The Role of Physical Educators as Allies for Students Who Self-injure

Julia L. Whisenhunt
Brent Heidorn

The topic of self-injury (SI) — referring to "direct and deliberate bodily harm in the absence of suicidal intent" (Nock, 2010, p. 339) and not for the purpose of body modification or adornment — is one with which educators are becoming increasingly familiar. For most people, purposefully injuring one's own body defies logic. However, for many people, particularly adolescents, SI serves as a powerful coping mechanism. Not surprisingly, people who self-injure experience heightened emotional distress (e.g., Armey, Crowther, & Miller, 2011; Brown & Kimball, 2013; Chapman & Dixon-Gordon, 2007) and are potentially at risk for suicide (Whitlock et al., 2013). Self-injury is relatively common, occurring in approximately 18% of the population (Muehlenkamp, Claes, Havertape, & Plener, 2012). It occurs more frequently among adolescents than adults, and it tends to emerge around the age of 13 or 14 (see Klonsky, Victor, & Saffer, 2014). As such, the question is not whether educators will work with students who self-injure, but rather whether those educators will be able to identify the signs and respond appropriately. Given their consistent contact with students and the trusting relationships they often build with students, educators are in a unique position to identify SI.

This is particularly true for physical educators, who have opportunities to engage with students in a different learning environment than traditional classroom teachers. Further, many physical educators are able to develop meaningful relationships with students in ways that extend beyond the typical hours of a school day through participation in extracurricular activities (i.e., athletic programs, running clubs). The potential for observation and, more importantly, identification and appropriate response may be greater for physical educators than for classroom teachers. In this way physical educators can serve as a lifeline to connect students who self-injure and who may be at risk for suicide with appropriate mental health services. The purposes of this article, then, are to review and highlight common indicators of SI, and to suggest appropriate ways for physical educators to respond to the signs of SI.

Understanding Self-injury

Although many questions still exist about how or why people initially begin self-injuring and the neurophysiological aspects of SI, researchers have provided a wealth of information to assist in understanding what SI involves and the functions it serves. Nonetheless, researchers, mental health practitioners, and educators are wise to remember that SI rarely fits into a single common mold; rather, students who self-injure often present differently and explain their experience with SI in varying ways. As such, all students who self-injure should be approached with sensitivity — in a way that is unassuming and that honors their individuality.

Who Self-injures?

Educators often want to know which students are most likely to self-injure, so that they can intentionally look for the warning signs in those who may be most at risk. Although there is some information on demographic risk factors for SI, the data on this topic is still emerging. For instance, SI was once thought to occur almost exclusively among females, but recent research indicates that there may be similar prevalence rates in males and females (e.g., Andover, Pepper, & Gibb, 2007; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007). Additionally, although it appears that rates of SI are higher among Caucasian youth (Wester & Trepal, 2015), some recent researchers have found high rates among Latino, multiracial (Wester & Trepal, 2015), and African American (Hankin & Abela, 2011) adolescents. However, the research consistently indicates an elevated risk among one group of students — adolescents who identify as lesbian, bisexual, gay, transsexual, queer or questioning (LGBTQ; Reisner, Biello, Perry, Gamarel, & Mimiaga, 2014).

What Does Self-injury Look Like?

The manifestation of SI is as diverse as the adolescents themselves. Students may self-injure on any part of the body, but it is common for them to injure in places that are easily hidden by clothing and accessories. There are many types of SI, but cutting and severely scratching or pinching the skin are the most common (Poland, 2008; Polk & Liss, 2009; Trepal & Wester, 2007; Whitlock, Eckenrode, & Silverman, 2006). Other types of SI may include burning, hitting, swallowing dangerous objects, and head banging (Trepal & Wester, 2007). Many people who self-injure use more than one method and/or may change methods over time. For some adolescents SI is very impulsive, whereas others harm themselves in a ritualistic way. Likewise, some adolescents may self-injure only occasionally, whereas others may engage in this behavior multiple times in one day. Research findings have indicated that people who self-injure repeatedly (Kakhnovets, Young, Purnell, Huebner, & Bishop, 2010; Wester, Ivers, Villalba, Trepal, & Henson, 2016) and those who use multiple methods of SI (Wester et al., 2016) are typically in elevated distress and may even be suicidal.

However, despite popular assumption, not all people who self-injure are suicidal. Approximately 60% of people who self-injure also experience suicidal thoughts and/or behaviors (Whitlock

Julia L. Whisenhunt is an associate professor in the Department of Communication Sciences and Professional Counseling, and Brent Heidorn (bheidorn@westga.edu) is a professor and associate dean for research and assessment, in the College of Education at the University of West Georgia in Carrollton, GA.

et al., 2013). The fact remains, though, that people who self-injure are in distress. It is possible that physical educators have a unique opportunity to identify these students, as the attire used for physical education classes is often different from what is worn in the classroom. In addition, while this may not always be the case, due to the nature of the physical activity environment, physical educators may observe students who are showing signs of distress that may be more easily concealed during classroom-based instruction. (Visit http://www.youthsuicidewarningsigns.org for a list of the common signs of suicide in adolescents. Although not all students who self-injure are also considering suicide, knowing the signs of distress can help physical educators identify those students who may be most in need of professional assistance.)

Why Do People Self-injure?

Although managing intense emotions, such as anger and anxiety, is the most common reason people self-injure (e.g., Klonsky, 2014; Klonsky & Muehlenkamp, 2007; Turner, Chapman, & Layden, 2012), five other functions of SI are established in the literature: (1) self-punishment, (2) anti-suicide, (3) feeling generation or anti-dissociation, (4) interpersonal influence and communication, and (5) sensation seeking. People who self-injure are often self-deprecating and unduly harsh on themselves. For seemingly obscure or illogical reasons, they may believe they deserve to suffer or should be punished. The *self-punishment* function of SI involves directing intense negative emotions or thoughts toward oneself in the form of physical punishment (Klonsky & Muehlenkamp, 2007; Turner et al., 2012). For some people who are in extreme distress, SI may be the way they continue to cope, rather than taking their life (see Klonsky, 2014). In this way SI may be *anti-suicidal* or life preserving. Others may feel disconnected from their own body (i.e., depersonalization) or disconnected from the world (i.e., dissociation), and SI helps them "stop feeling numb or dead" (Turner et al., 2012, p. 40). It may be the pain they feel or the sight of blood, but SI reminds them that they are alive. This *feeling generation/anti-dissociation* function of SI is common among people who have experienced trauma and those who suffer with depression.

Regrettably, much of the lay community assumes that SI is related to interpersonal manipulation. Admittedly, some people who self-injure do so as a means of *interpersonal influence or communication* (Turner et al., 2012), but this is not typically meant to be manipulative in nature. Rather, those who self-injure often experience alexithymia (i.e., difficulty identifying and describing emotions) and may struggle to express their pain to others. As such, they may use SI as a means of communicating their distress. As a general rule of thumb, even if the person is intentionally being manipulative, resorting to purposefully harming one's own body is an indicator of distress and warrants attention (Walsh, 2006). Finally, although not incredibly common, some people who self-injure may do so as a means of *sensation seeking* (Klonsky, 2014) or to feel positive, sometimes euphoric, emotions. An important consideration is that people who self-injure may do so because SI serves multiple functions for them, and those functions may change over time. Table 1 provides an overview of the common functions of SI established in the literature.

Although there is no known research that directly supports a relationship between SI and sports or physical education, adolescents' participation in these activities may contribute to SI in unique ways. Sports and physical education emphasize winning (Torres & Hager, 2007) and perfectionism (Humara, 1999), tend to be high stress (Humara, 1999), and involve highly competitive practices such as team tryouts and cuts (Seifried & Casey, 2012) and unsuccessful athletic attempts (Fields, Collins, & Comstock, 2010). Further, athletes may often experience marked rejection by peers and outright bullying (Fields et al., 2010). These elements can amplify any existing distress in adolescent athletes and, thereby, contribute to the exacerbation or development of harmful coping practices.

Identifying Self-injury

Although some adolescents who self-injure may do so for attention seeking or social reasons (e.g., social contagion), most people who self-injure are often very private about their SI and seek to hide their distress (Sweet & Whitlock, n.d.). This may also be true for eating disorders (e.g., anorexia nervosa and/or bulimia nervosa) and for students who are overweight or obese. Even so, there may be indicators of emotional distress that others can observe, such as social withdrawal or isolation, poor personal hygiene, diminished academic performance, poor attendance, critical self-talk, statements of hopelessness or helplessness, and increased anger and/or agitation. This list is certainly not all-inclusive, but it highlights some of the common signs of emotional distress in adolescents. Additionally, there are a number of common possible indicators of SI.

Sweet and Whitlock (n.d.) made several recommendations for identifying SI. First, students may have cuts, burns, or other injuries to the skin that they cannot explain, or for which their explanation is implausible. Second, others may find cutting instruments and rubber bands among the student's personal belongings. Third, the student may spend an inordinate amount of time alone, partic-

Table 1.
Six Common Functions of Self-injury

1. Emotion Regulation *Example:* "Self-injury is the only thing that calms me down when I'm angry or hurt."	**2. Self-Punishment** *Example:* "I self-injure when I get mad at myself or when I just can't stand myself."	**3. Anti-Suicide/To Sustain Life** *Example:* "Sometimes, I self-injure to help me keep from taking my own life. Self-injury works for me."
4. Feeling Generation/ Anti-Dissociation *Example:* "I self-injure to feel real again."	**5. Interpersonal Influence and Communication** *Example:* "I just want others to know how much pain I'm in. They don't get it."	**6. Sensation Seeking** *Example:* "When I self-injure, it feels good; it doesn't hurt, and I feel better."

Table 2.
Common Possible Indicators of Self-injury

- ✓ Having injuries to the skin that they cannot offer a plausible explanation for
- ✓ Often having cutting instruments and rubber bands among their personal belongings
- ✓ Spending an inordinate amount of time alone, particularly in the bedroom and/or bathroom
- ✓ Wearing clothing that is not appropriate for the weather or athletic activity
- ✓ Using bandages often
- ✓ Frequently wearing accessories that could disguise wounds
- ✓ Talking about friends who self-injure
- ✓ Refusing to participate in events or activities where others could see their exposed skin

ularly in his or her bedroom and/or bathroom. Fourth, the student may wear clothing that is not appropriate for the weather (Sweet & Whitlock, n.d.), such as long-sleeve shirts during the summer time. Fifth, students may use bandages often and/or frequently wear accessories that could disguise wounds, such as wristbands (Ernhout & Whitlock, n.d.). Sixth, students may talk about friends who self-injure (Ernhout & Whitlock, n.d.), and they may do so repeatedly. Finally, students may refuse to participate in events or activities where others could see their exposed skin. Table 2 provides a summary of the common possible indicators of SI.

Some of these possible indicators assume that students self-injure on exposed parts of the body, such as the arms and legs. However, as previously mentioned, people may injure any part of their body, and, as such, it can sometimes be difficult to see wound indicators. For that reason, it is advantageous to consider the signs of emotional distress. Likewise, it is important for teachers to remember that there are many other explanations for the above indicated signs, some of which could be directly linked to accidents that occur during physical activity. The onus is on physical educators to look beyond the typical signs of self-injury and to remain attuned to possible indicators of emotional distress. Even if the student is not self-injuring, when a student displays multiple possible indicators or significant single indicators, the likelihood is that the student is in distress and could benefit from appropriate intervention. Keen observation in a physical education or sport setting could contribute significantly to making a positive difference in a student's life.

Intervening

Talking with students about emotional distress is not something that educators should take lightly. Students often trust their teachers deeply and rely on them to be nonjudgmental. The very nature of SI, though, can be intimidating for educators. The number one thing to remember is this: *educators are not responsible for counseling their students on SI; rather, they are tasked with helping to identify students in distress and enlisting the school counselor's services.* And although physical educators already bear countless responsibilities, their support and intervention can make a life-changing difference for adolescents who self-injure. Indeed, the physical education environment can and should be a safe haven for students. Ideally, educators can facilitate a referral to the school counselor without talking about the specific issues with which the student is struggling. At times, though, educators may find themselves in a conversation with students about SI. When that happens, the following conversation tips may prove useful. Except where noted, these tips are adapted from Ernhout and Whitlock (n.d.).

1. The process begins before ever having a conversation with anyone about SI, by identifying one's own biases about SI and seeking educational resources and professional consultation to develop a nonjudgmental perspective about SI, or by identifying ways to avoid imposing one's biases about SI on others. When actually speaking with someone who self-injures, it is imperative that educators maintain a calm demeanor — both in body language and paralanguage — and make eye contact. If educators show signs of being uncomfortable with the topic or upset by the behavior, the student will likely shut down, minimize or deny any problems. Similarly, if educators are judgmental or shaming, the conversation will likely prove grossly unproductive. It is important to remember that people who self-injure often experience extreme self- and other-imposed shame. Facilitating a productive conversation about SI is important; therefore, it is imperative for the educator to use (or instill) a warm and trusting tone (Trujillo, 2015).

2. When actually broaching the topic of distress or SI, educators should be specific about their concerns and the reasons for those concerns, stating what they have noticed in a non-accusatory manner. Given that they do not need to know the details about the student's distress or even confirm that the student self-injures, educators may choose to talk with students using general language, rather than coercing the student to disclose details or label their distress. At times, students may want to talk directly about the SI with their teacher — someone they know and trust. When this happens, it is critical that educators do not try to convince the student to stop self-injuring or otherwise make the student feel guilty (Trujillo, 2015). Most people who self-injure do so to cope with intense and distressing emotions. Often, they have found that SI is the only effective means of managing their distress; other coping skills just do not work well for them. As such, it is typically ineffective, and can even elevate distress, for people to stop self-injuring prior to developing other coping skills. With that in mind, educators can respond to students' disclosures of SI by acknowledging their distress without condoning their self-harming.

3. Talking about emotional distress can be challenging for adolescents, particularly those who self-injure. It is best for educators to be mindful of this sensitivity and reduce the number of times adolescents are asked to disclose their internal pain. For that reason, when students talk about their distress or SI, educators can honor the courage it took to make those disclosures and affirm their willingness to help the student find appropriate support within the school. Educators can explain that support is available and either make a referral directly to the school counselor or walk with the student to the school counselor's office.

4. It is imperative that educators do not try to assume the role of counselor with their students and, instead, work to connect students with trained mental health professionals within the school. Although school counselors cannot disclose personal information about their students/clients, school counselors may be able to enlist educators as treatment allies — identifying ways in which educators can support students and facilitate their treatment. In this capacity educators can play a vital role in promoting their students' mental health.

Summary

By merit of the context of their interactions with students and the mentorship role many physical educators play, physical educators are in a unique position to identify the signs of self-injury or emotional distress in their students. Although physical educators should not attempt to counsel their students through SI or intense emotional distress, they are well equipped to serve as treatment allies for students. Through communicating in a genuine and caring manner, connecting students with the school counselor, and working to enforce treatment progress, physical educators can help students to get through challenging times. In this way physical educators can be a lifeline for students to receive appropriate care and support. Additionally, when considering SI, and in particular among adolescents who are at risk of suicide, the research suggests that physical activity may have a preventative effect on the potential triggers of SI (Biddle & Asare, 2011; Brehm, 2014). This further warrants the need for quality health, physical education, and physical activity opportunities for adolescents.

Table 3 provides additional resources to learn more about self-injury. Cornell University's Self-injury and Recovery Research and Resources website, for example, contains a wealth of helpful information for all people who wish to help students overcome self-injury.

Table 3.
Web Resources to Learn More about Self-injury

Cornell University's Self-Injury and Recovery Research and Resources website: http://www.selfinjury.bctr.cornell.edu/index.html
Youth Suicide Warning Signs website: http://www.youthsuicidewarningsigns.org/
The International Society for the Study of Self-Injury: http://itriples.org/
Signs of Self-Injury Prevention Program (peer training): http://shop.mentalhealthscreening.org/products/signs-of-self-injury-prevention-program

References

Andover, M. S., Pepper, C. M., & Gibb, B. E. (2007). Self-mutilation and coping strategies in a college sample. *Suicide & Life-threatening Behavior, 37*, 238–243.

Armey, M. F., Crowther, J. H., & Miller, I. W. (2011). Changes in ecological momentary assessment reported affect associated with episodes of nonsuicidal self-injury. *Behavior Therapy, 42*, 579–588. doi:10.1016/j.beth.2011.01.002

Biddle, S. J. H., & Asare, M. (2011). Physical activity and mental health in children and adolescents: A review of reviews. *British Journal of Sports Medicine, 45*, 886–895.

Brehm, B. A. (2014). *Psychology of health and fitness*. Philadelphia, PA: F.A. Davis.

Brown, T. B., & Kimball, T. (2013). Cutting to live: A phenomenology of self-harm. *Journal of Marital & Family Therapy, 39*, 195–208.

Chapman, A. L., & Dixon-Gordon, K. L. (2007). Emotional antecedents and consequences of deliberate self-harm and suicide attempts. *Suicide and Life-threatening Behavior, 5*, 543.

Ernhout, C., & Whitlock, J. (n.d.). *Bringing up self-injury with your clients*. Retrieved from www.selfinjury.bctr.cornell.edu/

Fields, S. K., Collins, C. L., & Comstock, R. D. (2010). Violence in youth sports: Hazing, brawling and foul play. *British Journal of Sports Medicine, 44*, 32–37.

Hankin, B. L., & Abela, J. R. Z. (2011). Nonsuicidal self-injury in adolescents: Prospective rates and risk factors in a 2 ½ year longitudinal study. *Psychiatry Research, 186*, 65–70. doi:10.1016/j.psychres.2010.07.056

Humara, M. (1999). The relationship between anxiety and performance: A cognitive-behavioral perspective. *Online Journal of Sport Psychology, 1*(2), 1–14.

Kakhnovets, R., Young, H. L., Purnell, A., L., Huebner, E., & Bishop, C. (2010). Self-reported experience of self-injurious behavior in college students. *Journal of Mental Health Counseling, 32*, 309–323.

Klonsky, E. D. (2014, September 12). *Non-suicidal self-injury: Description, motivations, and relationship to suicide* [webinar]. Retrieved from https://www.youtube.com/watch?feature=player_embedded&v=hjEEYL1gboY

Klonsky, D., & Muehlenkamp, J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology, 63*, 1045–1056. doi:10.1002/jclp.20412

Klonsky, E. D., Victor, S. E., & Saffer, B. Y. (2014). Nonsuicidal self-injury: What we know, and what we need to know. *Canadian Journal of Psychiatry, 59*, 565–568.

Lloyd-Richardson, E. E., Perrine, N., Dierker, L., & Kelley, M. L. (2007). Characteristics and functions of non-suicidal self-injury in a community sample of adolescents. *Psychological Medicine, 37*, 1183–1192. doi:10.1017/S003329170700027X

Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*, 10. doi:10.1186/1753-2000-6-10

Nock, M. K. (2010). Self-injury. *Annual Review of Clinical Psychology, 6*, 339–363. doi:10.1146/annurev.clinpsy.121208.131258

Poland, S. (2008, February). Self-injury: How to understand and help students who engage in this behavior. *District Administration, 44*, 56.

Polk, E., & Liss, M. (2009). Exploring the motivations behind self-injury. *Counseling Psychology Quarterly, 22*, 233–241.

Reisner, S. L., Biello, K., Perry, N. S., Gamarel, K. E., & Mimiaga, M. J. (2014). A compensatory model of risk and resilience applied to adolescent sexual orientation disparities in nonsuicidal self-injury and suicide attempts. *American Journal of Orthopsychiatry, 84*, 545–556. doi:10.1037/ort0000008

Seifried, C., & Casey, T. (2012). Managing the selection of highly competitive interscholastic sports teams: Recommendations from coaches on cutting players. *Journal of Sport Administration & Supervision, 4*, 79–96.

Sweet, M., & Whitlock, J. (n.d.). *Information for parents: What you need to know about self-injury*. Retrieved from www.selfinjury.bctr.cornell.edu/

Torres, C. R., & Hager, P. F. (2007). De-emphasizing competition in organized youth sport: Misdirected reforms and misled children. *Journal of the Philosophy of Sport, 34*, 194–210.

Trepal, H., & Wester, K. (2007). Self-injurious behaviors, diagnoses, and treatment methods: What mental health professionals are reporting. *Journal of Mental Health Counseling, 29*, 363–375.

Trujillo, N. P. (2015). Nonsuicidal self-injury: What physical and sport educators should know. *Strategies, 28*(6), 34–38.

Turner, B. J., Chapman, A. L., & Layden, B. M. (2012). Intrapersonal and interpersonal functions of nonsuicidal self-injury: Associations with emotional and social functioning. *Suicide and Life-Threatening Behavior, 42*, 36–55.

Walsh, B. W. (2006). *Treating self-injury: A practical guide*. New York, NY: Guilford.

Wester, K. L., Ivers, N., Villalba, J. A., Trepal, H. C., & Henson, R. (2016). The relationship between nonsuicidal self-injury and suicidal ideation. *Journal of Counseling and Development, 94*, 3–12. doi:10.1002/jcad.12057

Wester, K. L., & Trepal, H. C. (2015). Nonsuicidal self-injury: Exploring the connection among race, ethnic identity, and ethnic belonging. *Journal of College Student Development, 56*, 127–139. doi:10.1353/csd.2015.0013

Whitlock, J. L., Eckenrode, J. E., & Silverman, D. (2006). Self-injurious behavior in a college population. *Pediatrics, 117*, 1939–1948. doi:10.1542/peds.2005-2543

Whitlock, J., Muehlenkamp, J., Eckenrode, J., Purington, A., Baral Abrams, G., Barreira, P., & Kress, V. (2013). Nonsuicidal self-injury as a gateway to suicide in young adults. *Journal of Adolescent Health, 52*, 486–492. doi:10.1016/j.jadohealth.2012.09.010

World Health Organization. (2010). *Mental health: Strengthening our response. Fact Sheet Number 220*. Retrieved from www.who.int/mediacentre/factsheets/fs220/en/