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The Self-Destructive Behaviors of Adolescent Girls and Boys

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Senior Honors Thesis

Sociology Department

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Abstract

From a social constructionist perspective linked with a feminist standpoint, I examine three forms of adolescent self-destructive behaviors: eating disorders, self-mutilation and substance abuse. The social construction of adolescents' norms, values, and beliefs, as based upon their interactions with family, peers, and the media, helps explain these self-destructive actions. In addition to a comprehensive literature review, I interviewed five adults who work with adolescents in the state of Maine, and used these professionals' experiences and knowledge to support the current theories pertaining to these acts of self-harm. To better understand what drives some adolescents to harm their own bodies, I examined the sociocultural influences, personality traits, and the effects of gender on adolescent interactions and experiences.

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Introduction

Adolescent development – social, cognitive, emotional and physical – places youth at a high risk of self-destructive behaviors, especially eating disorders, self-mutilation, and substance abuse. Taking a social constructionist perspective coupled with a feminist standpoint, I examine how meanings in society are constructed and then further shaped by social interactions and relationships. Interactions between individuals are a crucial aspect of society and identity development; “Social interaction necessarily constituted the stuff of *group* life since it is only in interaction that a group has its being. In the human group, the most important form of interaction takes place on the symbolic level. Symbolic interaction is unique in that the participants respond to each other’s actions on the basis of the ‘meanings’ of those actions” (Blumer, 2004:37). Through relationships and experiences with others, individuals act towards their bodies based on the meanings derived from interactions and relationships. Using a feminist point of view, I analyze gender issues and stereotypes that harm both adolescent boys and girls. The current gender norms damage both boys and girls; girls often internalize their emotions while boys feel pressured to externalize them as both often lack healthy coping skills. This cultural opposition of masculine and feminine gender norms influences the forms of self-destructive acts. Adolescents’ experiences with their gender, relationships with their family, peers and the media helps explain self-destructive behaviors of this age cohort, as they act towards their bodies in ways derived from the meanings shaped by their social interactions.

The following paper details and examines the patterns of self-destructive behaviors among adolescents. In the introduction I develop the major themes and topics; in the first chapter I examine eating disorders; in the second chapter I focus on self-

mutilation, and in the last chapter I concentrate on substance abuse. In the conclusion I examine the counseling services, resources and support, or lack thereof, available in schools and the community to help address and decrease these acts. Each chapter follows a similar layout: I analyze the destructive act, its functions, predisposing personality traits, and the influences of gender, family, peers, the media, and education systems. In addition to an extensive review of literature, I draw on original empirical studies. I interviewed five professionals who work with adolescents and use their experiences and insights to support my consideration of the current literature and theories.

All of the adults whom I interviewed work in the State of Maine, and each has extensive experiences dealing with self-destructing adolescents. Cassie Smith works as a counselor at a small private boarding school in central Maine. Emily Davis is a nurse at another small private boarding school, in addition to working at the emergency rooms of Central Maine Medical Center (CMMC) and St. Mary's hospital. Kimberly Wagner acts as the school nurse for a middle school of about 600 students. Courtney Anderson is a social worker for the same private school as Emily Davis, and works at a public school. Stephanie Joseph is a guidance counselor at a larger public school of about 1250 students. All of these professional women have dealt extensively with adolescents who suffer from eating disorders, self-mutilation and substance abuse. They kindly shared their time and personal accounts with me.

The adolescent years, commonly associated with the ages of ten to nineteen, although these numbers may vary, marks the transition from child to adult. The term adolescent comes from the Latin word *adolescere* which means to grow into maturity (Steinberg, 1995:246). During this time, individuals experience extensive emotional,

physical, social, and cognitive development. The term adolescent is itself a social construct and the meanings of this developmental period have changed over time. For this paper I am not differentiating between the phases of adolescence, early middle and late, but rather group this time period together. The adolescent years are the transformation from the dependence of childhood to the full responsibilities of adulthood, placing them at a higher risk for developing self-destructive behaviors as they enter a new lifestyle in which they might not be prepared. School counselor Smith (2008) explains that “what places adolescents at risk more is that they have fewer coping skills because they have not had as many life experiences and that they also are at a very pivotal developmental time. So they have a lot of stuff coming at them, physiologically, psychologically, sexually, emotionally, academically and that is on a good day...”

When children reaches adolescence, much of his or her focus is on how their own bodies and actions stand in relation to others, and how others, in turn, perceive them. This intense reflection on the self can influence adolescents to focus on any assumed inadequacies and failures. “Many teens do not perceive themselves as meeting social standards of attractiveness, popularity, athleticism, and the like. Many do not even feel capable of managing their own impulses... Few escape without experiencing some feelings of anger at themselves for perceived inadequacies, and still others become consumed by self-criticism and self-loathing” (Plante, 2007:53). Adolescents often feel inadequate compared to those they observe in the media, or even amongst their own friends causing them to struggle with low self-esteem. School nurse Wagner (2008) notes that, “they are at such a vulnerable age... They are going through major changes in their lives, hormonally, they are growing, they are looking for their niche a lot them... It’s

very stressful.” Often when adolescents feel that they cannot meet the current social standards of beauty or perfection, they turn their anger and frustrations onto their own bodies, developing eating disorders, self-mutilation, or substance abuse.

In addition to the adolescent years being marked by puberty and bodily changes, individuals also change in the social arena. Adolescents often struggle trying to find their new place in society and meet new social expectations. For example, teachers typically have higher standards for adolescents in both their learning projections and the amount of work they are expected to complete outside of class time. Adolescents often spend less time with their families and more with their friends, as peer groups have an added importance to social interactions. Social worker Anderson (2008) argues that adolescents are at high risk for developing self-destructive behaviors due to the, “stage of life where they are at, pulling away from their parents, rebelling, taking risks, trying to figure out who they are, who they are going to be and also trying to fit in with friends as they get closer to their peers.” All of these changes in their lives and social relationships result in adolescents having a variety of new expectations being placed on them in accordance to the range of situations in which they find themselves.

Many adolescents suddenly find themselves struggling to live up to external or even internal demands as their expectations expand and change, and some become overwhelmed, turning their emotions and anger towards themselves. School counselor Joseph (2008) explains that participating in self-destructive behaviors often “has to do with the stress of being a teenager... your weight, how you look, how you dress, what’s cool, what’s not cool, whether or not you are fitting in...” Adolescents struggle trying to deal with their daily stresses and in maintaining an image of perfection. Rather than

disrupting this image of excellence, some adolescents do not discuss their struggles or emotional anxieties. Adolescents often, “hide and conceal from others the moods and feelings that are stirred up during puberty. Here, the defenses are seen as offering a protective cocoon, shielding an internal process from impingement by the external world: defense as a kind of brooding” (Frankel, 1998:35). Lacking a safe way to release their emotions, some adolescents will turn towards their own bodies and self-mutilate, develop an eating disorder or substance abuse problems. During adolescence, when individuals become more independent and self-sufficient, many adolescents will internalize or externalize their problems and try to take care of them on their own through acts of self-harm.

In addition to struggling with aspects of their new development, adolescents lack refined coping skills and maturity. Adolescent brains are still developing as complete brain development does not occur until around the mid 20’s. This means adolescents are limited in their ability to make complex decisions and exert impulse control. “Impulse control, planning and decision-making are largely frontal cortex functions (in the brain) that are still maturing during adolescence....one reason adolescents may have difficulty inhibiting inappropriate impulses is that the circuitry needed for such control is not fully mature in early adolescence, thereby making such tasks relatively difficult” (Weinberger, et al, 2005:2). The frontal cortex, the outer layer of the brain, deals with abstract information, crucial for learning and understanding norms of social conduct. Social worker Anderson (2008) explains the struggles of adolescents: “It is the developmental stage, with the developing brains and their lack of experiences, but it definitely has something to do with their brains.” At a time when society is encouraging independence

of adolescents, they are left with insufficient brain development to properly handle their actions, emotions and to care for their bodies.

Gender mediates everyday experiences and interactions. Notions of masculinity and femininity are cultural constructs which have come to be internalized in notions of the self. Gender carries a symbolic meaning that influences the interpretation and assessment of one's social role, as well as being a structural reality shaping a person's situation and opportunities. "Gender, a socially constructed concept, is governed by multiple sets of socially shared beliefs, meanings, and dominant norms, also called political institutions" (Piran and Cormier, 2005:549). Individuals become gendered through the learned social contexts of meanings about masculinity and femininity. As boys and girls develop contrasting meanings surrounding their development into mature social roles, acts of self-destructive behavior become gendered. Boys and girls experience eating disorders, self-mutilation, and substance abuse differently due to their internalized social assumptions, the enacted performance of their gender, and their social position.

Adolescents make sense of their embodied experiences based upon their gendered socialization. Through social interactions individuals learn the shared norms, values, and beliefs of their culture. A sense of self and subjectivity is not achieved in isolation, but, rather, depends upon relationships with others. Interactions influence the creation and perpetuation of meanings, which, in turn, affect actions and behaviors. "One proposal of interactional theory that applies to social-network dynamics is the idea that individuals who directly interact necessarily have an impact on the behavioral actions and states of each other" (Cairns et al, 1995:43). Interactions may shape mutual, similar, or different meanings as individuals may maintain, adjust, or transform their own actions and beliefs

based upon that relationship. Adolescents often develop their own meanings surrounding their bodies based upon social relationships and learn to evaluate their bodies based upon such definitions. Nurse Davis (2008) explains that the biggest problem she sees with adolescent self-destructive acts is, “peer pressure and the families.” Family and peer group interactions along with the influences of the media may modify or reinforce adolescents’ beliefs and systems of meanings.

Growing up, adolescents learn their basic set of meanings from their families. Parents transmit their own system of norms and values through the upbringing of their children. “Children learn who they are by studying the adults around them, and the family is a child’s first interpreter of the larger world” (Hesse-Biber, 2007:160). Primary socialization occurs during childhood when individuals learn their appropriate social expectations and actions from the adults with whom they interact. Children do not choose their parents, and hence do not pick their initial form of socialization and imparted meanings. As children begin to mature into adolescents, they gain more liberation from their family and often start spending more time with their friends. Nurse Wagner (2008) explains the added influence of peer groups on adolescents, “once they hit middle school... their parents think they are old enough, are starting to give them a lot of responsibilities like they are all grown up but they are just 12. So you know to have a lot of unsupervised time, for some of them it’s not so good...” As parents often give adolescents more independence and time to spend with their friends, peers may bring new perspectives to their interactions with each other, based upon their own upbringing and value systems instilled in them. “Secondary socialization is any subsequent process that inducts an already socialized individual into new sectors of the objective world of his

society” (Berger and Luckman, 1966:130). Interactions with peers allows for adolescents to broaden and even potentially change their system of meanings and values as they interact with and learn from others who often have slightly different beliefs and understandings than their own. “Groups are composed of individuals who after all, bring with them to their participation in cooperative activity a body of symbolization derived from their other memberships” (Strauss, 1959:237). Family and peer interactions do not stand alone in creating bodily meanings, rather the media acts as another influential source in how adolescents act towards their bodies.

Immersed in a consumer culture, adolescents find themselves surrounded by media on a daily basis. Ranging from television, radios, magazines, the internet, billboards, and brand names, the media play a crucial role in the development of adolescents. “The average American is exposed to at least three thousand ads every day and will spend three years of his or her life watching television commercials. Advertising makes up about 70 percent of our newspapers and 40 percent of our mail. Of course, we don’t pay direct attention to very many of these ads, but we are powerfully influenced, mostly on an unconscious level” (Kilbourne, 1999:58-59). The media often transmit subliminal messages, and we unconsciously internalize such ideas. The media play a role in the development of self-destructive behaviors through not only perpetuating and reproducing gender norms but also through its images and messages.

The current social norms and definitions surrounding not only adolescence but also the body have contributed to an increase in eating disorders, self-mutilation and substance abuse in adolescent girls and boys. The current social pressures placed on adolescents coupled with a dearth of healthy coping skills and support leaves many

adolescents struggling to deal with their emotions on their own and some may then turn to self-destructive behaviors. Once adolescents develop an eating disorder, start self-mutilating, or using substances, the acts become addictive and hard to terminate. As social worker Anderson (2008) explains these acts “are all really tough behaviors to stop.” The problem challenging us as caring adults is how to help prevent adolescents from engaging in such actions in the first place. Only with greater social knowledge about and awareness of self-destructive actions, can we hope that all adolescents will care for and respect their bodies and not resort to eating disorders, self-mutilation, or substance abuse.

Chapter One
Eating Disorders

Introduction: Adolescents and Eating Disorders

The development of eating disorders in adolescent boys and girls mostly stems from their sociocultural experiences and gendered norms. The family, peer groups, and media act as the major socializing forces that increase the likelihood of anorexia and bulimia. Adolescents often develop eating disorders at a very young age as emergency room nurse Davis (2008) has seen nine year olds come in with eating problems. As adolescents are at a major physical developmental stage, eating disorders become problematic when they deprive bodies of the proper food and nutrients, harming not only adolescents' present but also future health. "Successful treatment of this (young) age group requires an understanding of the normative psychological and social factors that define this stage of development" (Kirsh et. al, 2007:351). To understand how to solve and treat the problem of eating disorders, we must first comprehend the social and cultural forces that contribute to shaping the everyday life experiences of adolescent girls and boys. By examining how meanings surrounding the body are constructed, by whom, and what the consequences of such definitions are, we can better understand what makes some adolescents more susceptible to forming eating disorders than others.

The exact number of adolescents with anorexia or bulimia is hard to determine as many individuals try to keep their abnormal eating patterns a secret. "One in every 100 females between 10 and 20 suffers from anorexia nervosa.... Bulimia is thought to be 4-5 times more common than anorexia, but is more difficult to detect, since... (there) is often nothing about their external appearance to alert anyone to the presence of the disorder...." (Hesse-Biber, 2007:153). While these figures are often developed on the basis of clinical reports, and may not represent all adolescents, bulimia is thought to be

more prevalent than anorexia. Females are also ten times more likely than males to have an eating disorder (Costin, 1997:26; Hesse-Biber, 2007:152). Yet these statistics only measure the individuals with symptoms of a diagnosed psychological disorder, and do not include those with diets and disorders that go undetected. School nurse Wagner (2008) describes how many adolescents' eating disorders go overlooked even in her own school; "I think a lot of it is out there but people just don't know about it because I don't. I don't see very much of it and I am sure it's there at my school but it is not called to my attention.... I just think it is something that seems to be going on and not talked a lot about." Many adolescents, who suffer from eating disorders, often do so silently, undetected by their school or families. Even for the adolescents who do not develop official eating disorders, many diet and worry about their body image. School counselor Smith (2008) explains the high numbers of students who struggle with their eating habits, "dieting is everyone's favorite hobby. And so they're dieting and wonder why you are making such a big deal out of it and then when you point out the degree to which they are restricting calories is unhealthy, well then they will argue that this is just a matter of opinion because everyone is doing this." With the social emphasis placed on thinness and the need to diet, many adolescents develop eating disorders.

While eating disorders once seemed limited to upper/middle class white females, (Hesse-Biber, 2007) that is no longer the case today; adolescents of all races, classes and both genders may struggle with their body image and presentation. "Body dissatisfaction, fear of weight gain, appearance concerns, weight and shape concerns... among adolescents are associated with increased risk for eating disorders.... recent studies suggest that substantial proportions of most ethnic groups and both genders are engaged

in sometimes excessive weight control behaviors” (Lynch, et. al, 2007:179). Many adolescents seem to struggle with their external appearances, and such issues become manifested in the choices they make about the food they put into their bodies. By having society connect thinness with beauty, perpetual diets, and calorie counting, eating disorders seem to be almost encouraged.

Anorexia Nervosa and Bulimia Nervosa

Anorexia nervosa and bulimia nervosa, the two main forms of eating disorders, focus upon the consumption or abstinence of food, respectively. While food itself is the object of tension, it is the meaning of food that becomes problematic for individuals with eating disorders. “(I)t is the attitude regarding the food, the connotations the food has, and the relationship with food – not the food itself that is the problem” (Costin, 1997:xvi). Some individuals look to food as comfort, some view it in fearful terms as the enemy against their body, and some see food simply as sustenance for hunger. Adolescents are socialized to value and view food differently depending on their upbringing and experiences which then determines the likelihood they will develop anorexia or bulimia.

Anorexia nervosa is the condition in which individuals severely alter their eating habits in attempts to lose weight or prevent further weight gain. Anorexia is driven by an intense fear of gaining weight. According to the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV), there are four aspects of the criteria for anorexia: a refusal to maintain weight above what is minimally normal for one’s age and height (when one is less than 85% of that expected); an extreme fear of weight gain; distorted body image/ excessive emphasis on weight as self-evaluation/ denial of severity; and finally in females, having amenorrhea (missing at least three consecutive menstrual

cycles) (DSM-IV-TR, 2000:589). In addition to transforming one's body weight, anorexia also alters electrolytes, decreases bone growth and changes the neurotransmitters and hormones in the brain, (Gale Encyclopedia, 2003:61-2). There are two specific types of anorexia. The restricting type refers to minimizing and controlling the amount of food one intakes; the binge-eating/ purging type refers to regular episodes of binge eating and then purging behavior during the periods of anorexia (DSM-IV-TR, 2000:589). Individuals with anorexia restrict their eating intake to maintain a low body weight.

Bulimia nervosa is characterized by intense over-eating and then actions taken to purge the body of that food to counteract the intake. Similar to anorexia, individuals with bulimia excessively worry about their body shape and weight. The DSM-IV has five aspects of criteria for bulimia: recurrent episodes of binge eating (eating vast amount of foods in a limited time and feeling out of control when eating); recurrent counteracting behaviors to prevent weight gain (vomiting, laxatives, diuretics, enemas, fasting, or excessive exercise); the patterns of binge and compensatory actions must happen at least twice a week for three months; an undue emphasis of body weight on self-evaluation; and the disturbed feelings and actions must occur apart from any episodes of anorexia (DSM-IV-TR, 2000:594). The majority of bulimic individuals purge through self-induced vomiting, while others use laxatives, and a smaller portion use enemas (a bowel stimulant directly injected into the rectum) or diuretics (increases the excretion of water) (Gale Encyclopedia, 2003:156). There are two subsets of bulimia. The purging type eliminates the excessive amounts of food through purging methods while the non-purging type uses other compensatory actions such as fasting or exercise (DSM-IV-TR, 2000:594).

While bulimics tend to eat excessive amounts of food and then compensate with other actions to reduce weight gain, many individuals with anorexia often have similar binge-and purge episodes. “Self-induced starvation goes against normal bodily instincts and can rarely be maintained. This is one reason why so many anorexics ultimately end up binge eating and purging food to the point where approximately 50 percent develop bulimia nervosa” (Costin, 1997:7). Individuals with eating disorders may be anorexic, bulimic, or even a combination of the two behaviors. School counselor Smith (2008) explains how bulimics may go undetected unless, “somebody is vomiting on a regular basis, it is not as easily recognized.... The way they (many students) express their eating disorders is just by restriction of foods not necessarily purging and not necessarily binging but they severely restrict their diet.” While anorexic and bulimic individuals share the common traits of fearing weight gain and judging their self-worth by their body weight, their methods of restricting gaining weight differ. But, for the most part, their obsessive actions and traits are similar enough that they will not be further separated throughout this paper unless otherwise noted.

Factors Related to Eating Disorders: Personality and Gender

One’s personal meanings of food, experiences, and personality influence the course of disordered eating and eating disorders. Studies have indicated that certain types of characteristics seem to make some individuals more predisposed to developing eating disorders. “In general, those with anorexia nervosa have been characterized as reticent, introversive, constricted, obsessional, and compulsive, whereas those with bulimia nervosa have been characterized as relatively more social, impulsive, and affectively labile” (Pryor and Wiederman, 1998:293). Anorexic individuals appear to be more

emotionally reserved, highly ordered, and aware of their self-projection as they attempt to please others. Bulimic individuals present themselves as being open in demonstrating their emotions, less reserved, and more spontaneous. However, most adolescents with an eating disorder share the overall trait of perfectionism. Social worker Anderson (2008) explains that those with eating disorders have “a strong personality, more of a type A personality. I think they try to please everyone.” With their perfectionist tendencies, adolescents with eating disorders try to comply with the social norms surrounding their bodies. Nurse Davis (2008) elaborates on these flawlessness tendencies, “they are very tough on themselves. That is why they are so hard on themselves with the way that they look... it is just another stress for them, the pressures they put on themselves.” Adolescents who struggle with their eating often judge themselves harshly and expect to be perfect which includes having the ideal, meaning thin, body.

While anorexics and bulimics differ in some of their general personality traits, they share both a desire to be thin, and the dedication to achieve that goal. “They are extremely committed individuals and pride themselves on putting mind over matter, valuing self-discipline, self-sacrifice, and the ability to persevere. They are generally hard-working, task-oriented, high-achieving individuals who have a tendency to be dissatisfied with themselves as if nothing is ever good enough” (Costin, 1997:32). Bulimic and anorexic individuals appear highly sensitive to the social values of thinness and believe that if somehow they weighed less, their lives would be better. As these adolescents have to be tough on themselves to restrict their diets, they often are very driven individuals who set out to accomplish their goals without quitting. Both social worker Smith (2008) and guidance counselor Joseph (2008) describe such adolescents as

being “overachievers.” Individuals with eating disorders have a perfectionist personality type, where they dedicate themselves to accomplishing a goal, to “improve” their body.

In addition to having personality factors that place some adolescents at a higher risk for developing eating disorders, gender also plays a role. Gendered trends appear in eating disorders as gender is a major component of social identity and mediates interactions, relationships, and social responsibilities. A central part of gender focuses on the body, as the norms of physical appearances and actions differ between how adolescents interpret the meanings of being a boy or a girl. While masculinity has come to represent strength and power, femininity stands for thinness. Adolescents internalize those social norms of their gender which in turn influences their own distorted views of their bodies. “Regardless of ethnicity, boys consistently reported wanting to be larger more often than girls.... In all cases, females were significantly more dissatisfied with appearance, more concerned about weight and shape, and more engaged in risky eating behaviors than males” (Lynch, et. al, 2007:185). As adolescent boys often want a more masculine, and hence muscular body, not as many of them partake in eating disorders, which more girls do in hopes of having a more feminine and slight body figure.

Due to the sociocultural definitions of gender, adolescent boys and girls interpret and view their bodies in contrasting ways to comply with social norms, corresponding to the gendered rates of eating disorders. “(T)he female-to-male ratio of clinical eating disorders is about 9:1, and the ratio of subclinical levels is about 3:1” (Piran and Cormier, 2005:549). In the clinical setting, receiving treatment for a labeled psychological disorder, women outnumber men three times compared to the everyday setting. This demonstrates that girls either take their eating disorders to a more serious level or that boys simply do

not have as high rates of reporting them. The social norms and definitions surrounding the two genders influence the existence, participation in, or even acknowledgement of eating disorders.

Gendered traits appear not only in the numbers of eating disorders, but also in the demonstration of such disorders. Many adolescent boys discover that it is easier to be bulimic, rather than anorexic, for they can mask this version of disordered eating and still fulfill the social norms of masculinity. “An extremely interesting fact about male bulimics: they rarely binge alone. They tend to binge at mealtime and in public places, whereas women almost always eat minimally at meals and gorge later, in private” (Bordo, 1993:128). With their larger bodies, men traditionally eat more. Men bulimics can eat large amounts in public but then purge alone, where no one has to witness this form of gender deviance. Yet women bulimics often binge and purge alone, as notions of femininity consist of eating small amounts and watching their diets.

Even though body preoccupation has become an established part of conventional femininity and affects girls, many boys also struggle with their own body image. Such concerns boys face over their bodies are often muted in a patriarchal society where men yield the power and often feel pressured to hide any perceived weaknesses or anything that might threaten their projection of masculinity. Adolescent boys who admit to have an eating disorder face the risk of becoming feminized. “In this culture dieting, thinness, and obsession about appearance are predominantly feminine preoccupations...” (Costin, 1997:25). The norms of masculinity indicate that men can eat as much as they want and enjoy doing so, while women refrain from such over-indulgences. Adolescent boys who

limit their calorie intake and monitor their food, risk taking on the stereotypical traits of femininity.

Throughout history, the meanings of masculinity have centered on athletic participation and strong bodies, which can cause adolescent boys to struggle with their body image. Even today many men still feel the social need to gain accreditation through athletics and having “fit”, commonly defined as muscular bodies. With this emphasis on strong and athletic bodies, eating disorders in adolescent boys may risk becoming more prevalent. “While most men who are dissatisfied with their weight deal with it through exercise, there is evidence that others are taking to dieting” (Hesse-Biber, 2007:198). More adolescent boys are starting to diet in hopes of achieving a muscular, and not fat body. As recognized with girls, dieting often leads to disordered eating, and encourages eating disorders. Guidance counselor Joseph (2008) has found that, “more of the food issues with the boys are centered on sports.” Even though eating disorders have been seen as a female problem, this trend might be changing to being less gendered as boys too struggle with their body image even though they may be more reluctant to admit it.

For men, socially ideal bodies display muscles and strength, giving them an added challenge to be not only “solid” but also not “plump”. Adolescent boys are torn between wanting to gain weight and become stronger, and trying to lose weight and become less portly. “Research on body image in adolescent boys reveals that at any one time, between 20% to 50% of boys want to lose weight, while 20% to slightly over 50% are trying to ‘bulk up’” (Hesse-Biber, 2007:195). Adolescent boys have their own struggles with weight in regards to their desire to be muscular but not fat. Social worker Anderson (2008) explains the struggles boys face between trying to remain strong and lean. She is

currently working with a boy who has “a new eating disorder, the athletic one, obsessing about eating fewer and fewer foods because they want to be healthy, taking out carbs, taking out sweets. They read these muscle magazines about what you are supposed to eat and take out and then they end up not eating much at all. It is pretty bad obsessing about it and having serious body image problems, but they are trying to be healthy, going to work out and building muscles ... focusing on your diet and maybe taking supplements and protein drinks and those kind of multivitamin powdered drinks gets pretty obsessive I think for boys...” The current socialization for boys emphasizes athletics and having “fit” bodies defined as muscular but not fat. With such a focus on muscular and lean bodies, engagement in athletics can then encourage eating disorders in adolescent boys.

Participation and excellence in sports historically have allowed boys to gain respect from their peers and communities through their bodily actions, but at the expense of their individual personalities. “And although athletic masculinity symbolizes an image of physical health and sexual virility, athletes commonly develop alienated relationships with their bodies, learning to relate to them like machines, tools, or even weapons to be ‘used up’ to get a job done” (Dworkin and Messner, 1999:343). Reverence and admiration of popular athletes, mostly men, are not based upon their accomplishments of personality, but rather through their bodies. This can cause athletes to feel estranged and disconnected from their sense of self. In sports, bodies are seen as a means to an end when athletes train to become the best competitors possible. Sports therefore can influence boys to become alienated due to the separation of their bodies with their personalities. “This preoccupation with physicality meant that men’s bodies carried a different sort of weight than earlier. The body did not *contain* the man, expressing the

man within; now, that body *was* the man” (Kimmel, 2006:86). Several sports, in particular wrestling, directly center on weight and body. Nurse Wagner (2008) has noticed that the boys she has seen with eating disorders often are wrestlers who “have to meet a certain weight level, like they think they can be more competitive at a lower weight level. So they’ll go for days, they’ll try not to eat like you know if they have a meet, a wrestling meet, they’ll try to really get down to that lower weight class.” Athletes become heroes through the original accomplishments of their bodies viewed as strong and lean, and not through their personalities. This can lead to a risk of having their bodies objectified through sports.

While eating disorders often stem from athletics in boys, they occur at a higher rate among girls than boys due to the dominant social gender norms that promote a thin female figure as beautiful and the belief that girls care more about their bodies. This self-fulfilling prophecy almost encourages eating disorders in adolescent girls when social pressures indicate that they should be concerned with the presentation of their body. From their study on young women and body image, Piran and Cormier found that, “at any point in time about 40%- 45% of girls and young women are trying to lose weight through various means motivated by ‘normative’ body dissatisfaction” (2005:549). Approximately half of all adolescent girls are attempting to lose weight and many of those who are not actively dieting still face problems with their body image. The majority of women, around 95 percent, report being disgusted or disappointed with their bodies (Costin, 1997:45). The cultural meanings surrounding women’s bodies in contemporary society influences many individuals to view their figure in negative terms, believing that they must alter their bodies to be beautiful.

The meanings and norms of femininity become problematic for adolescent girls when social norms place an emphasis on appearances, and judge individuals based upon their looks. “(F)emale bodies have historically been significantly more vulnerable than male bodies to extremes in both forms of cultural manipulation of the body. Perhaps this has something to do with the fact that women, besides *having* bodies, are also *associated* with the body, which has always been considered woman’s ‘sphere’ in family life, in mythology, in scientific, philosophical, and religious ideology” (Bordo, 1993:143). Women often feel the demands to present their bodies in culturally pleasing ways. Such social pressure to achieve the “perfect” body, commonly understood to be thin and, hence, beautiful, encourages adolescent girls to diet. “Our desires to be thin, attractive, and sexually desirable and the meanings of these desires (happiness, approval, acceptance, heterosexual romance/bliss and so on) are powerfully shaped by the norm of physical appearance for women” (Blood, 2005:115). Contemporary society has come to define being thin with success and contentment, influencing many adolescent girls to believe that if they are thin, then they can accomplish all of their life goals. Nurse Davis (2008) has found that the social pressures to be thin and diet harms adolescents: “Some of these girls that I have seen are just starving, nothing left to them. I mean they probably were gorgeous girls but I think because they feel like they need to be what is expected of them...” Social expectations can influence adolescents to comply with stereotypical norms. The act of being female places adolescent girls at a higher risk for developing an eating disorder due to the dominant and socially recognized meanings of femininity that emphasize thinness.

In our current gendered society, many girls, consciously or unconsciously, learn compliance with male dominance. Through patriarchal power, men historically have influenced the creation of social meanings and shaped the notions of femininity. “Influenced by patriarchal institutions, from the conventional family to schools to the media, girls as young as 7 and 8 years old learn that the rewards of our society go to those who conform, not simply on the level of overt behavior, but on the level of biology” (Hesse-Biber, 2007:3). From a young age, many adolescent girls learn to conform to gendered ways and meanings, and do this not only with their actions, but also with their appearances. “In the end, our conception of our role becomes second nature and an integral part of our personality” (Goffman, 1973:249). Individuals internalize their perceived social role until it becomes second nature for them, and they no longer have to think to act out their social obligations, rather it becomes natural. Davis (2008) has observed that girls with eating disorders often have, “somewhat of a low self-esteem....” Low self-esteem robs adolescents of a strong sense of autonomy, making adolescents more likely to follow social gender norms rather than acting and thinking independently to create their own versions of beauty.

Adolescents internalize their role and social status in a patriarchal society and act accordingly. As complete gender equality has not yet happened, many young girls and women still feel subordinated and repressed. “It may be that women who are out of control in other domains of their lives try to achieve control through practices such as surveillance and restricted eating...” (McKinley and Hyde, 1996:210). Adolescent girls may internalize the dominant forms of patriarchy that still exist today, and in doing so struggle with their concepts and meanings of personal power. Feeling restricted and

limited, some adolescent girls may take a form of perceived control over their lives by monitoring the one thing they think they can command, their eating. Gender roles encourage eating disorders in different ways for boys and girls due to gender socialization.

Objectification theory is another attempt at explaining the gendered trends of eating disorders that prevail in a patriarchal society. The meanings shaped around women's bodies have commonly deprived women of their own subjectivity and agency as society has come to view these bodies simply as biological objects rather than individuals. "(O)bjectification theory... has examined the social discourse that constructs women's bodies as objects to be gazed at and its adverse impact on women's self and body experiences" (Piran and Cormier, 2005:549). Meanings of objects, and hence the understanding of one's body, are social products. In viewing their bodies as objects, adolescents have formed narrow meanings surrounding their own bodies, and how they should appear.

The female body is often constructed as an external object, one that should mold to the social patriarchal standards of beauty and satisfy the desires of the *male gaze*. "The central tenet of (objectified body consciousness) is that the feminine body is constructed as an object of male desire and so exists to receive the gaze of the male 'other.' Constant self-surveillance, seeing themselves as others see them, is necessary to ensure that women comply with cultural body standards and avoid negative judgments" (McKinley and Hyde, 1996:183). Many adolescent girls take upon that view of an outsider looking at and judging their own bodies, scrutinizing every bulge and curve from an external position. "The individual thus makes an object of himself or herself and by doing so,

acquires an ability to act toward himself or herself as with regard to anything else that becomes an object for the individual” (Blumer, 2004:58). By viewing their bodies as objects, the body takes on a meaning separate from one’s identity. Objectification influences adolescent girls to struggle with their body image as many try to configure their body to satisfy the perceived gaze of others, and to comply with social norms of femininity. Objectification also occurs with boys to a lesser degree through athletics, but in this context bodies are not seen as objects of pleasure to be gazed at but rather objects of use that perform for others.

Cultural and Social Influences

Even though gender acts as one of the major mediating factors that contribute to the likelihood that one will suffer from eating disorders, gendered meanings do not stand independently. Rather the family, peer groups and media all play a role in creating values and meanings not only of gender but also the body. Some families may place a high emphasis on body image, complying with society’s values of thinness, while other parents may modify the social importance of being thin to raise their children with a larger emphasis placed on actions rather than looks. Social values are filtered through interactions, experiences, and relationships within one’s family. Body image is formed through interactions as social groups help shape the importance of body size for adolescents. “(T)he family operates as a formidable influence on identity, contributing to the development of the self and the formation of self-image. The extent to which the family transmits cultural messages about thinness and body shape, and the manner in which the family conveys these messages about thinness and body shape, are crucial to understanding... the production of body image” (Haworth-Hoepfner, 2000:213). By

mediating cultural messages, parents or guardians highly influence one's identity and development of social understandings. School counselor Smith (2008) has found that, "for some kids they have gotten a real pressure from home to be a certain body type, lose weight, gain weight, watch what you eat." Parents may sway the development of eating disorders by the emphasis they place on body image and how they raise their children to regard their figures, as parents play a major role in the original formation of meanings for adolescents.

As individuals with anorexia and bulimia typically share a similar set of personality traits, their families do as well. Adolescents with eating disorders often come from critical family atmospheres where they have internalized a set of meanings that place a high emphasis on the body and perfectionist ways. In their study on women and body image, Hawthorn- Hoepfner found that women with anorexia or bulimia often come from "family environments in which perfection, control, and enmeshment are the norms and in which issues of weight and appearance are prominent" (2000:214). Parents who have coercive control over their children, and hold high values of being thin and impeccable are more likely to have children with eating problems. These family traits influence the development of personality characteristics of being reticent, obsessive, and compulsive that many adolescents with eating disorders display. Social worker Anderson (2008) has found that when people have difficulties in their lives, "they act it out with their eating. I don't necessarily think it has to be a divorced family but a more broken family..." The conduct of adolescents with eating disorders may reflect a troubled background with unsupportive or highly pressuring parents. Adolescents with eating

disorders often gain their drive for perfection and desire to please others through their experiences in the family.

Mothers play a role in the development of eating disorders, especially with adolescent girls who closely monitor their mother's actions and often model their own values after maternal figures. Girls learn about the construction of femininity, especially in regards to maternal values, from their mothers. In contemporary society, one of the connotations of motherhood requires the ideal mother to deny her own needs in place of that of her children. "The rules for the construction of femininity... require that women learn to feed others, not the self, and to construe any desires for self-nurturance and self-feeding as greedy and excessive. Thus, women must develop a totally other-oriented emotional economy" (Bordo, 1993:171). The commonly understood meaning and experience of a mother involves one who feeds and cares for her family before herself, always placing the interests of others above her own. Adolescent girls observe and witness their mothers making sacrifices for the family and learn to reproduce such denials of the self, including in regard to food. The cultural notions of motherhood can place adolescent girls at a higher risk for developing eating disorders when they internalize the message that a mother, hence a woman, is supposed to feed others before herself.

Many women feel the pressures to succeed in the workplace yet still raise a family, be fit, and be able to do everything, demands that adolescent girls internalize as well. Nurse Davis (2008) has found that coming from a family of, "high achievers or whatever can lead to them (adolescents) doing well in all areas and being tough on themselves." When girls see their mothers balancing a career and a family, they learn that they too must try to satisfy everyone's expectations. Conventional norms of motherhood may not

only deprive girls of the ability to self-care, but also cause them to internalize the message to not over-indulge by placing the need of others before her own.

While mothers play a crucial role in constructing notions of femininity, weight-consciousness and restricted eating patterns in adolescent girls, other members of the family also can influence the development of eating disorders. Fathers and siblings also account for the transmittance of their meanings through interactions. Adolescents with eating disorders often report coming from families with distant or strict fathers, as Hawthorn-Hoepfner determined from her studies. “Fathers...are reported to be either authoritative and strict or distant and uninvolved... also been linked to incidents of child abuse and battering” (2000:214). Many adolescents who struggle with their eating view their fathers as controlling and absent in their lives. In hopes of gaining attention and recognition from their father, some adolescents may try to mold their bodies to fit the social norm. Some individuals with eating disorders have been abused, either sexually, physically, or emotionally, at some point in their lives influencing them to treat their bodies in harmful ways.

Siblings also may influence the development of an eating disorder. “Eating disordered women tended to have sisters closer to them in age with whom they often developed a distant, conflictual, and rivalrous relationship... The sister who was diagnosed as anorectic... expressed conflict and jealousy toward her nonanorectic sister, and in fact had fewer friends and boyfriends than her non-eating disordered sister” (Hesse-Biber, 2007:168). Adolescent girls with eating disorders are likely to have a sister, with the sibling relationship dominated by rivalry. This makes sense that some adolescents may develop an eating disorder in an attempt to become thin, believing that

they will be more valued and acknowledged if they weigh less, as sisters often compete. Nurse Davis (2008) describes the relationship between siblings when one has an eating disorder, “I have found that they have a sister that has a problem, it is very very hard... Particularly if the sister has been the high achiever, the pretty one, and the other one tends to be the tom-boy. So it is just an additional weight put on them.” Adolescents with eating disorders often believe that their sister has everything and that they are less valued, a fear that they try to shed by losing weight. Guidance counselor Joseph (2008) has had students with eating disorders tell her, “life is easier for their siblings... ‘My sister has it so much easier than I do.’” Adolescents who compare themselves to their siblings often fear that they do not measure up, and may develop an eating disorder in hopes of achieving the perceived success and popularity that their sister has. The entire family dynamics, encompassing mothers, fathers, and siblings influence the likelihood that an adolescent may develop an eating disorder.

Peers also play a crucial role in the development of eating disorders. Individuals bring their experiences and meanings derived from their own unique history of primary socialization and early interactions to peer groups. Some adolescents may befriend individuals who place a high emphasis on body image, while other peer groups may simply not be as concerned about body size. “Peer modeling of dieting (or peer pressures to diet) has been correlated with disordered eating, and unconditional support from peers has been shown to reduce the negative influence of these pressures” (Kirsh et. al, 2007:352). Peer groups often have a shared set of meanings that influence the actions of such members, therefore they might contribute to, or decrease, the likelihood that one has an eating disorder. Nurse Davis (2008) has found that peers will endorse each other in

their eating struggles, “supporting each other, that is what they do. ‘Let’s diet today, let’s have 100 calories today, let’s just do this, let’s just have water and salad or soup.’ That is where it really starts to become socially popular, where you have someone that supports you, makes it easier.” Peers may become a support group for eating disorders, encouraging and perpetuating such troubles. Guidance counselor Joseph (2008) notices how, “if one is not eating at lunch, none of them eat at lunch. One is watching what she eats, all the others sort of compare what that one person may eat.” Adolescents will often go on such group diets and compare their food intake, encouraging each other to eat less and less to become popular. Adolescents learn from their peers as group interactions and peer value systems may influence the development of eating disorders. Some adolescents may find themselves caught up in perpetual group diets as peers influence not only thoughts but also actions.

While adolescents internalize meanings through their interactions and socialization from their families and peers, the media also create definitions along with shaping social norms, standards and beliefs through transmitted messages. The media perpetuate and reproduce gendered meanings of masculinity and femininity, particularly in regard to ideal body types and shape. “(T)oday, some twelve billion ads, three million radio commercials, and 200,000 TV commercials flood the nation on a daily basis....” (Knapp 2003:15). Through the constant bombardment of images, particularly through magazines, adolescents internalize how ideal adults should appear and look. Nurse Wagner (2008) has found that, “the teen magazines, *Seventeen*, those different magazines they look at the fashion and they see all of that as the norm. And they don’t really know that that’s not, that those are so computerized and you know completely fixed up. So I

think the media plays a huge role, all the people they look up to..." Adolescents learn gender norms through the media, viewing those thin images that constantly bombard them as the ideal and believing that their own bodies should look the same.

Many individuals begin reading popular magazines during the adolescent years, adding to the package of unreal images of beauty and messages of body standards. Advertisements are one of the forms that the media use to influence individual's thoughts and actions. "(B)y a ratio of 10.5 to 1, articles and advertisements concerning weight loss are more frequent in the ten most popular women's versus men's magazines. It is more interesting that the 10.5 to 1 ratio parallels that of women to men with eating disorders" (Costin, 1997:26). Men's magazines lack the dearth of advertisements directed towards dieting, consistent with the pattern in which fewer men report eating disorders. This indicates that the media, especially in regard to advertisements, may play a key role in contributing to eating disorders by promoting a specific ideal body type. Social worker Anderson (2008) explains how the media, "is just pretty powerful if you don't think about it at all. The media has a big impact on what you do. It just pigeons little girls (and boys) into who you should be and what you should be without many options." The media present bodily norms and expectations in such a narrow fashion, encouraging adolescent girls and boys to take extreme measures to accomplish such unnatural feats with their bodies.

The media depict images of masculinity and femininity that adolescents internalize and attempt to emulate, despite the fact that such images of beauty and thinness are almost impossible to healthily achieve. "(E)ating disorders are caused by the influence of extreme or unreal images of female attractiveness in the media" (Cussins,

2001:106). Adolescent girls see models in the media who are extremely thin, and internalize those images as the ideal standard of femininity, attempting to achieve that body type. Hawkins, Richards, Granley and Stein in their study of college women found that media influence females' perceptions of their bodies. "Exposure to thin-ideal magazine images increased body dissatisfaction, negative mood states, and eating disorder symptoms and decreased self-esteem... Exposure to thin-ideal media images may contribute to the development of eating disorders by causing body dissatisfaction, negative moods, low self-esteem, and eating disorders symptoms among women" (2004:35). Many adolescent girls internalize the media's display of thin models as reality, and begin to view their own bodies in negative ways. School counselor Smith (2008) explains how the, "body distortions are so enormous and all you have to do is to go into Abercrombie. First of all those models do not have nearly enough clothes on. For a clothing store they are barely wearing anything and they are just, you know, the guys are totally ripped and the girls are twigs." Media influence the development of eating disorders in adolescents through their depiction of skinny female models and strong male models as being beautiful and the norm.

Fashion models and celebrities do not reflect an accurate representation of average men and women. Male depiction in the media consists mainly of images of muscular and strong men. This emphasis on strength and a lack of body fat encourages adolescent boys to work out and bulk up in regards to their muscles. The "Adonis Complex" refers to the Greek ideal of masculine beauty, a man half god and half mortal, and has become more prevalent in men today as "the standard for the male physique has risen through the past few decades... the average *Playgirl* centerfold has dropped twelve

pounds of fat and gained twenty-seven pounds of muscle in the past quarter century” (Sedwick, 2001:222). Unlike female models who are detracting in size, male models seem to be growing. Yet such growths refer only to muscles, and in fact still include a decrease in body fat, encouraging adolescent boys to become stronger and more muscular.

While boys try to become larger, girls strive to become smaller. Both try to minimize their body fat in attempts to conform to the images prevalent in the media. “The average fashion model is white, 5’9” tall, and weighs 110 pounds, approximately 32 pounds lighter and five inches taller than the average American woman. Her good looks are relatively rare among the population...” (Hesse-Biber, 2007:188). The ideal image that adolescent girls hold as the standard of beauty is almost half a foot taller than most of the girls will ever be, and weighs much less than they ever will. Even though this body type is rare in everyday society, the image is not. Models are not positive examples for adolescents as they depict unnatural and unhealthy values. “Twenty-five percent of fashion models now meet the American Psychiatric Association’s diagnostic criteria for anorexia nervosa” (Hesse-Biber, 2007:3). Adolescent girls aspire to be the image of such unhealthy figures. Guidance counselor Joseph (2008) explains how it is hard for many young girls: “When they see the Hannah Montanas, that kind of thing that they want to like them and be like them, and act like them.... They are copying from people that they have seen and it is not ending well for them.” Girls, and also boys, use those unreal models they see in the media as the standard for how they should appear. “Definitions of reality have self-fulfilling potency” (Berger and Luckman, 1966:128). As adolescents use the body size of models as role models for their own lives, they are more prone to view their own bodies as over-weight, and hence develop the desire to diet. By attempting to

emulate the bodies of models, that are abnormally tall and thin for females and extra strong and muscular for males, adolescents attempt to mold their own bodies to such impossible standards.

Conclusion

The current socialization of adolescents, in which boys and girls learn their gendered role in society, and the common norms and meanings surrounding their bodies, place some adolescents at higher risks for developing eating disorders. Guidance counselor Joseph (2008) fears that the numbers of adolescents with eating disorders will continue to increase unless something changes as, “it is pretty much a widespread thing and it is very, so far it’s been very, almost trendy kind of thing.” Social interactions will be the location in which change must be made to help reduce eating disorders. By having the media, family, and peer groups, place an emphasis on the individual self rather than the body, adolescents may begin to accept themselves as they are and not have to conform to restrictive gendered bodily meanings.

Chapter Two
Self-Mutilation

Introduction: Self-mutilation and Eating Disorders

The self-mutilation of adolescent girls and boys stems in part from their sociocultural experiences, gendered norms, and interactions with their parents, peers, and the media. Many adults consider adolescents who self-mutilate as being so troubled that they are treated dismissively, arguably more so than other disorders, particularly eating disorders. “To noncutters, self-mutilation appears to be either self-destructive masochistic, or something irrational. But cutting has great meaning for those who do it. The meaning, however, is often kept hidden and unspoken because of the secrets it reveals and the shame it attracts” (Strong, 1998:36). Maine school counselor Smith (2008) has found from her own experiences that self-mutilation “creeps people out and if you are not a cutter it is hard to understand. I think for people who have used that for a mood equalizer and as a way to de-stress, they can understand but if you have not used that strategy, I think it is really hard to understand.” To the adolescents who do self-mutilate, the act carries an actual meaning, one that few adults come to comprehend. Most individuals dismiss self-mutilating actions as simply disturbing and distressing, as they cannot seem to understand what would drive these self-abusing adolescents to physically harm their bodies with their own hands. Hopefully once the experiences and interactions that contribute to self-mutilation are exposed, then many adults may look beyond their own biases and recognize that these adolescents require help and support.

While self-mutilation has different connotations than eating disorders, in fact, they are more similar and connected than many would initially imagine. Eating disorders and self-mutilation often coexist; approximately sixty to ninety percent of adolescents with eating disorders also self-mutilate (Farber, 2000:36). These two self-destructive

disorders are linked in many adolescents who find themselves participating in both harmful acts, one that marks the body on the inside by depriving it of food, and the other that marks the body on the outside with physical scars. Maine emergency room and school nurse Davis (2008) has seen many cases with both disorders: “progress from being anorexia and eating disorders not being taken care of, not receiving help. Then if they have not reached that goal that they are trying, they will try and take it out on themselves. I have had a couple of situations where they have become self-mutilators. I am finding it more and more common.”

Adolescents with eating disorders who do not receive treatment may become further overwhelmed and turn to self-mutilation as an attempted release. School counselor Joseph (2008) also has witnessed such a pattern with her students, as they try to “make themselves feel better from the eating disorder, trying to make themselves perfect but at the same time they are cutting themselves because that stress is overwhelming them.” Adolescents may turn against the very body they are trying to mold into perfection through their eating disorder and take out their anger and frustrations with self-mutilation. Bodily self-harm takes on several forms, with eating disorders and self-mutilation linked not only in their frequent coexistence but also in their sharing of many of the same attacks against the body and the experienced benefits.

While individuals can often recognize adolescents with anorexia, many cannot identify bulimics or self-mutilators simply by their general appearances. Yet self-mutilators, and to an extent bulimics, for purging is seen as more repulsive than starving, evoke more negative connotations than do anorexics. Bulimia is more similar to self-mutilation than anorexia is for “severe purging is self-mutilation from the inside out

rather than from the body surface inward” (Farber, 2000:239). While bulimics purge food, self-mutilators often purge blood. This purging behavior closely unites and links bulimia and self-mutilation, causing these disorders to be similar not only in their actions, functions, but also how others interpret them. Many individuals view bulimia and self-mutilation more negatively than anorexia because these acts are more hidden, secretive, and not out in the open; hence, they could belong to anyone, a neighbor, best friend, or even brother or sister and one may not know it.

Unlike eating disorders in which adolescents cannot immediately see the direct mark of harm upon their bodies, self-mutilators actively pain their bodies and then witness the sudden implications of their acts, often with blood and then scars. Self-mutilators do not physically harm their bodies for fun. Similar to adolescents with eating disorders, self-mutilators often have reasons, specific personality traits or a background that predisposes them to act. But many adults often overlook those factors and do not understand the problem. Social worker Anderson (2008) explains the negative public view of self mutilation: “People are afraid of death and death seems closer when they (adolescents) are actually physically hurting themselves directly, when there is blood and scars, you are doing something actual... And certainly in some way people really see it as a suicidal gesture, and that for some people can be very hard in itself.” With a greater acknowledgement and understanding of self-mutilation, many adults will no longer have to view these behaviors with terror and trepidation, but rather have the knowledge to help those adolescents.

Self-mutilation: Meanings and Functions

The term self-mutilation encompasses a variety of physically harmful acts that inflict pain upon the body. While the common form of self-mutilation is cutting, some adolescents partake in other acts as well. “Cutting on the wrist or forearms is the most common site of self-mutilation, yet other (therapists) have reported cuts to the thighs, legs, abdomen, and breasts....Other acts of self-mutilation in addition to cutting consist of burning the skin, interfering with healing of wounds, or hitting the body” (Zila and Kiselcia, 2001:47). Self-mutilation takes on a variety of forms. Some adolescents cut themselves on various parts of their bodies, sites that typically can be concealed by clothes, while others burn themselves, often with cigarette lighters. Other adolescents may pick at their scabs, or hit their body with another body part or against a hard object. School nurse Wagner (2008) has discovered in addition to the typical cutting, many of her students will do eraser burns, when they rub an eraser on top of their hands. Boys will often do ice and salt burns which, when combined, creates a bad burn. Ross and Heath (2002:67), in their study of adolescents, reported that self-cutting was the most common type of self-mutilating behavior, much more prevalent than self-hitting, pinching, scratching, and biting. Social worker Anderson (2008) also found that cutting is more frequent than burning except that much of the burns are, “just on the stove, things that could seem like accidents, sort of like passive ways, burns that don’t go away on themselves.” The major form of self-mutilation is cutting, most often in places that are covered or in a place that can be readily excused as an accident.

Similar to eating disorders, the exact number of adolescents who partake in self-mutilation is hard to determine, as many will attempt to hide their actions for fear of the

negative connotations. Scholars report a variety of figures, varying from one (S.A.F.E, 2006:1) to ten percent of adolescents who self-mutilate (Jenkins, 2005:11). Many researchers, however, believe the percentage to be in the middle of that range (Yip, 2005:80; Nock and Prinstein, 2004:885). Self-mutilation is about as common as eating disorders, with around five percent of adolescents participating in them both. This proportion may be so similar due to the frequent coexistence of the behaviors. Like eating disorders, the majority of self-mutilators are adolescents, with involvement peaking during the college years with a range of around fifteen to forty percent (Brown et. al, 2007:793; Plante, 2007:3; Gratz et al., 2002:132). Even though eating disorders and self-mutilation have similar prevalence rates both within overall adolescents and the college population, self-mutilation still lacks the label of being a diagnosed mental disorder.

Self-mutilation is not yet an acknowledged psychological disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR). While many psychologists would consider self-mutilation to be part of an impulse-control disorder due to its repetitive nature, it lacks its own diagnosis, hence, limiting a consensual understanding. “A deliberate self-harm (DSH) syndrome has been proposed for inclusion in the *Diagnostic and Statistical Manual* (DSM) characterized by multiple episodes of deliberately physically self-damaging acts of low lethality, often associated with alcohol abuse, including skin carving, wrist cutting, biting, burning....” (Farber, 2000:33). In the classification of official mental disorders, this syndrome has not yet gained that label. As self-mutilation has become more popular with adolescents evidenced by increasing numbers, a need for a diagnosis and shared definition is evident. Guidance counselor Joseph (2008) describes the popularity of self-mutilation, “I think it is a little bit trendier

and it definitely is more acceptable among certain groups of kids, it is more acceptable even than drinking, drug use, and smoking.” With the increase of adolescent self-mutilation, some psychologists are proposing inclusion of the disorder in the next edition of the Diagnostic and Statistical Manual.

Self-mutilation differs from suicide in that it brings a sense of relief rather than the cessation of life; mutilators also lack the persistent preoccupation with death and dying that suicide attempts bring. “(S)elf-mutilation is an act that is done to oneself, performed by oneself, physically violent, not suicidal, and intentional and purposeful” (Zila and Kiselcia, 2001:47). Individuals who partake in self-mutilation directly cause physical harm or pain to their bodies. “Deliberate self-harm is the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent...” (Gratz et. al, 2002:128). Self-mutilation is not the same as a failed suicide attempt. Self-mutilators are not trying to kill themselves despite the fact they deliberately attack their own body, rather they have other reasons for their self-harm.

Theorists, psychologists, and therapists have discovered several functions of self-mutilation which helps to explain why these adolescents willingly impose pain upon their bodies whereas most people try to limit feeling pain of any sort. When under pain or stress, the initial reaction of the brain and the body is to remove oneself from the object of harm. For example, when the hand touches a hot iron or stove, the original reaction of the brain is to rapidly move the hand away from the hot object. Therefore, self-mutilation seems to go against basic impulses that attempt to minimize harm and pain of the body. Yet adolescents who go against the instincts to avoid pain find that their self-mutilation serves a variety of functions which include: “(1) affect modulation, (2) management of

overwhelming experience, (3) self-punishment, (4) influence of control of others, and (5) self-stimulation. Often, self-injury serves multiple purposes simultaneously” (Plante, 2007:4). Self-mutilation can aid adolescents in their efforts to regulate their emotions, punish the self for perceived failures, and exert control over their bodies. Nurse Wagner (2008) describes how many self-mutilators feel depressed prior to the act and then feel momentarily better due to the release of endorphins. This endorphin rush lasts just a few seconds and then the self-mutilator finds themselves returned to their original emotions. Yet following the self-harm adolescents often feel guilt for acting and “would feel even more depressed after because of the fact that they did it.” Self-mutilation often becomes a vicious cycle in which adolescents who mutilate continue to do so again and again, in hopes of achieving that momentary relief as that release contributes to the addictive nature and severity of self-mutilation.

The most common purpose of self-mutilation for adolescents is to regulate emotions, namely reducing negative feelings. Pessimistic thoughts and feelings about the self and one’s body often trigger acts of self-harm influencing adolescents to self-mutilate to reduce “depression, anxiety, or stress; self-hatred and anger; self-punishment; loneliness or alienation; and distraction from problems” (Laye- Gindhu and Schonert-Reichl, 2005:454). Adolescents often cite depression and other aversive feelings as reasons for their self-mutilation. These negative emotions are reduced during and after acts of self-harm. Guidance counselor Joseph (2008) explains that “a lot of them will feel better after, they feel like they’ve sort of released whatever it was that was bothering them. They don’t really know how else to do it or come up with a healthy way to de-stress and feel better about what is going on in their lives.”

Self-mutilators do not regulate their emotions in socially acceptable ways but rather use socially defined deviant and abnormal methods to try to reduce their unhappiness. “The ability to regulate our emotions and behavior appropriate to a given situation is what gives us a sense of self-control. People who have great difficulty regulating their emotions develop problems controlling their behavior” (Strong, 1998:41). Adolescence itself is an emotionally tumultuous time and some youth struggle more than others in dealing with their emotions. While crying often serves the purpose of affect regulation as a tension reducer, self-mutilators turn to pain rather than their tears as a way to feel better and regulate their emotions. Some adolescents turn to self-mutilation in attempts to make themselves feel better due to the biological rush of endorphins after episodes of self-harm, the fact that the actual pain of injury feels better than the pain of sorrow, or just even the ability to momentarily ease their unhappiness. “Various forms of self-harm... can also be understood as attempts at self-medication” (Farber, 2000:xxvii). Social worker Anderson (2008) has found many students describe how “the pain is sort of a different feeling from their continuous feelings and then they just let go and it comes as sort of a release.” Although self-mutilation is not the healthiest way to reduce depression, some adolescents feel that they lack other methods to manage their emotions. “In absence of better coping strategies, self-mutilation becomes a way to calm down” (Zila and Kiselcia, 2001:50). Adolescents who self-mutilate often lack the knowledge of healthy coping methods and, when left on their own to cope with their feelings, some adolescents may turn to self-mutilation as attempts to ease their unhappiness and suffering.

Factors related to Self-Mutilation: Personality and Gender

Several specific personality traits and characteristics appear to be common across adolescents who self-mutilate, but these acts of self-harm are not limited to a specific social group. “They (self-mutilators) can be found in foster homes and prisons and psychiatric hospitals, but they are also in the best neighborhoods and private schools, in colleges and in the workplace. Self-injurers are often bright, talented, creative achievers-perfectionists who push themselves beyond all human bounds, people –pleasers who cover their pain with a happy face” (Strong, 1998:18). Self-mutilators come from all socioeconomic classes, races, and gender. Despite any possible demographic differences self-mutilators often share several similar emotional and personal characteristics. School counselor Smith (2008) describes the adolescents she works with who self-mutilate as “stressed out”, “very demanding of themselves”, having “low frustration tolerance” and being highly “self-critical”. Self-mutilators tend to be perfectionists, individuals who try to please others and to excel in all that they do. The quest for flawlessness drives many adolescents to self-harm.

Self-mutilators tend to have aspects of their personality that predisposes them to inflict pain upon themselves. Such adolescents often feel that they are alone in their struggles and that no one can understand them. Nurse Davis (2008) has found that self-mutilators often experience, “a sense of abandonment that they are alone. They often have low self-esteem.” Self-mutilators often see themselves as isolated and powerless. “(N)o matter how outgoing or confident she seems, she feels alone wherever she is, different from everyone around her, an outsider. She is often plagued by a fear of punishment – usually from a parent – for being deficient, inadequate, a

disappointment...” (Levenkron, 1998:46). Being a high achiever may separate such adolescents from others, causing them to feel different and alone as they focus their energies on achieving excellence. Self-mutilators commonly feel like they are “empty inside, unable to express emotions in words, afraid of getting close to anyone, and wanting desperately to stop their emotional pain” (Strong, 1998:26). Guidance counselor Joseph (2008) describes how the students she sees who self-mutilate report feeling “that no one understands what it is like to be in their shoes.” Self-mutilators often perceive themselves to be alone in their struggles, thus they turn to their knives, lighters, or whatever object of harm they use for solace and support rather than their families or friends.

Adolescents who self-mutilate, in addition to often feeling alone or different, also seek out the opinion and friendship of others, in an attempt to fulfill any emotional voids. Self-mutilators excessively rely on the judgment of others in forming their self-worth which often causes them to feel unworthy. They “are often hypersensitive to the opinions of others and easily feel hurt, rejected, or otherwise inadequate. They rarely feel any control over their own sense of worth and are therefore vulnerable to the real and imagined external judgment” (Plante, 2007:37). Such feelings of inadequacy and worthlessness may create the devastating feelings that contribute to cutting in the first place. Adolescents often have trouble finding self-contentment as they rely upon others to shape their sense of self-worth. Even though self-mutilators gravitate towards others to seek their approval, those who self-harm often lack close intimate relationships for they turn only to themselves with their problems. “(A) self-mutilator has a poor ability to form attachments to others while, paradoxically, she has an excellent ability to encourage

others to form attachments to her. She can be an excellent listener, and nurturer, to others” (Levenkron, 1998:100). The typical self-mutilator promotes others to befriend him or her, yet these relationships are often one-sided as self-mutilators turn towards themselves for comfort, not others. School counselor Smith (2008) describes how the self-mutilating students she has worked with feel “the lack intrinsically of a really substantive best friend, like a real heart-felt connection in their peer group.” For fear of being seen as flawed or being abandoned, self-mutilators often seek out a circle of friends just for superficial, not intimate, relationships.

As self-mutilators appear to hold many similar personality traits, the stereotypical label of the “delicate cutter” was developed to brand self-mutilating girls. “In the late 1960s and 1970s, a cutter profile was created by the first conference of psychiatric interest in a ‘delicate’ form of self mutilation: the delicate cutter is typically a white, adolescent girl” (Brickman, 2004:87). Professionals first began to acknowledge self-mutilators as being attractive white, suburban, teenage girls, a stereotype that still persists today. Even though times have changed, the image of the “delicate cutter” has not. “Many authors describe the typical self-mutilator as female, adolescent or young adult, single, usually from a middle-to upper-middle class family, and intelligent” (Zila and Kiselcia, 2001:79). This limited understanding of self-mutilation as a white middle class girl problem, based upon old gendered stereotypes, detracts from the real psychological basis of the disorder.

Based upon the widely acclaimed and accepted notion of the delicate cutter, many assume that girl self-mutilators widely outnumber boys, although in reality this may not be the case. The numbers range from girls outnumbering boys by four times (Jenkins,

2005:11) or by two times (Ross and Heath, 2002:67) to having them be approximately equal (Edwards, 1998:3-4). “This assumption (that females typically are more likely to engage in self-injurious behavior) has recently been challenged by research, however, suggesting that males today may be self-injuring at a rate as high as their female counterparts” (Plante, 2007:2). As with eating disorders, researchers struggle to definitively determine the gendered ratios of self-mutilation as many cases, especially those of boys, pass unobserved and unreported. Boys may currently be harming themselves at similar rates as girls. Researchers do not know if the increase in reported cases of boys stems from the narrowing gendered gap in self-mutilating behaviors, or by increased awareness of the inaccuracy of the delicate cutter stereotype. When Davis (2008) first began working in the emergency room “it was more females and now I see more males.” Davis has experienced a change in the gender of self-mutilators with the cases of boys exceeding that of girls, indicating the inaccuracy of the notion of a girl “delicate cutter.” Whereas both boys and girls are socialized to hide any weaknesses or pain, it is less socially acceptable for boys to demonstrate their emotional vulnerabilities, as they learn to hide and mask those emotions. When adolescents cannot communicate their feelings or freely express them, they are more likely to turn their emotions inward, harming themselves. The social norm of boys’ emotional repression indicates that, at least theoretically, there should not be gendered biases of self-mutilation, yet boys often feel pressured to not report their self-harm. Despite the historical discrepancies with regard to gender representation, gender does play a role in self-mutilation as boys and girls harm themselves differently.

Self-mutilation tends to become gendered in the types of harm that girls and boys inflict upon themselves. Researchers Laye-Gindhu and Schonert-Reichl found that “cutting-type behaviors were the most common type of self-harm reported by girls, whereas for boys these behaviors ranked second, with more boys reporting hitting, biting, or punching themselves to cause harm” (2005:454). While girls tend to cut themselves with an object, thus removing themselves from the process, boys often use their own bodily parts to cause the pain. School counselor Smith and Nurse Davis (2008) both describe how they would often see boys punch walls or windows. Guidance counselor Joseph (2008) explains how boys will smack their heads on tables when they “get so wound up, stressed out, upset that they don’t want to deal with it and they try to knock themselves out” and social worker Anderson (2008) has seen boys who will “set themselves up in a situation where they were always getting hurt, fighting with people.” All of these professionals have noticed how boys turn to more physical methods as their form of self-mutilation. As masculinity is represented through strength, boys will hit themselves repeatedly or cause themselves to be in a fight. While femininity reflects more of a reserved nature, girls will cut themselves, often with a knife by their own hands yet not with their own hands.

Just as gendered patterns appear in the forms of self-mutilation, they appear in the atmosphere in which such acts occur. As masculinity encourages boys to demonstrate their strength and resilience to pain, boys will often self-mutilate in public with others while girls do so privately. In their study, Laye-Gindhu and Schonert-Reichl found that while, “girls indicated that they always self-harmed when alone, boys not only did so when alone but also with peers... Boys were more likely to report harming themselves as

a ‘test of will’ or strength or in the context of a peer game” (2005:454). Gender stereotypes influence the acts of self-mutilation through not only the form but also the atmosphere.

Just as objectification influences the development of eating disorders in adolescent girls and boys, it plays a similar role with self-mutilation. Adolescent girls and boys become distanced from their physical being when they lack subjectivity. This experienced distance then makes it easier to inflict pain upon one’s own body. When the body is viewed as existing outside of the self, it is easier to think of it in negative terms. “It is argued that a negative view of the body may facilitate self-harm because the body is seen as a hated object. Adopting this view makes it more likely that an individual will feel detached from her/his body and the emotional investment in caring for the body will decline, making it easier to harm” (Muehlenkamp, 2005:24). When adolescent boys and girls see their bodies as inferior objects then, in their thinking, they do not need to take good care of their bodies. Self-mutilation, therefore, can be both a product of and a consequence of body objectification.

As previously mentioned adolescent girls face greater risks of treating their bodies as objects, which often starts happening around puberty. For adolescent girls, puberty brings not only menstruation but also increased body fat, two aspects that they cannot command. Lacking control of these aspects of their lives, some adolescent girls view their bodies as imperfect, making it easier for them to physically inflict harm upon the body that appears to have failed them. As adolescent girls experience their unstoppable and perceived negative bodily changes, some may “see their bodies as fragmented, foreign, unfamiliar, frightening and out of control – as objects, not subjects, as (Lisa)

Cross puts it. Add in social and cultural pressures – which lead teenage girls to define their bodies by their attractiveness, while boys define theirs by strength and function – and it is easy to understand what a perilous passage puberty can be for young women” (Strong, 1998:125). The struggles adolescent girls face with their bodies, viewing them as objects which often disappoint them, makes it easier for them to turn their anger inward and physically harm themselves, marring the very body that suddenly seems foreign to them.

With the emphasis on appearances and the external body through objectification, the inner self suffers. Self-mutilation then reunites and reconnects objectivity, the body as existing independently, and subjectivity, the ownership of not only one’s body but also sense of self. “The body has become the locus of subjectivity, and is linked to language, feeling, pleasure, pain, power, and history. And so what we do to and with our bodies, what and how we eat... the daily rituals through which we attend to our bodies, are all part of our unconscious individualism” (Farber, 2000:7). One’s subjectivity and sense of self resides within the body. Some adolescents then claim their individuality upon their bodies through self-mutilation, demonstrating their pain, confusion, or anger through their scars. Self-mutilators assert and create their own subjectivity by their ownership and control over their bodies through their mutilating actions. Social worker Anderson (2008) has found that adolescents who self-mutilate often want “control and do not necessarily have any control...” Feeling a lack of control over their own bodies, some adolescents will take ownership through self-mutilation. The physical act of harm upon the body tells the story of the individual who grounds him or herself through the marks and pain, for in self-mutilation the body and the self are reunited. By acting as subjects upon the object of

their body, self-mutilation reconnects the object to the subject, silently telling the story of the self, a story that too often falls upon the deaf ears of society.

Cultural and Social Influences of Self-Mutilation

Just as with eating disorders, the socialization of adolescents influences the likelihood they will participate in self-mutilation. While childhood abuse is not always a precursor to self-mutilation, it does increase the likelihood. An invalidating environment, which may increase the chance of self-mutilation, consists of “one in which the communication of private experiences is disregarded, trivialized, or punished, displays of negative affect are generally not tolerated, the control of emotional experience and expression is expected, and caregivers may be both overinvolved and nonresponsive to children’s needs” (Gratz, 2006:239). In his study on self-harm, Gratz reported that an environment in which children often refrain from discussing their private experiences or from displaying negative emotions increased the likelihood that they would then internalize their problems. When adolescents hide their struggles and lack a supportive family, they are more likely to project their emotions onto their own bodies.

The relationships and attachments that a person develops both in childhood and also early adolescence relates to the chance of participating in self-harm. Attachment behavior explains the relationship between the agents of both primary and secondary socialization; the child and the initial caretakers, and the adolescent with his or her peers. Individuals attach themselves to others in a variety of ways, some become easily attached, and others may struggle trying to separate from those attachments even when necessary. “Attachment behavior... is any form of behavior that results in that person bringing himself nearer to some other person whom he perceives as being a source of comfort and

strength” (Farber, 2000:120). Anderson (2008) explains how “attachment definitely can be a big concern with this type of behavior. Well, I say ‘attachment issues’ because it looks like overly attached but there is a problem with the attachment... where it wasn’t very effective attachment early on in their lives...” Many adolescents have struggled with their attachment as children by forming distant relationships or even an over-reliance upon their parents which increases their chance of self-mutilating.

Some children may become *excessively* attached to their parents leading them to struggle in early adolescence when social norms indicate they should become more self-reliant and autonomous. Some adolescents view that push for independence as abandonment. “Self-cutters are acutely sensitive to abandonment. Because they never properly attached to and then separated from their early caretakers, they live in a perpetual state of separation anxiety so unbearable it feels annihilating” (Strong, 1998:55). One view is that adolescents who self-mutilate may have been overly attached to their caregivers as infants and toddlers. These children then never “properly” separated from their parents as they matured and often feel abandoned when they reach adolescence. Self-mutilators, as previously discussed, typically are highly sensitive to the perceptions of others and have trouble trusting others. This lack of trust and extreme reliance upon others for measurements of self-worth leads some adolescents to fear any signs of separation as rejection.

While some self-mutilating adolescents do come from invalidating environments in which parents treated them poorly, others come from homes where they were constantly cared for and loved. Self-mutilators are “as likely to have a smothering mother as an inattentive one” (Strong, 1998:123). Many self-mutilators do come from caring

parents. “Those who were cared for excessively and indulgently and those who were stimulated excessively in early life can come later in life to hunger for what they had received excessively” (Farber, 2000:83). Sometimes parental love and care may create a need for a kind and loving affection that can never be fully satiated at an older age, given how society encourages adolescent independence. Many adolescents, who still require a similar form of secure attachments that they had as a child, may deal with their sense of abandonment and frustrations by harming their own bodies. A person’s socialization impacts the chance an adolescent will participate in self-mutilation, with the relationship to one’s parents acting as a crucial factor to such acts.

Just as parents may play a key role in adolescent self-mutilation, so too may peers. Adolescents with friends who self-mutilate are more likely to themselves participate in self-harm than those who lack such exposure. “When individuals mutilate themselves in a group, the drama, intensity, and ‘realer than life’ quality of the experience cements the bond so that more ordinary group experiences pale in comparison... Repeated exposure to a group of self-mutilating peers provides a modeling influence that makes the behavior more attractive and lowers the individual’s resistance to participation” (Farber, 2000:64). As previously mentioned adolescent boys often self-mutilate in a group, and therefore redefine their friendship in a stronger way as they share this new form of connection. Even if adolescents lack a peer group that self-mutilates together, some hear about such acts from classmates or schoolmates and become inspired to do the same. Nurse Wagner (2008) has discovered that because her middle school students ride the same bus as the high schools students, “they learn a lot from the buses, some of them are on there for an hour and a half and the only supervisor on the bus is the driver... I hear a lot of kids say,

‘You know so-and-so from the high school bus said...’ Upon hearing about self-mutilating acts from peers some adolescents decide to experiment with self-mutilation. Increased contact with self-mutilation not only enlightens adolescents about the act, but also normalizes self-harm through repeated exposure.

The impact of the media on self-mutilation occurs through the encouragement of body objectification and the accounts of the behavior that may make it easier for some adolescents to inflict harm upon themselves. “Few behaviors are as shocking as a young person intentionally carving herself in blood, immediately declaring herself a spectacle of pain and fascination. In an ever-competitive society, it may be more difficult to distinguish oneself through one’s accomplishments than through the demonstration of victimization or dysfunction” (Plante, 2007:38-9). The media often highlight sensationalized deviant behavior, and some adolescents may see self-mutilation as a way for them to assert their problems and sense of self. Due to conveying a stereotypical image of self-mutilators through the media, some adolescents feel that they should also self-harm if they share those characteristics or social label, identifying with the act. Wagner (2008) has found that many adolescents “feel depressed so then they feel like they have to play the part of it and they learn... that this is what I am suppose to do because I am depressed. And so they do it because I think they think they are supposed to do it... The Goth kids, they are dark and they are supposed to be gloom and doom.... it is the part that they are supposed to play.” School counselor Smith (2008) also explains how such a “fascination with flat affect and dead appearances” are celebrated in the media. Media depictions of self-mutilation may appear in positive ways to some adolescents, but the media also create a negative meaning for the majority of society.

“The media often depict self-mutilation as disgusting, shaping the perspectives of how many people view it in negative ways” (Levenkron, 1998:60). The negative connotations of self-mutilation often derive from the media’s depiction of self-harm as revolting and repulsive. Such messages end up degrading and demeaning the actual adolescents who do inflict bodily pain upon themselves, when society lacks the proper understanding of the action.

The internet often plays a role in promoting self-mutilating behaviors. Social worker Anderson (2008) has found that the internet can increase rates of self-mutilation as adolescents talk about what they do through, “facebook and all of those social things. Kids talk and learn about stories how to do it. Kids struggling violently and doing nothing can go online and get an idea about something that might relieve them temporarily.” Guidance counselor Joseph (2008) explains how adolescents can also “learn a lot of different ways to hide it and cover it up or something” through the internet. The internet may serve as an unhealthy source of education about self-mutilation as many websites implicitly encourage some adolescents to participate in it by praising such actions while not mentioning many of the associated risks or harms of the behavior or offering support to receive help.

The other institution that has the potential to positively change not only the image of self-mutilation but also its prevalence among adolescents is education. School personal should both be aware of self-mutilation among its students and also know the factors that influence adolescent participation in self-harm. “If self-harm is connected with low self-esteem, lack of self-confidence and high levels of anxiety, schools need to ask themselves what they can do to promote a healthy self-concept and equip young people with the

confidence and skills necessary to handle problematic situations without experiencing overwhelming levels of anxiety” (Best, 2006:173). As adolescents who self-mutilate often lack viable coping methods and ways of handling their emotions, they would benefit from such lessons incorporated through their health curriculum at school learning how to better deal with their stress, anxiety and pressures of being perfect in an ever-competitive society.

Today’s students face an inordinate amount of pressures and expectations, leaving many adolescents overwhelmed and unable to cope. “Academic demands, competitive college admissions pressures, and the vast array of extracurricular activities undertaken by middle school and high school students have become staggering in their intensity” (Plante, 2007 :40). Pressures associated with school often contribute to adolescents’ feelings of anxiety. Students will benefit from support and awareness by school personal in encouraging students to come forward asking for help and in learning about healthy coping methods to deal with their stresses and demands. School counselor Smith (2008) explains that “if you can find other ways to stabilize the emotions then you do not need to cut.” School personal have a fine line between educating students about such activities and unwillingly promoting them. Nurse Davis (2008) describes the lack of beneficial health programs pertaining to self-mutilation. “It is a kind of double edged sword, no pun intended. I think you can also help push someone, someone who is more susceptible. It is difficult. I think the most important part is to be aware of the signs and symptoms.” Health classes that discuss self-mutilation may inspire some adolescents to try such actions, therefore schools struggle with a way to address such issues without promoting them.

Conclusion

Self-mutilation is deeply entwined with the culture in which it exists. Therefore any examination of self-mutilation, just as with eating disorders, that lacks a cultural component cannot be complete. Social interactions with the family, peers, the media, and in schools all shape the development of a personal sense of self as the body represents not only the self but also the society. “The body is a vehicle for interaction between people and consequently often serves as a symbol of society... (expressing) cultural conflicts, confusions, religious beliefs, and positive social interactions.... This (body alteration) may be an act of denial of imperfections of the body, or an act of rebellion against cultural norms of beauty if it is performed contrary to social approval” (Hewitt, 1997:12-3). The acts of self-mutilation symbolize not only troubled adolescents but also a troubled society with diminished care for this generation. As self-mutilation and eating disorders often go together, these forms of self-harm can be seen as a rebellion towards society, as some adolescents feel the pressure to shape their public appearances to social norms, but in private will go against those norms and scar the very body they attempt to mold into perfection. The body reflects the social order, and scars of self-harm demonstrate that society is depriving many adolescents of a healthy experience.

The current social meaning of self-mutilation simply pathologizes and degrades the female body, detracting from the feminist movement and quest for equality. Labeling self-mutilation as a girl problem also harms boys by discouraging them to seek help for their own self-destructive acts. Just as eating disorders are starting to gain public attention as being more prevalent in not only females but also males, we can only hope that soon self-mutilation will be seen as a psychological disturbance in adolescence rather than as a

revolting act. Nurse Davis (2008) explains that, “I am starting to see more of it, and I really think it is just that society has too much going on, focusing on just the wrong things. It needs to be made more aware of. I mean we have all of this prevention and awareness for things that are life threatening, but these kids, it is hard with nothing.” Many people do not understand self-mutilation, and struggle in providing the necessary resources and compassionate understanding to help adolescents deal with their self-harm. I believe that by classifying self-mutilation as a real disorder in the DSM, it will lose much of its negative connotations and finally be seen as an illness, in which some adolescents suffer. Only when self-mutilation has gained the label of a psychological illness and loses some of its negative connotations can society come to understand the disorder and better help such adolescents. Only once we have created a caring culture, can adolescents start caring for their own bodies and will no longer need to inflict self-induced pain with their own hands.

Chapter Three
Substance Abuse

Introduction: Substance Abuse, Eating Disorders and Self-mutilation

While eating disorders and self-mutilation have received increased awareness as an adolescent problem in the past decade, substance abuse has consistently been considered a crisis for adolescents. Many adolescents view substance use, in particular alcohol, as a rite of passage into maturity, as drinking appears almost ingrained in not only the college culture but also that of many high schools. School counselor Smith (2008) has found that substance abuse seems more common and widespread because, “it attracts the broader population” spreading across adolescents of all genders, socioeconomic class, race, peer groups and throughout many social events. As these substances are illegal to adolescents, when they use them they violate legal norms, yet this does not detract adolescents from using. The socialization of adolescents influences the high use of alcohol and other drugs as one’s disposition, peer pressure, and family background contribute to the likelihood that one will become a substance user.

Compared to both eating disorders and self-mutilation, the repercussions of substance abuse appear extensive and more severe, in part due to the increased level of users. In the news every few months or so, there is a story of an adolescent who died or killed someone else while under the influence of alcohol. “Alcohol use among teens has been associated with the three most common forms of adolescent mortality, specifically accidental deaths (e.g., fatal automobile or boat crashes), homicides, and suicides” (Windle, 1999:1). Alcohol use contributes to the most frequent deaths of adolescents, making it deemed more dangerous than eating disorders and self-mutilation. Smoking also, according to the common consensus, carries a higher danger than other forms of self-destructive behaviors. “Smoking-related illness is the leading preventable cause of

death in the United States, and smokers on average live 6.5 (males) to 5.7 (females) fewer years than those who never smoked” (Gruber and Zinman, 2001:70). While smoking is known to cause many health risks, alcohol is associated with many deaths, and other illicit drugs always carry the risk of an over-dose; substance abuse may appear to be the most dangerous out of the three forms of self-destructive behaviors. Yet one cannot compare or rank these actions, for in doing so we lose track of the actual individuals. Eating disorders, self-mutilation and substance abuse are all equally bad and harmful to adolescents, and to understand many of their causes we must examine again society and the socialization of adolescents to uncover now the pressures to use and abuse substances.

Many individuals who do self-destruct often use more than one method, due to their similarities and often inter-changeable ways. Nurse Davis (2008) has found that the three forms of self-destructive behaviors, “all go pretty much together. I think eventually you cross that line and then you turn to something else.” Adolescents who find a void in their lives will turn to a variety of methods to try to heal it, and in doing so often will move amongst the various forms of self-destructive behaviors.

Just as many adolescents with eating disorders self-mutilate, they also often turn to substance abuse. “Both bulimia and self-mutilation are thought to be impulse control disorders that were associated with other disorders of impulse control including drug and alcohol abuse. Not surprisingly, both bulimics and self-mutilators demonstrated high rates of substance abuse” (Farber, 2000:78). Due to their many similarities of these behaviors, adolescents who often self-destruct will do so in a variety of ways. Cigarettes have long been associated with dieting for women, and alcohol can act as an escape from the calorie counting and bingeing. “More recently, frequencies of cigarette and alcohol use

were linearly related to eating-disorder attitudes including body dissatisfaction and drive from thinness among college women” (Muehlenkamp et. al, 2005:25). Substance use has been linked to eating disorders in the way many dieters use and abuse cigarettes and alcohol. Many adolescents who self-mutilate also abuse drugs. Guidance counselor Joseph (2008) has found that, “the self-mutilators do tend to be smokers, drinkers, maybe using more than normal.” One becomes addicted to that altered state as both substance use and self-mutilation are often used to sooth the mind and body. Substance abuse, self-mutilation, and eating disorders therefore are closely linked and related. Yet to understand them, we must examine and study them separately while keeping in mind their similarities and connections.

Substance Abuse: Meanings and Functions

Unlike self-mutilation, but like eating disorders, substance abuse is a classified disorder in the diagnostic manual of mental disorders. The official definition of substance abuse refers to how it damages and restricts one’s daily activities and routines. According to the Diagnostic and Statistical Manual of Mental Disorders IV, substance abuse is a harmful pattern of use that leads to clinically significant impairment or distress, causing one or more of the following within the past year: failure to fulfill major obligations at work, school, or home; use in dangerous situations; legal problems; continued use despite having interpersonal problems caused by or exasperated by the effects of the substance (DSM-IV-TR, 2000). Many substance users become addicted, whether that addiction falls on a daily basis or just on a weekend basis. “(A)ddiction refers to the compulsive use of habit-forming substance. The two characterizing features of addiction are tolerance- the need for higher doses of a substance in order to produce the same effects-

and the occurrence of withdrawal symptoms upon quitting” (Hurley, 2000:45). Substance use is considered an abuse when it becomes an addiction and interferes with one’s daily obligations in the private and public spheres. Therefore the fine line between substance use and abuse is not clearly defined and allows for a variety of interpretations. For this chapter, just as how eating disorders and disordered eating were considered similar, substance abuse and use will not be differentiated.

Substance abuse serves a variety of functions for adolescents just as the other forms of self-destructive behaviors do. While the motives for using substances differ between all individuals, the majority of them center on personal or social reasons. “*Coping motives* refer to drinking to avoid adverse.... conditions and *social motives* refer to drinking to socialize with others... *Social conformity* motives refer to drinking so as not to be rejected by your peer group ... *Enhancement* motives refer to drinking so as to increase positive affect (e.g., pleasurable, euphoric emotional states)” (Windle, 1999:51-52). While these reasons mention alcohol in particular, they can be applied to all types of substances. Some individuals will use substances to prevent negative experiences such as ridicule, some will use to interact with others or to avoid peer exclusion and others will use to increase positive emotions. Social worker Anderson (2008) has found that, “if there is some kind of an issue that kids have about wanting to feel different and not liking how they feel then it can take on a life of its own. It (substance use) is a way to solve problems, to deal with life, like it’s not just an escape, it is a pleasant way.” Once adolescents start using, they find that the substances will bring positive experiences. “Drug use... causes the brain to release dopamine, a chemical involved in experiencing pleasure” (Hurley, 2000:13). Drugs change the chemical composition of the brain,

causing some individuals to feel better when they use. Many adolescents will initially use substances to fit in and to have fun and then realize that they enjoy the cognitive changes the substances create.

Substance abuse can take many different forms with the variety of substances used, ranging from alcohol, marijuana, abuse of prescription pills, heroin, cocaine, and other illegal street drugs. Adolescents on average use alcohol at the highest rates with marijuana coming in second. “Marijuana is by far the most commonly used illicit substance among adolescents... The prevalence of marijuana has consistently been about half that of alcohol, far greater than the overall proportion using any of the other illicit drugs” (Pacula, et. al, 2001:272). In addition to alcohol and marijuana, many adolescents often use tobacco, in the forms of smoking and chewing, which then becomes legal at the age of eighteen. Alcohol, marijuana, and tobacco have consistently been some of the most popular substances of choice. All of the people that I interviewed described the popularity of those three substances, and mentioned a relatively new form of drugs that are becoming more and more popular, prescription pills. Joseph (2008) sums it best by saying, “I mean we have smokers but not as many, mostly in the upper grades. The three that really hurts the kids are the alcohol, pot and pills.” Adolescents use a variety of substances that come and go in trends throughout the years but with alcohol and marijuana consistently remaining popular.

In recent years the amount of adolescents abusing prescription drugs has increased, most likely due to the rise in teenagers being prescribed pills, making them more accessible. Anderson (2008) reported that, “the prescription pills, they are more prescribed these days so they are being abused more.” But adolescents do not even need

an actual prescription or a friend with a prescription to purchase such drugs, as the internet has become a major source of unregulated websites. The National Center of Addiction and Substance Abuse (CASA) at Columbia University reported, “a total of 581 websites advertising or selling prescription drugs in 2007, compared to 342 sites last year. Eighty-four percent of the sites did not require a prescription” (Monti, 2007:2). With the internet even more accessible than drug dealers on the streets, more adolescents are abusing prescription pills. Smith (2008) talks about the popularity of prescription pill abuse for adolescents who use them in “pharm parties,” parties based on the use of pharmaceutical drugs. She continues, “so you know prescription drugs are big... With this population here that is what it primarily is. Percocet, adderall, vicodin, all that kind of stuff.” Adolescents will abuse such drugs to achieve stimulation, pleasure, calmness, or extra energy. With the wide availability of prescriptions, adolescents can find easier access to the pills and do not even need a drug dealer for many can find such substances from the comforts of their home on their own computers or in the medicine cabinet. In this instance substance abuse differs greatly from eating disorders and self-mutilation through the large option of drug choices and availability, in addition to the fact that this form of self-destructive behavior requires access to illegal substances.

Substance abuse is about twice as prevalent as eating disorders and self-mutilation, while rates of substance use are even higher. Nine percent of adolescents under the age of 17 are considered to have substance abuse problems (Terry-McElrath, et. al, 2005:334). Many more adolescents will use these illegal substances at much higher rates than those who develop addictions. All of the middle and high school public students in the state of Maine were surveyed in the Maine Youth Drug Alcohol Use Survey (MYDAUS) which

reported that alcohol, tobacco, and marijuana were the most common substances used; 47.7% of students have had alcohol in their lifetime, 28.7% have smoked cigarettes, 25.0% have used marijuana, 12.2% of students have used inhalants, 12.0% have used prescription drugs illegally, 10.9% have used other illegal drugs, and 9.7% have used smokeless tobacco. The substances used least often were cocaine, LSD or other psychedelics, stimulants, MDMA (Ecstasy) and heroin (MYDAUS, 2006:5). Almost half of all middle and high school students in the state of Maine have had alcohol, almost a third have smoked cigarettes and about a quarter have used marijuana. This higher projected prevalence of drug use puts it as a more visible and extensive problem than eating disorders and self-mutilation, and for this reason it is often considered more socially dangerous and severe.

Factors related to Substance Abuse: Personality and Gender

Even though substance abuse attracts a wide variety of adolescents, there are several personality traits that place some at a higher risk, just like those with eating disorders and self-mutilation. Some general personality traits include extroversion, impulsivity, low attention span, novelty seeking and lacking self-restraint (Hesselbrock and Hesselbrock, 2006:98-99). Adolescents who use and abuse substances often have less self-control, making them more vulnerable to peer pressure, are easily bored, and often unrestrained in their actions.

Similar to adolescents who self-mutilate, those who abuse substances seem to lack healthy coping skills and will often use to self-medicate against any negative emotions. “(S)ome individuals may cope with a negative affect by using drugs and alcohol to relieve their unpleasant symptoms...” (Hesselbrock and Hesselbrock, 2006:99).

Substance use may temporarily mask any feelings of depression or inadequacies but, just like self-mutilation, does nothing to fix any emotional difficulties in the long-term. “In addition, teens who utilize drugs and alcohol on an ongoing basis are likely self-medicating and acting out in response to preexisting emotional difficulties. Depression, loneliness, poor self-esteem, anxiety, and a host of environmental problems may be responsible for the teen’s distress and consequent efforts to alleviate it through substance abuse” (Plante, 2007:11). Substance use and abuse may be an adolescent’s attempt to seek relief from any emotional turmoil when they feel that they lack the resources and coping skills to deal with their stressors and negative feelings. As drugs will change the chemical composition of the brain, they bring a temporary change of emotions, and for many adolescents, especially those depressed, this is a much needed release. The National Survey on Drug use and Health found that adolescents who experienced depression were twice as likely to use alcohol and drugs (Monti, 2007:1). Although society seems to blame substance use and abuse on peer pressure, which does play a significant role, all too often the adolescents themselves seem to be forgotten. Depression and other negative feelings along with a dearth of healthy coping skills often precipitate the use of substances.

While eating disorders and self-mutilation can be seen as internalizing behaviors, where one acts out ones emotions projected onto the body, substance abuse is viewed as more of an externalizing behavior where adolescents cast their struggles outwardly. Children and adolescents who outwardly act out their emotions, often in energized ways, appear more at risk for developing substance abuse problems. “Several long-term prospective studies have supported an association between externalizing childhood

behavior problems (physical aggression and violence, symptoms of conduct disorder) and the subsequent development of early-onset alcohol problems and the expression of alcohol disorders...” (Windle, 1999:43). Individuals who are more aggressive and hostile, indications that they cope with their emotions by acting out, are more likely to use substances.

Gender differences also appear with substance abuse in the types of substances used the reasons for using the substances, and the stereotypical image of the user. In the state of Maine, boys and girls differ in their past month and lifetime use of substances. The prevalence rates were higher for boys than girls for smokeless tobacco, binge drinking, marijuana, LSD, cocaine, ecstasy, stimulants, heroin, and other illegal drugs. Prevalence rates were higher amongst girls for cigarettes and lifetime use of alcohol, inhalants, and prescription drugs. Rates were identical for past month use of alcohol, inhalants, and prescription drugs (MYDAUS, 2006:6). Boys are more likely to use smokeless tobacco while girls smoke cigarettes. Boys seem to use illegal drugs more while girls seem to turn more to prescription drugs on a regular basis. However in the past month use, substance use rates appeared very similar for both genders, yet differences become more pronounced when looking at lifetime use of the substances for boys and girls. Despite the common assumption that boys use and abuse substances at a higher rate than girls, in reality this is not the case. All of those that I interviewed described the similar gender ratios of adolescents using substances and school counselor Smith (2008) summed it up best, “seems to be pretty equal. They all party together.” Boys and girls seem to use substances at similar rates.

Unlike self-mutilation where girls take on the assumed role of the “poster child,” girls are not socially assumed to have substance abuse problems. Just as this undermines the actual boys with eating disorders and who self-mutilate, this false postulation harms the girls who do use and abuse substances, making them either be seen as extremely troubled or by being simply ignored. “Today women who drink are still generally seen as more pathological than men who drink because women who drink are violating traditional gender roles by engaging in a male activity and failing to perform their traditional role of maintaining the moral order” (Collins, 2002:198). As substance abuse, in particular that of alcohol, has historically been understood as the masculine form of acting out and self-destruction, girls who drink and use are considered deviant. Yet often many girls will in fact use substances because their peers do, and just as with eating disorders, girls are taught to please others before themselves. “Consequently, some girls and women attempt to conform by drinking in response to how much peers are consuming” (Collins, 2002:207). Peer pressures play a crucial role in the substance use habits of girls who are socialized to put others before themselves and then will drink or use in social situations to comply with others’ wishes. The social stigma attached to substance use has excluded girls who still use at similar rates of boys.

Common notions of masculinity include risk-taking and acting in dangerous ways to assert the stereotypical image of toughness. As eating disorders and self-mutilation stereotypically are thought of as a “female problem” some boys may find substance abuse as a more socially acceptable form of self-destruction. Social worker Anderson (2008) explains that for boys substance abuse, “may be one of the more acceptable ways of self-destructive behaviors that it may be the one that they turn to.” Boys may be more likely

to brag about their illegal habits in trying to affirm their masculinity. “Holding one’s liquor has long been associated with masculinity...” (Farber, 2000:293). Adolescent boys may also act out hyper-masculine behaviors in hopes of becoming accepted into a patriarchal society, influencing their decision to use substances.

While many consider using alcohol and drugs as a more masculine trait, girls may therefore act more covert about their patterns of use, meanwhile boys may flaunt it to comply with social gender norms. Guidance counselor Joseph (2008) found that, “the boys are more likely to be caught for it in school more often than the girls... (and they are) not as anxious about being caught because they don’t really, don’t think twice about coming to school stoned or drunk.” At her school Joseph reported that boys are more likely to use on school property while the girls do not for fear of “embarrassment” if their teachers learn about it or that they might find themselves in trouble. But with the notions of masculinity and boys as trouble -makers, these gender notions make it more socially acceptable for boys to use in school. “Because male socialization pushes adolescent boys to experiment, be tough, and take risks, boys move in dangerous circles and have more opportunities to acquire and use drugs” (Collins, 2002:210). The current definition of masculinity pressures boys to use substances to demonstrate their manhood while girls usually hide such acts from the adult population.

Cultural and Social Influences of Substance Abuse

The family, peer groups and media exposure greatly influences adolescents’ thoughts, actions, and beliefs. Family dynamics and the upbringing of adolescents influence the likelihood that they will use and abuse substances. Adolescents coming from unstable and unsupportive families are more likely to turn to alcohol or drugs at a

younger age. “Disruptions of basic family management processes, such as lack of support and abusive parental behavior, parent- child conflict, erratic and inconsistent discipline, and inadequate parental monitoring raise the likelihood of youngsters’ substance abuse....” (Moos, 2000:184). Adolescents from families where parents lack proper control, cooperation, and supervision are at a higher risk for forming self-destructive behaviors. Nurse Wagner (2008) describes, “a lot of them have some issues at home, parents are not that involved, they are not the typical kids that will be involved in sports or extracurricular activities... For this one, I see that the kids are not supervised. Supervision is a big one, they have too much unsupervised time.” When parents give their children too much freedom without any regulations, some adolescents will use their free time in unhealthy ways. But this does not just stem from deliberate parental neglect, as nurse Davis (2008) has found. “I think with the drugs, probably less parental involvement and not because they don’t want to be. They might be hardworking and they are just not being there.” With an increased number of single mothers, absent fathers, and a struggling economy, parents may have to work several jobs simply to make ends meet leaving more and more adolescents without parental regulation or attention. Lacking support and guidance from their parents, many adolescents will turn to substance use.

While abuse of any kind constitutes a major life stressor, other unhealthy family dynamics also detracts from the upbringing of children. High levels of marital conflict, family stress and violence are associated with increased adolescent alcohol use (Windel, 1999:55). Parents with marriage problems, who are violent, angry or upset, often will create a negative atmosphere that increases feelings of frustration and unhappiness in adolescents. Some adolescents will turn to substances to escape family problems,

especially when they lack supportive and involved parents. Joseph (2008) has found that many of the students she sees with substance abuse problems come from broken families lacking structure and consistency. “Single parents, a lot of parents, step-parents... a lot of these kids don’t have a lot of structure, don’t have a lot of rules, don’t have a lot of strong attention given to them from their parents so they can kind of do whatever they want.”

Parents’ marriage situation may relate to adolescent substance abuse, as adolescents who come from unstable backgrounds are more likely to use substances.

Young children learn through imitating the adults around them, and to some extent adolescents will continue to emulate and reproduce the behavior of their parents. Therefore when substance use becomes socially reinforced in the home situation, adolescents learn that such use is acceptable and supported. “There is no doubt that parental substance dependence is related to a substantially increased risk for developing substance abuse problems in both male and female offspring” (Hesselbrock and Hesselbrock, 2006:97). A parental history of alcohol or drug problems predisposes adolescents to face similar issues. Davis (2008) indicates that adolescents will often drink heavily if, “their parents are heavy drinkers. They will see their parents sit down at night and have a glass of wine and then have a glass more and again.” Regardless of a genetic link to dependency and addiction or not, adolescents growing up in a household with substance using adults learn that such behaviors are acceptable. A using parent will struggle in trying to prevent their adolescent from using, for any arguments against use will not be viable to the child. Parents dependent on substances will also lack the time and energy to invest in their children, impairing their relationship. Social worker Anderson (2008) found that, “if there is alcohol or substance abuse in the parent, then the

family structure is going to be pretty unhealthy.” If a parent uses substances, then he or she will not be able to fully devote themselves to his or her child. This form of rejection will often correspond to decreased supervision and feelings of self-esteem, placing adolescents at a higher risk to turn to substances themselves. Therefore a cycle of substance abuse problems exists, with children of users often becoming users themselves.

A positive and healthy relationship with one’s parents will reduce one’s likelihood of using substances. High family involvement and support will not only increase an adolescent’s self-esteem but also reduce their chance of substance use and abuse. Parental nurturance, involvement, monitoring, and high communication are all inversely related to adolescent alcohol use (Windel, 1999:54). Even though adolescents are beginning to become more independent and self-sufficient, they still require their parents’ love and attention. Parents who spend more time with their adolescents and who provide emotional support will not only instill in them positive values but also decrease their likelihood of becoming involved in self-destructive behaviors.

In addition to parents, siblings also sway one’s decision to use substances. Similar to the influence of peers and to a lesser extent parents, “older siblings have also been identified as role models and influential agents that contribute to higher rates of adolescent alcohol use” (Windel, 1999:55). Siblings often have more of a peer relationship where they participate in similar activities. Younger siblings often will spend time with their older brother or sister and his or her friends, gaining them more access to the resources and opportunities to use and abuse substances. Younger siblings who often look up to their older brother or sister as role models, will be more likely to use in hopes

of not only gaining acceptance from their sibling but also in emulating their perceived exemplary brother or sister.

Just as with eating disorders and self-mutilation, one's peer group influences one's actions, thoughts and beliefs. Out of all of the self-destructive behaviors, substance abuse is the one that peers most likely partake in together. School counselor Smith (2008) explains, "alcohol is social, pot is social." Even though disordered eating can become a group activity with peer diets, eating disorders are more hidden and private. Despite the fact that some adolescents, in particular boys, may self-mutilate together, most adolescents will often do that act in private. Therefore because substance abuse is the most public self-destructive act of them all, peer pressure becomes a crucial influence as adolescents simply crave acceptance and to fit in with their classmates.

Due to the social nature of substances, when some adolescents are using, chances are that the majority those in his or her peer group are using as well. Davis (2008) reports that, "with peer pressure, it is just what you do. It is very difficult to not do it. A lot of freshman will do it to look cool, definitely the peer pressure." Adolescents strictly follow the social norms of their groups for many of them fear exclusion and ridicule. "Peer influences have consistently been cited as risk factors for the initiation of alcohol, tobacco, and other drug use among children and adolescents. Peers influence adolescents' values, behaviors, attitudes, and choice of other friends" (Hesselbrock and Hesselbrock, 2006:104). Specific personality traits also may make some adolescents more susceptible to peer pressure, especially if they are extroverted and have low self-esteem. Peers often pressure their friends to drink or use in social situations.

Just as peers may influence an adolescent to drink or use drugs, peers may also act as a positive force in deterring any substance use. As adolescents often surround themselves by peers who think and act similarly, they often will complete activities of shared interests. Some peer relationships “exert positive influences that reduce the likelihood of exposure to substances and of substance use and misuse. Friends who model conventional norms and behavior and engage in activities that are incompatible with substance use may protect youngsters against association with deviant peers and subsequent drinking and drug use” (Moos, 2006:188). As peers can also have a positive influence on abstaining from substances, one must not condemn all peer relationships. Joseph (2008) found that at her school peer pressure actually can decrease substance use, “it definitely deters them from doing it in school, because it’s not, not as cool as it used to be to come to school drunk or stoned.” As peers play a crucial role in creating a set of norms and values, peers can help create a culture not based on substance use for entertainment. Adolescents would benefit from families, schools, and social norms that encourage relationships based on socializing activities besides substance use.

Even though parents and peers provide a source of strong messages regarding substance abuse in either positive or negative ways, the media may, in turn, further influence the use of substances. Through television, commercials, shows, movies, and you-tube clips, advertisements try to create a sense of insecurities in adolescents with the promise that their product, typically alcohol, will make everything better. Especially on sports channels, beer commercials appear abundant and flawless, creating a world in which adolescents want to partake. In her work school counselor Smith (2008) has found that the media play a huge role in adolescent substance use. “First off there’s the whole

industry of the drinks that are really sweet like Mike's... it used to be just hard liquor and beer and then they introduced wine coolers... and all of these sweet drinks that are hard. And so that is all media driven..." The introduction of sweeter alcoholic drinks accommodates to the adolescent population. Yet television does not just promote alcohol through commercials but also popular movies catered to adolescents will depict parties with vast amounts of alcohol with ideal characters enjoying themselves. Smith (2008) notes that the students, "watch a lot of movies and there are a lot of drinking in movies especially the kinds of movies that high school kids watch... there is always someone getting trashed or drunk." The media depicts alcohol as a natural beverage of choice encouraging adolescents to consume more.

In addition to alcohol advertisements, the media also influence the use of cigarettes. In their study on tobacco Gruber and Zinman found that, "smoking among adults was relatively dispersed across many brands, with the top three brands... (Marlboro, Camel, and Newport) accounting for only 35 percent of the total cigarettes smoked. But smoking among youths was much more concentrated, with the top three brands... accounting for 85 percent of cigarettes smoked" (2001:74). The smoking patterns of adolescents, compared to adults, center more around the largest name companies, indicating that many adolescents who smoke will do so for the brand name and image it carries. Adolescents will smoke cigarettes from popular brands in hopes of achieving status, popularity, and all the other pleasant things the ads promise. Guidance counselor Joseph (2008) describes the effect of media advertising on adolescents, "I think that they've gotten the message that it's ok to drink, ok to smoke pot, ok to smoke cigarettes. It's not going to kill you. You will be fine, you will have a good time, people

will like you and everybody's doing it kind of thing." The media promote substance use through advertisements, movies, commercials and the internet, influencing adolescents to use those substances.

While adolescents constantly internalize media messages that promote the use of substances, school programs try to teach them a different mentality. School curriculums often go against the general culture on substance use, telling a different message than that given by society, many parents, peers, and the media. "What does it mean to a child/adolescent to hear these repetitive tirades, year in and year out, against the evils of the very substances that may play a central role in the life of family members and relatives and are promoted by the media and the advertising industry? Does this create a confusion about who is telling the truth which leads to curiosity and experimentation...?" (Frankel, 1998:226). Substance abuse programs in schools, in particular the well known DARE (Drug Abuse Resistance Education) play an integral role in health curriculums. But when school programs discourage substance use and many children's parents or friends use them, that child is left bewildered and perplexed. Joseph (2008) describes how students go through "DARE, the kind of scare-tactics that if you smoke pot you know your head is going to explode, something like that, and they know that's not going to happen. And they don't take it seriously because they don't see that it is bad for them because they've done it and they're still here and they're fine." Adolescents who use themselves or know of people who use substances realize that despite the shock method many programs try to convey, they have survived and hence undermine the school's message of discouragement. Many adolescents find that the abstinence message they hear in school conflicts with the social values in their culture, homes, and peer groups.

Some adolescents also might learn more about substances from the actual programs and become curious, therefore schools have a hard time trying to discourage substance use. Smith (2008) describes how, “we have had in the past different preventative programs and they have had sketchy results. Actually one program that we had here, the kids came away so curious that a couple of kids were like, ‘Well I decided to get high.’ And I asked how come and they said, ‘Well it peaked my interest.’ So we are in the process of trying to look at what other sources there are. There definitely is a need and we have not been able to find a good way to fill it well.” Substance prevention programs, just as with self-mutilation, have to find a way to educate students about the harmful effects while discouraging them from using by not sparking curiosity. School programs often stand alone in their fight against substance use, making adolescents even more confused and torn between following a set of contrasting norms that varies between social institutions.

Conclusion

Out of all three forms of self-destructive behaviors, the greatest proportion of adolescents struggle with substance abuse and use problems. Adolescents often will drink to cope with their negative emotions or to comply with peer pressure. Currently there is more peer pressure to use substances than to engage in an eating disorder or self-mutilate, indicating that substance use appears more embedded in social norms. Smith (2008) explains, “I think the substances have always been a problem and always will be a problem. They are so part of society, embedded. The media, everyone is invested in continuing and the fact that companies are making drinks that are sweeter (means they are) marketing to adolescents.” Substances, especially alcohol, have become an accepted

part of adolescent culture, almost marking a transition into adulthood. Substance rates, although decreasing from a peak in the mid-nineties still remain high. “The overall lifetime alcohol use rate among Maine’s 6th to 12th grade students has dropped consistently over the past decades- from 70.7% in 1995 to 47.7% in 2006.... After holding steady since 1995, the prevalence rate of lifetime marijuana use has decreased slightly from 2002 (29.8%) to 2006 (25.0%)” (MYDAUS, 2006:17). The prevalence rates of lifetime cigarettes use has decreased steadily since 1995 from 52.8% to 28.7% in 2006 (MYDAUS, 2006:22). Although the rates of many substances have slightly decreased they still remain high, indicating that social norms have not significantly changed but that they need to do so.

Similar to eating disorders and self-mutilation, parents, peers, media, and society influence substance use. As substance abuse occurs at a higher rate than the other forms of self-destructive behaviors, adolescents find themselves more exposed to it. This increased exposure makes substance use seem almost normal, a fact that school programs struggle against while attempting to discourage such use. For many families and communities, substance abuse continues in a cycle of use throughout the generations. Joseph (2008) describes how, “as a community there is so much of it that it is hard to break the cycle, you hear that it’s not going to kill you if you drink but its still not a good idea and you really need to understand what you are doing to yourself...” Many communities, especially in Maine, lack the resources to provide for their youth in teaching them healthy coping methods and reducing the rates of substance use.

Conclusion

To better understand self-destructive behaviors so that we, as a society, may help and heal those adolescents, we must understand the social pressures, as indicated through the media, family, and peers that influence eating disorders, self-mutilation, and substance abuse. Awareness is the first step to any solution. Gaining knowledge about the external social influences that may encourage some adolescents to self-destruct will help us reduce these problems. “Especially important is the notion that the individual does not exist in a social vacuum, that subjectivity (including our experience of and understanding of our bodies) is constituted through discourses that are socially and historically specific” (Blood, 2005:47). Adolescents shape their own meanings through social interactions and cultural norms. When self-destructive behaviors often carry negative connotations, many adolescents will not seek treatment for such disorders for fear of the stigma it carries.

Many adolescents who partake in one or more self-destructive behaviors do not receive the help or treatment they need. According to the National Eating Disorder Association, in 2003, only one-third of the individuals with anorexia, and only six percent of those with bulimia received mental health care.¹ Therefore a new cultural dialogue surrounding the body must be had to encourage treatment, one which is slowly occurring as more and more people become aware of the high prevalence of eating disorders. “Even though individuals suffering from eating disorders are reluctant to admit it, they do so more now than in the past because they and their significant others are more likely to know that they have an illness, the possible consequences of that illness, and that they can get help for it” (Costin, 1997:3). By having open communication surrounding eating disorders, adolescents realize that they are not alone in their sufferings, and that they can

¹ http://www.nationaleatingdisorders.org/p.asp?WebPage_ID=320&Profile_ID=41138

receive help. By educating students about eating disorders in schools, discussing the often unreal portrayal of the body in media, and having a discourse that places a higher emphasis on the individual rather than the body, then slowly this epidemic may shift and individuals can move from fighting with food to accepting their bodies the way they are.

Just as the insufficient treatment for adolescents with eating disorders demonstrates not only the negative social stigma of acknowledging such behaviors, but also the lack of access to counseling, similar trends appear for substance abuse. Not all schools have the resources to provide internal counseling services for substance abuse and many communities, especially in more rural areas, lack adequate treatment centers. “(I)n 2003, 74.2% of students had access through external counseling and 24.5% through internal counseling services. However, 21.2% of students had no counseling service access of any kind via schools” (Terry-McElrath, et. al, 2005:340). While many schools offer the recommendation of counseling in the community, fewer provide such treatment offers on their own campuses. This becomes extremely problematic for impoverished families. Adolescents who come from families lacking health insurance, a reliable form of transportation, and with parents working, may have particular difficulty attending private treatment sessions. Whereas many adolescents would find it easier to receive substance abuse counseling in their own school, this often does not happen. As indicated by the high portion of adolescents that have substance abuse problems, this data on counseling availability indicates a real need for change.

Even though schools act as a source of education for adolescents, many schools currently are failing their students in regards to education about treating their bodies in healthy ways and by not offering direct treatment for eating disorders, self-mutilation and

substance abuse. All of the professionals whom I interviewed, from the community, private and public schools noted the need for more resources to adequately provide for adolescents. School counselor Smith (2008) explains how “the need is greater than the resources.” Nurse Wagner (2008) describes, “there always could be so much more... when I go to state conferences and hear how so many of the nurses spread themselves so thin, like a lot of districts only have one nurse.” Guidance counselor Joseph (2008) indicates her school could “use a couple more social workers. It’s overwhelming I think for those two social workers.” Joseph’s school has only two social workers for about 1250 students, and the four guidance counselors must also deal with academic issues. Nurse Davis (2008) has found that due to the lack of resources it is hard for adolescents “without advocates, falling through the cracks.” Social worker Anderson (2008) explains her neighboring primary school; “They don’t even have a guidance counselor at the elementary school, they really struggle... it is definitely related to the budget.” All of these professionals describe the lack of resources provided for the mental health of adolescents in the school system. “The fewer resources for children... the more mental health problems one should expect...” (Collins, 2002:275). By not providing adequate counseling nor offering support for adolescents and the struggles they face, we, as a whole society, harm this young generation.

This vast lack of resources contributes to the cycle of self-destructive behaviors along with other social factors. Yet schools cannot simply add more counselors, for in the end the problem comes back to larger monetary issues and the budget. “The strong decrease in internal counseling availability and participation may be related to current national and state budget scarcity; funding for such services may have dropped as efforts

to continue core educational services become more difficult” (Terry-McElrath, et. al, 2005:341). Because of a lack of money for providing such services, schools have few options left. With increased budget cuts, counseling becomes secondary to academic matters and often disappears from the curriculum.

Schools are not the only one that face financial burdens regarding mental health matters, communities and hospitals do as well. Joseph (2008) explains the struggles she has in trying to advise students to seek counseling outside of school. “It is hard to come by in Oxford County, there just isn’t much... it is hard to get in, the wait list is homogenous... I’ve got kids with serious mental health issues that see their counselors once a month or they don’t even have a counselor and go to the hospital and try to get medication or something but there is no therapeutic follow up.” Meeting only once a month does little to help adolescents deal with their self-destructive behaviors; they require more intensive and regular sessions. With a void in counseling services in not only the schools but also the communities, many parents have no choice but to take their adolescent to the emergency room where no one is denied treatment. Yet the situation is not much better there. Davis (2008) describes how in the emergency rooms, “There are budget cuts all of the time, we are sending people on the streets that I have to tell you if... the general public knew that, then I think something would be done. The budget cuts have been horrible, so I think we are really failing the community. That is why our numbers have doubled in the ER, why we are now starting to fill beds in all of the areas because we lack the resources.”

Without support in schools and communities, people will often turn to emergency rooms. This over-utilization places an added burden on hospitals that also lack adequate

budgets to provide help for all of their patients. With more patients than beds, hospitals have to turn people away and are providing a disservice to the community. Davis (2008) explains how due to this current crisis of lack of resources, most of the beds in hospitals are filled and sometimes they will even have to send patients to treatment programs in Massachusetts because “there are so few beds here”. Until we as society, make mental health a priority and provide adequate funds for schools, communities, and hospitals, then adolescents will continue to suffer from self-destructive behaviors.

Even with adequate funding and resources, the current insurance situation deters many individuals from receiving the help they need. Even adolescents whose families have health insurance may encounter problems trying to find a treatment program covered by their own insurance companies as Davis (2008) has found. “The insurance process now.... Let’s think of the detox people. The majority of the detox people if they are not suicidal there is no reason to hold them, so we try to find a program that is open and if St. Mary’s doesn’t have any beds, we start making phone calls but the biggest part of time is dealing with the insurance. And sometimes it has taken 4-6 hours and by that time they have changed their mind and are going through so much drug withdrawal that they leave.... It is just turning nurses away... it is just so hard, in situations like this seeing all of the people turned away.” During the hours taken trying to find treatment openings and then trying to have insurance companies agree to such programs, many patients will have begun suffering from withdrawal symptoms and move from having a desire for help to instead just wanting another fix of their substance. Emergency rooms cannot hold people who have abused drugs beyond what is required for normal care unless they are a threat to themselves or society. Davis voices the frustration that many

health care professionals face as they try to help individuals but struggle doing so by a lack of resources, budget cuts, insurance companies and other things they cannot control.

Despite the hardships that adolescents face dealing with possible treatment and counseling offerings, many caring adults have not yet given up and are working to help reduce self-destructive behaviors in adolescents. All of the professionals whom I interviewed spoke passionately about their work and are making a difference one child at a time. Many programs do work on successfully educating adolescents about how to care for their body, the negative influence on the media on one's body image, and adolescent struggles in general. Anderson (2008) explains, "I am really interested in *Hardy Girls Healthy Women* up in Waterville and the books that Lyn Mikel Brown has written." Anderson uses such philosophies that promote discourses to examine adolescent struggles in not only her own work, but also in raising her own young children. Smith (2008) explains the positive effect of similar programs and school health classes; "Recently over the past year or so I have heard kids talking more about manipulation of media images through digital computers and that is a totally new discussion. So I think that there is an increased awareness that the media does manipulate, but I don't think it makes any difference in terms of what the kids see as attractive." With an increase in media awareness, adolescents are learning that many of the faces that they see and admire on the covers of magazines are, in fact, not real. This knowledge hopefully will begin to improve adolescent body image and the destructive acts associated towards the body not fitting perceived social norms. Educational programs, parents, and professionals can and do make a difference in educating adolescents to care for their bodies, but these discourses must continue to be expanded.

This paper holds several implications for adolescents in contemporary society. The lack of available resources in schools, communities, and hospitals is harming adolescents. Just as with a need for continued media education, adolescents should also be taught more internet awareness. The internet plays a huge role and support group in perpetuating these self-destructive behaviors. Anderson (2008) explains how on the internet “you can get access to how cool it might be and how great and how it might work... it does not paint a helpful picture about it about why you might not want to get started with this because it takes on a whole life of its own and before you know it they cannot stop.” Internet use by adolescents should be monitored and discussed. Parents, or other adults, should talk about the messages adolescents learn not only from the media but also from the internet. Parental support and supervision are also key as Wagner (2008) describes “if you are roaming around town from 2-5 every afternoon... you are at a higher risk for getting involved in groups of kids that maybe you shouldn’t be.” Parents can act as a support system to allow for healthy coping methods and alternative releases of tension and emotions. Anderson (2008) believes that, “for teenagers I think you need to have a safe place for them to talk.” Adolescents need to be able to openly discuss their frustrations and struggles with their emotions, bodies, and peer pressure. By talking about such problems then they can form alternative solutions.

Adolescents should be able know that their concerns are taken seriously and that there are resources to which they can turn for support and encouragement. “It is also important to advocate for a caring society for adolescents... so that adolescents can have better development in self-identity, better coping mechanism and less stress in their adolescence” (Yip, 2005:84). Once society starts caring for adolescents, through

providing enough resources, funding, support, healthy role models, and diminished gender norms, then adolescents can learn that they are valued as individuals and will be empowered to care for their own bodies. In addition to creating a caring community, many people need to be more responsive to the struggles that adolescents face. Davis (2008) explains how “people need to be more aware of the signs and the need to have more resources and not be afraid to say to someone that they need help.” When people are aware of self-destructive behaviors and understand the reasons behind an adolescents attack on the body, then they can help those individuals with early detection and by providing support. Adolescents should also not be afraid to ask for help and should not fear the stigma attached to self-destructive behaviors.

This paper presents only a broad overview on three forms of self-destructive behaviors. Adolescents face many more issues than discussed here. And more can be said and explored with regard to eating disorders, self-mutilation, and substance abuse. Future research examining eating disorders in athletes and boys is needed. The gendered trends of self-mutilation also call for further examination. Regarding substance abuse, educators need to continue focusing on ways to help adolescents resist peer pressure. Future research needs to be done on adolescent depression, suicide and the choking game. Research should focus on the process of adolescence and why it seems like such a challenging time for many. “Without some way of bestowing meaning to what happens in adolescence, it is all too easy to fall into the trap of pathologizing adolescents as sick, crazy, or delinquent” (Frankel, 1998:117). By studying the array of destructive actions that adolescents direct toward themselves, we can come up with solutions on how to stop them and understand why such individuals suffer and treat them with care.

While it is easy to categorize and generalize adolescents who partake in self-destructive acts, adolescents are not all the same. Despite some general overarching similarities, adolescents who self-destruct have their own unique experience which compels them to act in harmful ways towards their bodies. Therefore, this paper contains only the partial understandings of an adolescent who has an eating disorder, who self-mutilates, or who suffers from substance abuse problems. This paper must not speak for all self-destructing adolescents, for they each have their own unique story to share. Once we take the time to listen to these stories showing them that we care, then we can help adolescents heal and teach them how to care for their bodies with the same love and attention that we direct towards them in other ways.

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