

Self-Injurious Behavior: Who's Doing It, What's Behind it, and How to Treat It*

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Abstract

Over the last few years, increasing media attention has been given to self-injury behaviors among adolescents, which has subsequently led to increased awareness among treatment providers. Self-injury is of particular concern within residential programs, with some estimates showing that 40-80% of adolescents in clinical settings engage in self-injury. Complicating the matter is that assessment and intervention for suicide risks have been applied to dealing with self-injury behaviors, even though there are important differences between the two issues. The purpose of this paper is to provide an overview of current trends in adolescent self-injury and to provide recommendations for the development of policies and procedures.

Self-Injurious Behavior: Who's Doing It, What's Behind it, and How to Treat It*

In recent years, increasing attention has been given to self-injury behaviors among adolescents, which has consequently led to an increase in the examination of the frequency of the behavior, its causes, and effective treatments. Residential programs treating adolescents have struggled in their efforts to develop effective best practices for responding to self-injurious behavior. The purpose of this article is to address some of these common concerns, and outline some considerations that should be taken into account when developing appropriate policies. In this article, we will use the definition of self-injury advocated by Klonsky (2007): “the intentional destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (p. 1039).

Behaviors that constitute self-injury are cutting, burning, carving (words/symbols), scratching, hair-pulling, preventing wounds from healing, biting (to cause bleeding), hitting (to bruise or otherwise damage tissue), tattooing or piercing (if done to moderate emotion), and embedding objects (in the skin, to moderate emotion). It should be noted that “body modification,” such as piercing and tattooing, does not necessarily equate with self-injury. In many cases, body modification does not fit Klonsky’s (2007) definition of self-injury since the behavior is largely sanctioned by society. However, it is possible for body modification to cross over into self-injury, especially when the intent of the person engaging in the behavior is to mediate an unpleasant emotion.

Historical Perspectives

Before delving into current trends, it is important to recognize that self-injury is not a new phenomenon. Timofeyev, Sharff, Burns, and Outterson (2002) provide a good overview of some of the major historical examples where self-injurious behavior was reported. Below are some of the examples they described:

- Between 496 and 406 BC, Sophocles wrote the play titled *Oedipus the King* in which Oedipus unknowingly kills his father and marries his mother. Upon discovering what he had done Oedipus blinds himself and declares: “Wicked, wicked eyes! You shall not see me nor my shame - Not see my present crime. Go dark, for all time blind to what you should have never seen” (Sophocles, trans. 1909).
- Between 460 and 370 BC, Hippocrates outlined the precepts of “humor” theory and describes the utility of “...bloodletting, blistering, purging by vomiting or anal purgatives, or other potions that would cleanse the body” (Hippocrates, trans. 1891).

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- In the first century BC, the Roman priests participated in the “Day of Blood.” On this day, priests openly slashed themselves and sprinkled their blood on the statue of Cybele in celebration.
- During the 11th century AD, some within the Christian faith began to participate in self-injurious behavior. Followers of the faith were known to starve, purge, flagellate, and scar themselves as a demonstration of devotion or penance.
- In 1886 the first case study was written about self-injury. The document describes the case of a widow who enucleated her eyes (i.e., removed them) while grieving for her husband.
- In 1888 Vincent Van Gough famously cut off his own ear and sent it to a prostitute.
- Menninger (1938) provided one of the first modern descriptions of self-injury that distinguishes suicidal intent from self-injury. He wrote that “local self-destruction is a form of partial suicide to avert total suicide” (p.271).
- Pattison and Kahan (1983) wrote the first article in modern psychiatry devoted to self-injury where they described predisposing factors and characteristics of those who engage in deliberate self-harm.

Since Pattison and Kahan (1983) published their findings, a number of important developments have occurred that have affected public awareness of self-injury among adolescents. Probably the most noteworthy of these is the emergence and growing acceptance of “emotional hardcore” or “emo” music, which is characterized by lyrics heavily-laden with distressing emotion. Emo was originally a break-off from the punk bands of the 1980’s and steadily gained fans throughout the 1990’s. Given the type of music emo bands produce, it is not surprising that those adolescents drawn to their music might be experiencing distressing emotional states, and adolescents who experience high levels of emotional distress are also more likely to participate in self-injury. Over time, emo culture consequently became associated with self-injury in general (though somewhat unfairly).

The public became increasingly aware of emo culture between the years 2000 and 2005, during which time emo bands like “Dashboard Confessional” achieved national recognition and financial success. Despite the commercial success of the music, the general public was distrustful of emo music, but somewhat tolerant. Perceptions changed dramatically in 2008 when a 13 year-old girl named Hannah Bond committed suicide after becoming a fan of the band My Chemical Romance. Shortly before Hannah committed suicide she had shown her father cuts on her wrists and explained that they were part of her “emo initiation” (Levy, 2008). Her father had accepted her explanation and her commitment not to do anything like that again.

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Despite the ensuing backlash against emo, the visibility of self-injurious behavior has risen sharply in recent years. Numerous websites devoted to self-injury currently glamorize the behavior. A simple search on a video service like YouTube also reveals over 100 clips devoted to self-injury. Furthermore, several celebrities (e.g., Johnny Depp and Angelina Jolie) have added to the public's awareness by speaking openly about their history of self-injury.

Current Trends

Profile of the Self-Injurer

A common myth concerning self-injury is that this is a new problem, or one that only affects certain groups of people (e.g., emo kids). In reality, self-injury is seen across many different ethnic groups (e.g., Whitlock, Eckenrode, & Silverman, 2006), though some studies have found that Caucasians are more likely to engage in self-injury than non-Caucasians (e.g., Gratz, 2006). Furthermore, self-injury is not limited to adolescents and young adults. In fact, Klonsky and Muehlenkamp (2007) reported that up to 4% of the adults in the general population engage in some form of self-injury, with 1% engaging in severe self-injury.

Even so, Klonsky and Muehlenkamp (2007) argue that the prevalence rate is still much higher among adolescents and young adults (i.e., approximately 15%), and one recent study of 9th and 10th graders found that 46% of those surveyed had engaged in at least one self-injurious behavior within the last year (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007). Not surprisingly, the prevalence rate among adolescents in a clinical population is even higher, with 40-80% engaging in some form of self-injury (Darche, 1990; DiClemente, Ponton, & Hartley, 1991; Nock & Prinstein, 2004). Finally, although many assume that females engage in self-injury more than males, large sample studies have not found this to be the case (Briere & Gil, 1998).

Among the various types of self-injury, the most common form is cutting, with up to 70% of those who have self-injured engaging in this practice (e.g., Briere & Gil, 1998). When treated for self-injury in the emergency room, 25% of 17 to 24 year olds also reported use of this method (Olfson, Gameroff, Marcus, Greenberg, & Shaffer, 2005). Klonsky & Muehlenkamp (2007) pointed out that despite cutting probably being the most frequent method used, the more important thing to understand is that most individuals who self-injure are likely to use more than one method. Finally, self-injury may occur on various parts of the body, with the arms, hands, wrists, thighs, and stomach being the most likely (Whitlock et al., 2006).

Contagion

Perhaps one of the most striking trends in self-injury is that the rate seems to be increasing among adolescents. One possible reason for this observation may be related to the phenomenon of "contagion."

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Contagion is derived from social learning theory, which posits that individuals are likely to reproduce the behavior they see in others (Muehlenkamp, Licht, Azure, & Hasenzahl, 2008). Muehlenkamp et al. studied contagion as it relates to self-injury among college students and found that those who were exposed to suicidal or self-injurious behavior were significantly more likely to engage in self-injurious behavior themselves. Given increasing media attention and the increasing frequency of public displays of self-injury (as discussed above), it is not surprising that more adolescents are engaging in this type of behavior.

Contagion within therapeutic programs for adolescents can be problematic for all those involved (e.g., Walsh, 2006; Walsh & Doerfler, 2009). In fact, Walsh (2006) wrote: “treatment programs can be hotbeds of contagion” (p.232). Parents send their children to a program in the hope that the symptoms exhibited by their child will be reduced, not so that they can develop new issues. Therapists and line staff are likely to feel increased burden and even guilt when a student begins to engage in self-injury during his/her stay in the program. Accordingly, it is important to manage contagion effectively. In order to do so, it is essential to be aware of some factors that contribute to contagion in a residential setting. Once other students become aware of self-injury among their peers, there are generally two possible directions for contagion to develop. The first is based on competition, and the second is based on affiliation.

With regard to competition, there may be a desire on the part of another student to “one-up” the adolescent who is participating in self-injury. The message being sent is, “I can hurt myself better (more, worse, longer) than you” (e.g., Walsh, 2006). Students may also see the amount of time staff devote to the self-injurer and engage in self-injury themselves to draw the staff back to them. In addition, they might use self-injury, rather than violence or substances, to express strong emotions while avoiding more aversive program consequences of the latter behaviors (Walsh, 2006). One last form of competition arises when the student engages in self-harm with the implicit (and sometimes explicit) intention to punish parents or program staff for keeping them in the program, or otherwise “hurting” them.

In terms of affiliation, the most common occurrence is for a student to begin engaging in self-injury to develop a relationship with the original self-injurer, in this case based on shared interests. Also, when one student engages in self-injury it may provide an excuse for others to “take the leap” (e.g., Walsh, 2006). In this sense, self-injury may act as a form of peer pressure to conform, especially when the original self-injurer holds a position of power within the group. Finally, when an individual lacks effective communication skills, mimicking behavior provides a way to demonstrate understanding and empathy to a self-injurer.

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Motivation

The reasons adolescents engage in self-injury are varied and sometimes contradictory. For example, some adolescents report that they self-injure because they are overwhelmed with emotion and need something to distract themselves. In this sense, self-injury can act as a means to gain control or reduce anxiety. The unbounded distress the adolescent feels becomes manageable and restricted. On the other hand, some adolescents report that they feel emotionally numb, and will self-injure just to be able to feel something. Self-injury may provide an excuse for treating oneself as worthy of care, even if it is limited to treating self-inflicted wounds.

Others self-injure as a “cry for help,” hoping that someone will notice how much distress they are feeling. This particular type of behavior can sometimes be confused with simple manipulation or “attention seeking,” instead of the more accurate interpretation of “attention needing” (Sutton, 1999). One client who came through our program proudly showed the approximately 25 cuts on his arms to staff and students alike. When he was asked in private what led up to the behavior, the bravado quickly faded as he described feeling severely depressed and wishing that his parents would have noticed sooner. This student’s experience supports the research as well, showing that up to 83% of hospitalized adolescents report the primary reason for engaging in self-injury was to alleviate feelings of depression (Nixon, Cloutier, & Aggarwal, 2002).

Although some adolescents are fairly open about their behaviors, it is important to keep in mind that many adolescents who engage in self-injury experience significant levels of shame and attempt to hide their wounds. In such cases, adolescents are likely to suffer from a distorted sense of self, often to the point of feeling disgusted. When others discover their behavior and react with shock or disgust, it confirms the self-image they have constructed, which only increases feelings of shame and the likelihood that they will self-injure in the future (Levenkron, 1998).

After such an adolescent engages in self-injury, the impetus to continue the behavior can be connected to the relief she/he was seeking. This relief then reinforces the behavior, and the next time the adolescent is feeling distressed or numb, self-injury is again seen as a viable option for dealing with the problem. In this way, self-injury can begin to develop into an addictive behavior. The same pattern as that seen in other addictive behaviors (e.g., gaming, gambling, etc.) is demonstrated in self-injury as well. When an adolescent engages in self-injury the endogenous opiate system in the brain is activated, which over time becomes dependent on the self-injurious behavior to get a “fix” (Sandman, 1990). The addictive nature of self-injury bears out in recent research as well, showing that 97.6% of adolescents who engage in repetitive self-injury endorse at least three addictive symptoms related to their behavior (Nixon, Cloutier, & Aggarwal, 2002).

Assessment

Although self-injury is not synonymous with suicidal ideation, there is a correlation between the two. One study found 70% of adolescents who engaged in self-injury reported having made a suicide attempt as well (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Accordingly, it is important to conduct a thorough assessment whenever self-injury is a concern. Some of the correlates Nock et al. identified for suicide attempts were absence of pain during self-injury, longer history of self-injury, and use of multiple methods to create wounds. Despite this relationship, one of the major problems with the current standard of care is that assessment for suicidal ideation is also often considered sufficient to assess for self-injury. This section will focus on what we have found to be the most important aspects of assessment specific to self-injury.

History of Self-Injury

When it comes to self-injury it is important to ask clear and direct questions early in the admission process. One useful way to increase identification of self-injury is to have multiple opportunities for assessment. Questions about self-injury should be incorporated into the admissions application, initial screening during the intake process, and during the clinical interview at the least. The question we most often use to begin the clinical assessment for self-injury is: "Have you ever cut, burned, carved, or otherwise deliberately hurt yourself?" Asking about self-injury in such a direct manner provides the student with an initial level of confidence that we want to hear the answer, and will be able to handle an affirmative response.

When the student affirmatively answers a question about self-injury, a number of follow-up questions can be asked. These questions are intended to determine the frequency/duration, severity/location, precipitating events, consequences of the behavior, and potential for future self-injury. The interviewer should use sound clinical judgment to select questions that will provide essential information, without over-focusing on self-injury. Below are some questions that can be used to assess each of these dimensions for a student with a history of cutting (and can be tailored to other forms of self-injury):

1. How often have you cut yourself in the past? How old were you the first time you did it? Has there been an extended period of time when you didn't cut?
2. Have you ever had to get stitches, or see a doctor, after you cut yourself? What have you used to cut yourself? Is there anything else that you have used to cut yourself? Where on your body have you cut yourself? Is there more than one place that you have cut yourself?

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3. What was going on for you in the moments and hours before you decided to cut? Are there times in your life when you are more likely to be tempted to cut yourself?
4. How did you feel after you cut yourself? Did you feel better or worse? How did other people around you act when they found out? Did you feel pain when you cut yourself?
5. When was the last time you felt like cutting? Are you currently having any thoughts of cutting?

We have found it is also useful to ask students to show us easily accessible marks (e.g., on their forearm) that they have made through self-injury. The primary purpose of doing so is to: 1) demonstrate to the students that we are not disgusted by their behavior; 2) show confidence with clients in the face of self-injury; and 3) be able to gauge the severity of past injury. Students possessing a history of self-injury often feel deep shame about their past and benefit greatly from having someone who can show a neutral reaction to their behavior (Levenkron, 1998). When observing the evidence of self-injury it helps to make factually grounded observations to the student. For example, the interviewer might comment that “the injury looks like it is healing well,” or “that looks like it was pretty deep.” From the latter comment, the interviewer might ask for further information regarding what led to a particularly deep injury, helping to increase understanding of what function the behavior serves or gathering information about significant emotional events the student experienced. Again, the intent is to send the message to the student that they are not a “freak,” and that they can have confidence in us to treat them with dignity and respect. As one may surmise, it is essential for interviewers to manage their personal reactions to the student’s self-injurious behavior. Looks of disgust and judgmental statements only serve to confirm the shame felt by the student, which in turn may lead to an increase in self-injurious behavior.

Case Example

What follows is an example of what might occur during a typical initial intake screening when a student first arrives at the program. In order to protect client confidentiality, the following dialogue does not represent any single student, but instead represents the accumulation of commonalities across numerous initial screening interviews.

Therapist: (After building rapport and asking non-pertinent questions.) “Have you ever cut, burned, carved, or otherwise deliberately hurt yourself?”

Student: “Yes, but I haven’t done it for a while.”

Therapist: “What led you to stop?” (The therapist moves onto discussing consequences of the behavior and likelihood of recurrence, given that the behavior does not appear to be active.)

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Student: “I didn’t really like how it felt. Basically it hurt! The only reason I tried it was because my friends said it would help.” (This statement implies that the behavior was isolated (i.e., frequency), and gives an indication of motivation that can be used in follow-up questions.)

Therapist: “What did you use to hurt yourself, and where did you do it?” (Here the therapist is assessing severity and location.)

Student: “I used a knife and cut myself on the arms.” (Student points to each of her arms and shows the therapist the scars.)

Therapist: “That one on your left arm looks like it was deep, but also appears to have healed well. What was going on for you at the time you cut yourself?” (Therapist makes factual comments about the injury, without showing a negative emotional response, and then moves onto assessing motivation.)

Student: “I was just really depressed and my parents were always mad at me. It was just a really bad time.” (This statement provides a glimpse into the underlying issues that motivate the behavior.)

Therapist: “Do you currently feel depressed enough that you are thinking about cutting yourself?” (Therapist is again assessing the likelihood of recurrence of the behavior.)

Student: “No, like I said, it was just a really bad time.”

Therapist: “That’s good news but, I should point out that this program can be stressful, so if you do begin to feel stressed or depressed would you be willing to let your therapist or one of the staff know so that we can help you?” (Here the therapist shifts focus from the outward manifestation of self-injury to addressing the underlying issues driving the behavior.)

Student: “Yes, I’ll let someone know.”

At this point the therapist moves on to other questions that are part of the initial intake screening. The dialogue that comprises this example only requires a few minutes of time; however, when this short screening is complete the therapist has valuable information that can be passed to the primary therapist and line staff who will be working with the student. When the primary therapist conducts a full initial assessment, the topic would be revisited and additional information gathered.

Active Self-Injury

When a student is suspected of actively engaging in self-injury, or is directly observed performing the behavior, the assessment process needs to be modified. Nevertheless, it is still important to determine the role of past self-injury in the student’s life. Accordingly, the staff/therapist should use the above outlined questions to fill in gaps about the student’s history. This process can also be particularly helpful in determining whether contagion plays a role in the student’s current behavior.

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Although the student's history provides relevant information for current problems, when conducting an assessment for active self-injury there is a need to focus on the dynamics of the current situation. This provides important clues on how best to work with the student to overcome or decrease the behavior. The interviewer should ask specific questions focusing on the most recent incident and assess the function it serves. Examples of such questions include: "What feelings led you to consider hurting yourself today?" or "How did hurting yourself today help?" Discovering the antecedents of self-injury can significantly benefit the treatment process by helping the student/therapist identify the underlying issues that motivated the behavior. This also helps to draw attention away from the act of self-injury itself, and instead focuses on the underlying issues.

Another way to use the assessment process to facilitate future treatment is to ask solution-focused questions about coping strategies. For example, the interviewer might ask "Has there been a time when you were able not to hurt yourself when you wanted to?" and "What did you do instead?" Asking these types of questions helps to instill the idea that self-injury is not the only option and provides students with hope that they can deal more effectively with their problems. When assessing active self-injury it is always important to remember that the focus should be identifying factors that will aid in the treatment process.

Treatment

When considering treatment issues, one of the first considerations is whether the student has a desire to stop the behavior. Much like with substance dependence (e.g., Prochaska & DiClemente, 1983), it is not uncommon to encounter a student who feels that the behavior serves a purpose and has little desire to change. In such a case it may be best to begin by highlighting dissonance between the desired and actual outcome for the student (Miller & Rollnick, 2002). Some of the consequences that can be contrasted with the benefits include: 1) the risk of significant injury and/or death; 2) the potential for developing a psychological/physical addiction; 3) the need to increase severity to obtain the same effects over time (i.e., tolerance); 4) how the behavior interferes with daily life (e.g., time spent hiding wounds); 5) a deepening sense of shame and despair; 6) permanent scarring and tissue damage; and 7) that the underlying issues don't get any better.

When the student shows a commitment to recovery, providers (i.e., line staff, therapists, etc.) should work with the student to identify underlying issues that motivate the behavior, and then deliver interventions designed to ameliorate these issues. There are a number of effective interventions and programs that can be used to decrease self-injury. One of the more well know treatment programs is Dialectical Behavior Therapy, which has been effectively applied to adolescents with a high potential for self-harm (e.g., Katz & Cox, 2002; Linehan, 1993).

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Another resource for treatment has been developed by the Cornell Research Program on Self-Injurious Behavior (<http://www.crpsib.com/>). Their website provides a number of documents outlining how providers can effectively work with someone who engages in self-injury. We refer those interested in increasing their knowledge about specific treatments to the above listed resources for further information. Note the general “guidelines” presented in this paper can be applied to all cases of self-injury, regardless of the chosen treatment method.

As was described for the assessment process, one of the major concerns with treatment is that providers consciously need to manage their own reactions to self-injury. Severe reactions to self-injury rarely have a positive effect on prognosis for the student. In the case of a student who self-injures because of shame, a negative reaction confirms the negative view of self. For “attention needing” students, dramatic reactions reinforce that self-injury will get them the attention they are seeking. Although it is easy to understand why this is important, it is not always easy to manage our reactions, especially since it is hardwired into our brain to react negatively to any kind of physical distortion (e.g., Perry, 2009).

When engaging the student directly it is important for the provider to focus on emotions and motivations, not on the behavior itself. This can be accomplished by exploring the underlying needs of students and showing interest in their perspective. When discussing the self-injurious behavior, guide the discussion back to a consideration of how the behavior is ineffective at resolving the real underlying issues. To this end, motivational interviewing techniques are particularly valuable (Miller & Rollnick, 2002). When providers focus extensively on the specifics of the injurious behavior itself, the tendency is to begin making demands (e.g., “You must quit doing this!”) or asking judgmental questions (e.g., “Why on earth would you ever want to do that?”), both of which are likely to actually increase the behavior over time.

Providers should also consistently convey to the students they are committed to helping and empathetic. Expressing empathy is very different from expressing sympathy. Telling a student “I can see how much pain you are experiencing” shows empathy, while saying “I feel so sorry for you” is sympathetic. It is important to convey acceptance and understanding while not condoning the behavior. Another helpful recommendation is to make a conscious effort to see self-injury as an attempt to communicate, rather than an attempt to manipulate. When the provider consciously attends to the communicative nature of self-injury, she/he will be much more likely to get to core issues quickly and treatment will be more effective. Sometimes providers are legitimately concerned about the welfare of the student. When expressing concerns it is important to be direct and honest while avoiding value statements. For example, a provider may effectively convey concern to a student by saying “I am concerned for you and I don’t like to see you hurt

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yourself.” On the other hand, including a value statement such as “Your body is a temple and it pains me to see you defile yourself” is clearly inappropriate.

It is also important to remember that self-injury is not something that is likely to immediately dropped by the client. Providers should help the student by encouraging small steps toward recovery. One possible way of accomplishing this is to interrupt the rituals and routines the student has for self-injury. For example, if the staff notices that a female student begins to isolate herself, the student can be encouraged to join a group activity or help the staff with a project. Interrupting the student’s rituals and routines also serves the purpose of increasing the amount of time before the student engages in self-injury. The resultant delay is a good opportunity to work with students to increase their use of healthy coping skills to increase their ability to tolerate distress (Linehan, 1993). Providers also exert positive influence when they model healthy coping skills, effective communication, firm boundaries, and awareness of their locus of control.

Should it become necessary to examine the injuries, providers should be conscious of maintaining the student’s dignity. If the student reports injuries to private parts of the body, qualified medical personnel should be called in to conduct the examination when necessary. Just because a student has engaged in self-injury does not mean that they have waived their right to privacy. Medical personnel can also be helpful in determining if medication might be a useful additional to the treatment plan. At least one study has shown that interrupting the endogenous opiate system through psychotropic medication significantly reduced rates of self-injury (Sandman, 1990). One final point to consider is that some providers will be tempted to ignore the problem, or hope that “it will just go away.” All incidence of self-injury should be taken seriously and appropriately addressed.

Managing Contagion

One of the most difficult aspects of working with self-injuring adolescents, especially in a residential setting, is effectively handling the potential for contagion. Both Walsh (2006) and Walsh and Doerfler (2009) offer good suggestions for addressing this issue. They suggest that providers should avoid triggering language, examples, details, or “war-storying” during group sessions. It can also be useful to have students who self-injure cover their wounds (with clothes or jewelry, not with bandages), and providers can explain to students they may be hurting others by discussing or displaying their own self-injury. As can be surmised from the above information, it is critical that staff be trained in how to recognize self-injurious behavior and how to compassionately insulate other students from the negative behavior of another student.

Policies and Procedures

Within our organization, the original impetus for learning about self-injury was the lack of a formal policy for responding to it. At that time, the standard response was to conduct a suicide evaluation and place the student on a corresponding level of suicide watch. However, this felt incongruous since the student would firmly deny any suicidal ideation. Over the last few years we have developed a number of standards for dealing with self-injury, including: 1) the need for staff training; 2) opportunities for assessment; and 3) responding to active self-injury.

Training

The most pressing need we identified was that line staff were largely unaware of the difference between non-suicidal self-injury and true suicidal ideation. Regular training is needed to disseminate information about self-injury. Because of turnover in staffing, this type of training should be repeated at least bi-annually, and possibly more frequently (i.e., quarterly) depending on the program. Among the topics covered should be: the various types of self-injury, the difference between self-injury and suicidal ideation, the ways to identify and assess the behavior, the person to whom the behavior should be reported, and the best immediate response.

Staff should also be taught to avoid hyperfocus on the injurious behavior, process underlying needs and emotions, and manage their own reactions to the self-injurious behavior. We have found it useful to show pictures of self-injury to staff in order to help them become less sensitive to what they might see from a student. A common question from staff is whether they should use a therapeutic hold to stop the student from self-injuring. In our program avoiding a therapeutic hold is strongly encouraged, except in situation where the staff feel that the student is engaging in behavior that can endanger life, limb, or eyesight. Finally, staff members need to be taught how to properly document the process they followed and decisions made about intervention.

Assessment and Response

It is not uncommon for students to disclose self-injury to someone other than the primary therapist. As mentioned above, multiple opportunities for assessment should be structured into the program's procedures. Again, some possibilities include questions about self-injury on the admissions application, during the medical intake process, and during the initial clinical assessment conducted by the therapist.

When line staff identify active self-injury, they should conduct an on-the-spot assessment, evaluate the risk of suicide versus self-injury, and report the findings of the assessment to the therapist. With this information the therapist will develop a response plan and deliver it to staff, inform parents of the plan, and debrief staff after it has been implemented. The response plan is tailored to the student and addresses

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the specific behaviors of the student. Having a “one size fits all” approach is unreasonable given the diverse ways that self-injury presents itself. For example, taking away all sharp implements would have little effect on a student whose primary method of self-injury is burning.

Nevertheless, there are some common topics that should be covered in the response plan. First, actions may need to be taken to separate the student from potential self-injury implements. Providers can explain to students they cannot in good conscience provide them with the means to hurt themselves. Second, the plan should cover how medical care will be delivered. There may be a temptation to provide less adequate care when the injury is self-inflicted (McHale & Felton, 2010). Regardless of the source of the injury, the policy of the program must be to treat all injuries with appropriate medical intervention. Third, the appropriateness of collaboration with the student in plan development should be determined. In some cases the student may be able to accurately identify strategies that will help effectively manage the behavior, and in other cases this would be inappropriate. Finally, various methods for limiting contagion should be discussed and appropriate methods should be selected.

Within these issues there are a couple of unique situations that should be highlighted. The first is the use of “no harm contracts” to solicit student cooperation. We avoid the use of strict no harm contracts because of the potential for relapse with self-injury. When a well-intentioned student signs a no harm contract and then relapses, the result is an increased sense of failure. Conversely, when the student does not have a desire to cease self-injury, this type of document can result in a power struggle between the providers and the student. However, collaboratively developing “agreements,” where the student expresses a sincere desire to cease self-injury, can be very helpful.

Another situation that should be considered is the use of a therapeutic hold during “dissociative self-injury.” The general policy we advocate is to avoid a therapeutic hold except in the case of threat to life, limb, or eyesight. A possible exception might arise in the case of dissociative self-injury. Dissociation is often associated with a history of severe sexual abuse (Levenkron, 1998) and is characterized by a mental detachment from consciousness. Those who engage in self-injury while in a dissociative state report that they do not have any memories of hurting themselves, and these injuries are often quite severe (Levenkron, 1998). Therefore, when a student engages in dissociative self-injury, it may be appropriate to use a therapeutic hold to reduce the potential for significant injuries. However, this should be handled on a case-by-case basis, and may still fall under the threat to life, limb, or eyesight exception described above.

Conclusion

Self-injury is increasingly a concern for those who provide services within a residential setting. Regardless of whether this is due to more

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awareness of the problem or increasing prevalence, there is a significant need to develop industry standards for addressing the issue. Our intention in this article was to discuss issues related to the motivation, assessment, and treatment of self-injury, and begin a discussion of how programs should respond. This discussion should be seen more as a starting point that needs to be continued forward, with the hope of eventually establishing standards that can be adopted industry-wide.

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