoto, 1998; Turell & Armsworth, 2000). Thus, self-injury may be a result of a problem in family functioning, not just a symptom of the individual.

Self-injury has been mistaken for suicidal behavior, even though it is not synonymous with suicide. Thus, in attempting to decipher how a family member might react to youth engaging in self-injury, we might turn to the literature on reactions to suicide attempts (Yip, 2005). McBride-Valente (1981, cited in Pehrsson & Boylan, 2004) indicated that family members of suicide attempters tend to be unclear about the reasons for the attempt, mourn for the family network, feel isolated from others, or feel shame. Family members may also feel out of control or in crisis themselves and may suffer in silence. McBride-Valente also indicated that the family as a whole, or individual members, may have inadequate coping resources themselves. This makes sense as the youth who attempted suicide, or who currently engages in SIB, tends to lack more adaptive coping methods (e.g., Ross & Heath, 2002).

According to family systems perspectives, each family member may have a unique and valid perspective on the SIB of a family member; thus, some family members may experience fear, and others may experience anger whereas other members approach the behavior nonchalantly. Although not much is known about a family's reaction to a member self-injuring, the response of mental health professionals to SIB is known (Gamble et al., 1994, cited in Deiter & Pearlman, 1998). Because family members and mental health professionals are in no way similar, it can only be imagined how a family member might react because typically they are closer and more intimate to the self-injuring client. In addition, a counselor might have access to professional training to learn more about the behavior and to supervision to debrief and/or consult with another professional. Family members may have neither of these resources.

Although counselors have access to support systems and training, researchers have found that they tend to be at a loss when attempting to understand SIB (Zila & Kiselica, 2001), along with being frightened, repulsed, and frustrated (Favazza, 1996; Himber, 1994). Counselors may attempt to get the client to stop the behavior

immediately or feel the need to control the behavior (White-Kress, 2003); however, this need for control or a startled reaction typically results in the client feeling misunderstood (Himber, 1994) and possibly may lead to the client engaging in more severe behavior or using alternative techniques that might cause more damage (Turp, 1999). It can be extremely frustrating working with a client who continues to self-injure, especially when he or she continues to purposefully or unintentionally undoes the work that has been done by medical or mental health professionals (e.g., undo stitches sewn in an emergency room, regress to previous self-injuring behavior after picking up an adaptive method of coping).

These strong reactions to clients who self-injure can impede a counselor's judgment or lead to vicarious trauma or burnout; thus, it is important for a counselor to monitor his or her reactions and receive supervision or consultation (White-Kress, 2003). However, imagine a family member, such as a mother or father, who finds out his or her son or daughter has been cutting himself or herself on the arm or even the genitalia. This individual may not have the clinical training to understand the meaning behind his or her son's or daughter's self-injury—leading to frustration, anger, fear, confusion, anxiety, apprehension, or worry.

If a family member is unsure of the reason for self-injury or misunderstands the purpose of the behavior, he or she may experience an increase in emotion (e.g., frustration, isolation, blame, anger) and completely withdraw from or attempt to gain control over a youth or other family member who self-injures. Being that communication and patterns of communication are vital issues in systemic theories, responses of avoidance or excessive control may increase the conflict felt within the family or decrease the amount of communication that needs to occur between parent and child, ultimately provoking an increase in the frequency or severity of SIB (e.g., Yip, 2005). In addition, family members may triangulate other individuals to figure out how to interact with the self-injurer. For example, a father who is unsure how to talk to his daughter who has been burning her breasts may avoid her completely or communicate with her through her brother or mother.

In regards to a youth who attempts suicide, Rickgarn (1994) mentioned that family members need to be able to openly communicate and express concerns and feelings with the suicide attempt instead of tiptoeing around the youth; otherwise the youth might feel more isolated from the family. Similarly, lines of communication need to be kept open and fostered when a youth self-injures.

Taking all of these systemic concepts into account, it is easy to see how complex a case of SIB in the family might be. Therefore, one of the responsibilities of a counselor working with a client who self-injures should be to educate the family on SIB and provide postvention.

POSTVENTION FOR SIB

Postvention is a term that was coined in 1972 by Shneidman (1981) and that describes appropriate and supportive action taken after a dire event or trauma. Postvention specifically refers to services (e.g., intervention and education) that are provided after a traumatic event (e.g., attempted or completed suicide, accident, SIB) to a family and/or community, along with intervening with the client (Evans & Farberow, 1988; Rickgarn, 1994). Shneidman provided eight principles of postvention that include immediate response, encountering resistance, exploring negative emotions, testing reality, monitoring declines in well-being, avoiding banal platitudes, and employing a multifaceted approach to treatment. Leenaars and Wenckstern (1998) took these principles a little further by asserting that depending on the situation, event, and timing, the principles and type of postvention may be modified.

As mentioned by Campbell, Cataldie, McIntosh, and Millet (2004), postvention efforts have typically been passive, which entailed survivors receiving education through indirect means, such as literature, brochures, or simply “by chance.” However, they describe an active model of suicide postvention that involves providing outreach to survivors to inform them of available resources.

Thus, taking into account and adapting Shneidman's (1981) principles and Campbell et al.'s (2004) active postvention model, postvention for a youth who self-injures should be active and include immediate

intervention with the client and his or her family. Counselors should be prepared for negative attitudes, resistance to the information, intervention, and SIB itself, a decrease in client well-being, and an increase in family crisis and other maladaptive coping methods. In addition, postvention for a family dealing with a member engaging in SIB should be modified to include education about SIB and the differences between suicide and self-injury.

The first aspect of designing a postvention program for SIB should be active postvention. Active postvention for the individual who has self-injured, or who is currently self-injuring, should be composed of some form of professional intervention, such as counseling and referral for medication evaluation, so that the client can learn adaptive forms of coping, how to regulate emotions, ways to feel connected to others, or ways to feel comfortable in his or her own skin.

For the family, postvention should include education, training, and support so that each member can contribute to the well-being and progress of the client, understand the differences between suicide and self-injury, and avoid creating more distance or isolation by learning how to decrease or avoid problematic communication and minimize conflict because both can be antecedents of SIB (Yip, 2005). A primary goal of postvention is to help individuals understand the emotions they may have as a reaction to the trauma (e.g., SIB) and gain a clear understanding as to the reason for and purpose of the SIB. As Rickgarn (1994) mentioned, “Adherence to various forms of the mythology and fears about what might happen if we have contact with a [self-injuring] person ... creates many barriers” (p. 168). Thus, the authors of this article suggest adapting a suicide postvention model and discuss aspects that should be included in an SIB postvention model with family members.

FAMILY POSTVENTION STRATEGIES FOR SELF-INJURY

Postvention actions are commonly employed after completed suicides and suicide attempts (Campbell et al., 2004) and are intended to assist affected family members, encourage community healing, and reduce the risk of contagion (Laux, 2002). Counselors must take care when employing the following postvention model and be flexible as each situation will be unique. There is not a “typical” self-injuring individual or typical reaction by family members. Family systems tend to be complex; thus, reactions to and reasons for SIB will differ within each individual and family.

Postvention is not considered a clinical intervention; thus, specific clinical techniques for working with clients are not provided. Postvention is a model of quickly conducting assessments and providing education to facilitate clinical work with a client and/or family or to gather enough information to provide appropriate referrals.

Counselors also need to be aware of some cultural implications when providing postvention to families of youth who self-injure. It has been found that family reactions to the behavior or other mental health concerns may affect the client, and although there is no stereotypical reaction based on race, there have been some patterns that have been found. For example, a study of patients stabilizing with schizophrenia suggested that individual and family adjustment may be most compromised for Black families by anxious family interactions and patient-initiated discussions of substance use (Rosenfarb, Bellack, Aziz, Kratz, & Sayers, 2004). In addition, Rosenfarb et al. (2004) found that White families’ reactions increased patient problem behavior and increased parental criticism. Factors such as recent immigration, spirituality, community involvement, and beliefs about health care may further affect individual and family responses to a variety of mental health concerns, including SIB (Sen, 2004; Turell & Armsworth, 2000).

Thus, postvention for SIB should be seen as a family intervention and education that benefits the client and entire family network. Adopting from the suicide postvention model, we recommend the following components in family postvention with self-injury: (a) information and education, (b) assessment of family system, and (c) support, referrals, and resources.

Information and Education

Typically, postvention is a process that should be entered into quickly after a crisis situation occurs. Family members may find out their child or adolescent is self-injuring in many different ways, such as a trip to the emergency room, call from the school counselor, report from a counselor in the community, discovering burns or scabs on the youth's body by accident, or the youth informing the family on his or her own accord. Once a family finds out about the SIB, postvention components should start immediately. By beginning early and starting with education and information, counselors can begin to deglamorize and dedramatize self-injury, and the negative attention received by the self-injurer can be counteracted (Laux, 2002). In addition to reducing the negative attention, early, accurate information may reduce the potential spread of contagion in family members and friends.

With issues such as suicide, it has been recommended that response teams and others responsible for notifying loved ones use direct terminology and avoid euphemisms (i.e., tried to hurt himself or herself or passed away; Wrenn, 1999). Similar thinking can be applied to self-injury. Many paraprofessionals and others categorize self-injury as mutilation, parasuicide, or hurting oneself; when discussing self-injury with family members, it is recommended that counselors use the term *self-injury* and then further explain the type of injury (e.g., cutting, burning, hair pulling). It may also be useful to assess the family member's knowledge of self-injury asking, for example, "Tell me what you know about self-injury?" This question can be used as a guide to assess the level of factual understanding about self-injury. There has been recent attention focused on SIB both in the media and professional literature, and family members are not immune to the effects. It is also advised to have educational pamphlets or information on SIB easily accessible in one's office or agency.

In addition to providing basic information on self-injury and using appropriate terminology, it may be helpful to offer psychoeducation. These approaches to family-based treatment entail teaching a family about a particular diagnosis, behavior, or disorder from beginning to end. This might include prognosis, course, possible medication issues, management, and treatment (Fristad, Goldberg-Arnold, & Gavazzi, 2003). For example, in SIB postvention, the counselor may discuss that the typical onset of SIB is approximately at age 13, that SIB can increase and decrease in frequency and severity throughout the course of treatment, and that depending on how much the youth relies on SIB as his or her main coping method and the underlying reasons for it, the prognosis may be favorable for the behavior to decrease or extinguish altogether. However, families should also be informed that the treatment of SIB may take a long time.

To prevent blame and confusion, families should be taught a no-fault approach, where the individual is separated from his or her symptoms and neither the family, nor the individual, is blamed for the diagnosis or behavior (Fristad et al., 2003). Psychoeducation and family-based treatment approaches have been used with other diagnoses including adults diagnosed with schizophrenia (Hogarty, Anderson, Reiss, & Kornblith, 1991) and bipolar disorder (Miklowitz & Goldstein, 1990), children and adolescents diagnosed with depression and mood disorders (Brent, Poling, McKain, & Baugher, 1993; Fristad, Arnett, & Gavazzi, 1998; Fristad et al., 2003) and bulimia (Le Grange, Lock, & Dymek, 2003), and children with intellectual and developmental disabilities (Keen & Knox, 2004). Care should be taken not to place blame on the family members, as they may be feeling some pressure on themselves for not knowing about the SIB or not intervening earlier. Externalizing the behavior (Le Grange et al., 2003) may also relieve family members' feelings of guilt and thoughts that they caused the SIB. In addition, family members' expressions of feelings, such as guilt or shame, could reinforce these feelings in the self-injuring youth.

With regard to SIB, psychoeducation would involve informing a client's family about self-injury, including information on what it is, how it progresses, possible treatment and/or medication, and therapeutic issues. In addition, educating a family on the differences between suicide and self-injury is vital. Dispelling myths about SIB is also important. The myths families may hear or assume may include that SIB is always a suicide attempt, that self-injurers are crazy, or that people who self-injure always suffer from a border-line personality disorder diagnosis. Once education and information have been provided, it is important to conduct a family assessment.

Family Assessment

A significant portion of SIB postvention should involve assessment. In traditional family therapy, family functioning can be conceptualized in terms of function and dysfunction among the system as a whole, as exhibited by individual members (Goldenberg & Goldenberg, 1996). All families, regardless of composition, function as institutions with their own rules and rituals. If a family system senses a threat regarding patterns (closeness, etc.), then counseling interventions might fail. The youth might want to, or think that, he or she can only feel connected with his or her family if he or she maintains his or her SIB. Therefore, careful family assessment is a crucial step.

A counselor can begin assessment by attempting to join with the family. This includes such actions as mirroring the family's language and trying to connect with them. Next, the counselor should pay particular attention to the family's communication issues, both verbal and nonverbal. Communication in families can be positive, negative, or somewhere in the middle.

Counselors can also assess basic family structure. For example, several authors (e.g., Bowen, 1978; Minuchin, 1974) have discussed the concept of triangulation, where some other person, behavior, or activity is involved to reduce anxiety among a two-person subsystem. Children are often triangulated into parental subsystems and thus may show behavioral problems (Minuchin, 1974).

Another area of assessment includes boundaries. Boundaries are invisible lines that define familial subsystems (e.g., children, parents) and patterns of interaction (Minuchin, 1974). There are several types of boundaries. With diffuse boundaries, family members become overinvolved with each other's problems. In this case, the youth with the SIB and the parents might be overly involved in each other's lives. Conversely, families with rigid boundaries support independence and disengagement. From this perspective, parents might assert that they do not want to be involved with their child's SIB. Flexibility is required to respond to the complex needs of intervention. Changing one person's behaviors has an effect on the others (Goldenberg & Goldenberg, 1996). In addition to assessing family structure and functioning, it is important to assess individual family members' reactions. Following Shneidman's (1981) postvention principles, it is important to assess individual family members' coping strategies and resolution of the crisis and their reactions and emotions. It has been suggested that there are three pivotal issues related to resolution: (a) initially confronting and dealing with one's emotions, (b) communicating these feelings and emotions to others in hope of gaining understanding, and (c) adapting to a new and changed environment (LaGrand, 1985).

It is important to ask each family member how the issues affect him or her and the role he or she sees himself or her-self playing (Crethar, Snow, & Carlson, 2004). This assessment may alter the type of education provided and direct additional treatment and services. The emotional responses of family members may include shock, horror, frustration, blame, fear, or guilt. Thus, in postvention, a counselor needs to assess each family member's reaction to the SIB. Conversely, a family whose child is a recurrent self-injurer may eventually turn numb or express frustration at "having tried everything" and "having been through this before." Again, it is important to assess the ability of the family to respond to the youth and to meet his or her needs.

An important aspect of SIB postvention is to keep lines of communication open and ensure communication does not impede the well-being of the client. This includes communication between family members and from family members to the self-injuring youth. It is imperative that the youth not be isolated from the rest of the family because of his or her fear or shock of the behavior and dread of an interaction spurring on an occurrence of SIB. In addition, it is important that emotions be discussed and lines of communication remain open so that family members are aware of the youth's feelings, reactions, and reasons for SIB. Open communication may also assist in decreasing the parents' need for control or constant supervision of the youth.

Once the SIB is known in a family, dynamics of the system may change. There may be challenges to relationships within the family system or shifts in communication styles, and family dynamics and interactions can change related to the crisis and the postvention. In fact, Pehrsson and Boylan (2004) postulated that after a

crisis, the challenge of family is to reorder relationships with the person and in the family overall. A counselor should use assessment skills (e.g., completing a genogram, family sculpt, or another form of structural assessment) to discuss and address these ongoing changes in the system and structure of the family. Some of the changes may be healthy, whereas others may be more maladaptive. For example, it has been suggested that attempts to help the client may be thwarted by the parents to maintain homeostasis in the family (Podovoll, 1969, cited in Suyemoto & MacDonald, 1995). However, once the changes in the family system are known, a counselor can use that information to determine how to intervene, work with the family, or understand the referrals and resources the family currently needs.

Support, Referrals, and Resources

Similar to any crisis situation, finding out that your child self-injures can be disconcerting and may throw your family into upheaval. Campbell et al. (2004) have suggested that a significant goal of postvention is to let the family members know that they are not alone, to provide emotional and tangible (in the form of referrals and resources) support, and to instill hope.

When some form of dysfunction exists in a family system, the members may be prone to using poor or unhealthy coping techniques when faced with a crisis (Reiss, 1981). Even though they may initially refuse a personal counseling referral, it is important that family counselors provide one and continue to assess the situation to meet the family's needs. It has been indicated that trauma work is complex and that postvention efforts need to be multifaceted (Leenaars & Wenckstern, 1998; Shneidman, 1981). These concepts can clearly apply to family work with self-injury. Different families and different family members may respond best to various forms of intervention and treatment. When appropriate, individual and group counseling and support groups should be investigated for families as a whole and for individual members. It is also recommended that counselors seek consultation with peers, supervisors, and other key resources in their community regarding the treatment of self-injury and additional referrals.

Finally, given that some known correlates of SIB involve challenges and dysfunction experienced in families, counselors must consider whether or not working with the family is warranted. For example, the youth may express a fear of his or her parents finding out about his or her self-injury. This fear may be based in reality (e.g., a parent is physically abusive and tends to retaliate when angered) or not (e.g., many children express apprehension at telling parents uncomfortable or unexpected news), and the counselor needs to make a thorough assessment of the risk factors. Legally, when working with minors, the client is the parent, but ethically, the client is the youth (Lawrence & Kurpius, 2000). Thus, a counselor needs to keep in mind that a thorough assessment to determine if referral to child protective services may be warranted, depending on the situation.

CONCLUSION

There is a paucity of information pertaining to working with families of clients who self-injure. However, with the knowledge and prevalence of SIB increasing, more and more families are dealing with this traumatizing behavior. To assist families, counselors should provide active postvention, which may decrease the negative reactions and impact SIB may have on a client and his or her family.

The authors described three main areas an active SIB postvention model should entail: (a) information and education; (b) family assessment; and (c) support, referrals, and resources. These three areas were derived from the eight principles discussed by Shneidman (1981). A SIB postvention program should be active, thus providing the family with education, information, and resources immediately made available as soon as possible after the family finds out about the youth's SIB and should assist in the assessment of reactions, feelings, communication patterns, family structure, and coping methods so that appropriate referrals and services can be provided. Counselors should also keep in mind that their first priority in postvention is the client with whom they are working. Thus, postvention efforts should contribute to the well-being of the client. With this in mind, the well-being of the family may be directly related to the well-being of the client.

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