Self-Injurious Behavior: Assessment and Treatment Considerations

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Abstract

Self-injurious behavior (SIB) is on the rise. An increasing number of clinicians are being presented with clients who harm themselves. It is currently estimated that 21% of the clinical population engages in SIB (Stone & Sias, 2003). Some counselors may have not received specific training in working with this population. In dealing with clients who may be harming themselves, proper assessment and treatment is critical.

This article attempts to provide a clear understanding of SIB by describing SIB, explaining the role of counselors when working with these clients, appropriate standards of practice and clinical implications, and the utilization of specific assessment and treatment procedures. In addition, a case study is presented demonstrating the use of the recommended procedures.

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Several definitions have emerged regarding self-injurious behavior (SIB) over recent years. It has been described as a direct, socially unacceptable, repetitive behavior that causes minor to moderate injuries (Suyemoto & Kountz, 2000), a deliberate destruction or alteration of the body tissue (Gratz, 2001), a direct act of inflicting damage to oneself (Jeffrey & Warm, 2002), and a self-defeating behavior used to express or communicate something that is otherwise perceived as unacceptable (Stone and Sias, 2003). For the purpose of this article, SIB is defined as deliberate and direct injury to one's own body surface without suicidal intent that is socially unacceptable (Claes, Vandereycken, & Vertommen, 2005). This particular definition was chosen because it incorporates important aspects of the definitions mentioned above and adds to the understanding that SIB lacks suicidal intent which is a distinguishing factor between SIB and a suicide attempt. Although these definitions carry common themes, the clinical field continues to lack a solid understanding of SIB partly because clinicians and researchers don't agree on a single definition to describe it (Muehlenkamp, 2005). In lacking a solid understanding of SIB, appropriate assessment and treatment may not be taking place. This article attempts to provide an understanding of SIB, clinical implications and standards of practice for counselors, and recommendations for appropriate assessment and treatment of clients who self-injure. Special cultural and ethical considerations when working with clients who self-injure are addressed in this article as well.

Understanding SIB

One common misconception of SIB is that it is not serious because it is self-inflicted (Jeffery & Warm, 2002). SIB may be disregarded as an attention-seeking

behavior. Many who engage in SIB are private about the behavior and often hide the wounds. Another false belief is that someone who engages in SIB is attempting suicide. SIB is distinct from suicide. Suicide is used to cease living, it is infrequent with high lethality, and in most cases only one method is used. SIB is used to feel better, it is repetitive and has low lethality, and tends to use multiple methods. Although SIB does not have suicidal intent there is the risk of suicide. Some who engage in SIB have been known to "accidentally" commit suicide (e.g., cutting deeper than intended). The risk of suicide in individuals who self-injure range from 13%-16% over a five year period or 3% per annum (Crowe & Bunclark, 2000). However, it is estimated that approximately 59%-72% of people who engage in SIB do not have suicidal thoughts at the time of the SIB (Muehlenkamp, 2005).

Someone who self-injures is typically experiencing severe emotional pain who doesn't have an available outlet. Physical pain can be a temporary cure for the emotional pain (Levenkron, 1998). It is usually a person that is unable to verbalize feelings. They may even have difficulty identifying their feelings. When one is not able to verbalize painful experiences, he or she can become overwhelmed by the feelings stuck inside of them.

Many who engage in SIB report feeling tense, anxious, angry, or fearful prior to hurting themselves and then feeling relief, release, calm, or satisfaction immediately following the SIB because this puts an end to the anger, dissociation, and tension (Suyemoto & Kountz, 2000). Self-injury transfers the internal pain into something tangible, external, and treatable. The wound can signify intense suffering and survival (Alderman, 2000).

Self-injurious behavior can be a way of managing moods and feelings, responding to beliefs (e.g., self-punishment for intrinsic “badness”), and managing interactions with others (Allen, 1995). In addition, Nock and Prinstein (2004) identified four functions of SIB. They refer to it as self-mutilative behavior (SMB). Automatic-negative reinforcement refers to using SIB to stop pain. This is the most common function of SIB. In automatic-positive reinforcement, individuals engage in SIB to feel something, even if it is pain. Social-negative reinforcement is used to avoid punishment from others or to avoid something unpleasant. Social-positive reinforcement is used to let others know how unhappy the individual is. Some researchers (Alderman, 2000; Claes et al., 2005; Jeffery & Warm, 2002; Warm, Murray, & Fox, 2002; White, Trepal-Wollenzier, & Nolan, 2002) may disagree with this last function because of the belief that SIB is not an attention-seeking behavior.

Clinical Implications and Standards of Practice

Counselors have had an increasing number of clients who present with SIB (White Kress, 2003). Rates of SIB are highest among adolescents and young adults aged 15-35 to a high of 12% in a general college student population (Suyemoto & Kountz, 2000). It is approximately 4% of the general population that self-injure and 21% of clinical clients (Stone & Sias, 2003). It is important that practitioners are genuine, empathic, and are not critical of this behavior. It is crucial to refrain from over-reacting to the behavior. Such overreactions can be stigmatizing for the client. Many who engage in SIB feel shameful about this behavior, however, continue to engage in it because it can be a survival skill (Haines & Williams, 1997). Practitioners must keep in mind that SIB is an attempt to relieve emotional pain even if it lasts momentarily. In addressing SIB, it is

important to find out what these behaviors mean to the client and for what reasons the client believes that she or he engages in this behavior. This is the clinician's attempt to understand this behavior from the client's reality or perspective (White Kress, 2003).

Clinicians who work with self-injury should engage in close supervision. Hearing about how clients physically harm themselves or actually seeing the scars can be emotionally wearing on the clinicians who work with these clients. It is important to seek support and guidance. Supervision is warranted from the very beginning stages of working with clients who self-injure. Consultation as early as following an assessment of SIB can aid in enhancing clinical judgement and may provide some relief to the treating clinician through the support of a fellow professional.

Assessment of SIB

As a standard of practice, an assessment of SIB should take place during the initial interview with every client, especially with adolescents and young adults. The first step in assessing SIB is determining the frequency, duration, and onset of SIB and the antecedents and consequences of the SIB (White Kress, 2003). Unexplained scars, burns, or cuts can be physical indicators of SIB for those clients who may not disclose SIB initially. These scars are often prevalent on the arm opposite of the dominant hand (White Kress, Gibson, & Reynolds, 2004).

In addition, clinicians should assess for client safety by questioning the severity of the injuries and how the injuries have been cared for. It is critical to note if the client has needed medical attention to address his or her self-inflicted injuries. If medical attention has been warranted at any time, a referral or additional services may be needed.

Clinicians should have some knowledge of what diagnoses frequently co-occur with SIB. Suyemoto and Kountz (2000) explained that SIB most often occurs with a diagnosis of borderline personality disorder. Some other diagnoses associated with SIB include: depression, dissociative identity disorder, obsessive-compulsive disorder, alcoholism and other substance abuse, eating disorders, schizophrenia, anxiety disorders, and several personality disorders. In addition, SIB has also been associated with antisocial behavior, increased suicidal ideation, and increased past suicide attempts (Suyemoto & Kountz, 2000). Lastly, there is growing evidence that individuals who self-injure have a history of trauma (Muehlenkamp, 2005). It is important to note that many people who engage in SIB have a history of sexual or physical abuse, however, not all who self-harm have been abused. Some may be coping with painful feelings that come from different experiences, not linked to abuse (Jeffery & Warm, 2002). A more severe level of pathology may be indicated if the individual adopts an identity as a cutter or a burner (Muehlenkamp, 2005).

Although specific SIB assessment tools are scarce, there are some available. Gratz (2001) developed an assessment tool for SIB called the Deliberate Self-Harm Inventory. This measure assesses frequency, severity, duration, and type of SIB. The specific acts of SIB listed in the questionnaire were based on clinical observations, numerous testimonies of individuals who engaged in SIB, and common behaviors reported in the literature. This is an assessment tool that could be of use to mental health agencies, inpatient facilities, and school settings.

Other things to consider when assessing for SIB is the client’s family history. The clinician should pay special attention to include a history of emotional disorders, family

substance abuse, and if the client experienced parental divorce, or death of a parent (Levenkron, 1998). These are all factors that enhance the likelihood of SIB.

Through a thorough assessment, the clinician has the opportunity to gain a better understanding of the SIB of each particular client. This ensures appropriate treatment. The better understood the client, the better care he or she will receive. In addition, the assessment allows the client to spend time verbalizing and expressing their feelings. The assessment procedure itself is likely to be therapeutic (Haw, Hawton, Whitehead, Houston, & Townsend, 2003).

Treatment Interventions

Most people who self-injure avoid attention by hiding scars. This may be out of fear of rejection of those who don't accept this behavior. Therefore, a primary goal in treatment is to create a safe, structured environment characterized by consistency, respect (White et al, 2002), and a trusting therapeutic relationship. Self-exploration is a significant part of the treatment of individuals who self-harm. Self-exploration involves recognizing and developing one's own identity as an individual. It includes allowing oneself to feel rather than immediately alleviating feelings only for them to return again. Important goals may include developing and enhancing verbalization skills, alternative coping skills, and broadening client supports. Increasing the ability to cope with and accept feelings and developing insight into the meaning and function of the SIB (Suyemoto & Kountz, 2000) are crucial elements of treatment.

Counselors must empower self-harming clients to become active participants in therapy. Encouraging these clients to take control can be very powerful considering many who engage in SIB sometimes do it for a sense of control. Counselors can instruct

individuals to monitor their SIB each week by keeping a diary or some sort of documentation surrounding triggers for the SIB, frequencies, cues, and reducers of the behavior (White et al., 2002). Once these things are accomplished, the counselor and client can begin to identify ways to avoid the SIB by engaging in alternative behaviors. These can include exploring safe people and safe places to go to when wanting to self-injure, deliberately getting rid of objects that can be used to injure, (White et al., 2002), avoiding being alone, and engaging in healthy physical activity.

Once a trusting, therapeutic rapport has been developed, family counseling may be considered. Individual treatment requires the client to identify underlying issues, recognize patterns of SIB, acquire alternative coping skills, track behaviors, restore daily functioning, and enhance interpersonal skills. Process, structure, safety, and consistency are key during counseling. Family therapy focuses on family dynamics and specific interaction between client and the rest of the family (Stone & Sias, 2003).

It may be helpful for those who self-injure to have more services available to them than a single weekly counseling session. Often, people engage in SIB at night when no one else is around. This can be a particularly vulnerable time. It would be beneficial for service providers to make themselves available in a supporting role at these times (Warm et al., 2002). If this is not possible, a twenty-four hour crisis hotline number could be provided for when the individual feels like hurting him or herself.

Crowe and Bunclark (2000) described treatment interventions used in an in-patient self-harm program at the Bethlehem Maudsley Trust (est. in 1992). This program encourages the use of alternative means of expression. These include creative writing, creative art, drama therapy, and projective art. Weekly groups include: a coping skills

group aimed at distress tolerance, improvement in assertiveness, changing restrictive patterns of thinking, and learning interactive skills. These coping skills groups focus on relationships. Family therapy aims at improving understanding and communication within the family and is offered to those in later stages of their stay.

Although these treatment interventions may use different techniques, some common themes promote the creation of a safe, trusting, therapeutic environment. They promote identification of feelings, identifying triggers, and frequencies. Gaining control over one's feelings and actions and the development and use of alternative means to SIB is of vital importance. These are central aspects to treatment of clients who self-injure.

Treatment Planning Considerations

Establishing and developing trust is a key factor in all therapeutic relationships. It is particularly important when working with clients who self-injure. These clients often come from poor relationships that lack trust. Many who have experienced these relationships avoid trusting again. The counselor must keep this in mind and make the development of trust a priority. The therapist must prove to the client that he or she is both worthy of her trust and dependable enough to form an attachment, so the client can take what he or she has learned outside of the office and build positive attachments with others as well (Levenkron, 1998).

A counselor must break through client's defenses to establish trust (Levenkron, 1998). It is important for the counselor to show that he or she is comfortable in getting close to the person's pain, rage, and despair. Helpful steps in this process include: validating and supporting feelings, allowing time for trust to build, expecting the client to depend on that attachment during the course of therapy, encouraging the client to accept

and incorporating positive ideas to replace his or her negative self-image, and helping the client to build his or her own strength on new positive ideas. These all aid in developing healthy independence (Levenkron, 1998).

It is extremely important to refrain from treating the SIB as a secret. The counselor needs to assess for SIB every session. If the client has injured him or herself since the last session, the counselor can ask to see the injury providing it is in an appropriate area to be displayed. By reducing the secrecy of SIB, the shameful feelings attached to the SIB are reduced. The counselor's willingness to talk about and look at clients' self-injuries displays interest and acceptance of him or her. It is critical that this be done non-judgmentally.

Additional available services (e.g., group therapy, case management, psychiatry) may be included in treatment planning. A team approach may be warranted; including a physician and psychopharmacologist who will evaluate and prescribe medication when needed (Levenkron, 1998).

Those providing care to the client must work closely together, giving careful attention to treatment goals. The benefits are twofold. The care and safety of the client who self-injures is enhanced and more professional support is available for all service providers working with the same client.

Self-injurious behavior can be a very sensitive issue. It can be difficult to work with clients who physically harm themselves. Working with this particular clientele can be an intense experience. The therapist involved must utilize his or her peer supports and close supervision.

Cultural Considerations

What may be considered SIB in one culture may be an acceptable behavior or ritual in another culture. For example, culturally sanctioned rituals and practices in the U.S. include ear piercing and tattooing. Some self-mutilation is included in ritual dances among Native Americans (Stone & Sias, 2003).

There is a common misconception that women are the majority of people who self-injure. According to one study, rates of SIB among men and women did not differ significantly. The difference found was the particular way men and women self-injure (Gratz, 2001). White Kress (2003) explained that this misconception might be related to researchers' use of help-seeking clinical populations that are more likely to comprise of women (e.g., persons diagnosed with BPD, and sexual abuse and incest survivor populations).

The issue of SIB might be difficult to accept as part of one's culture especially if it is viewed as a harmful behavior because part of a counselor's job is to promote safety and good health. It also can be confusing when ethical and legal considerations are involved. As mentioned earlier, clinicians working with this population must seek guidance and support from their peers and supervisors.

Ethical Considerations

Many counselors have had little exposure managing issues of clients who self-injure. Clients who engage in SIB require counselors who understand the etiology and functions of SIB as well as appropriate interventions. Counselors who work with this population must achieve a degree of competency in this area or refer out. In addition,

counselors should consult with physicians if there is concern around infections or the severity of the injury (White, McCormick, & Kelly, 2003).

When such a client comes to trust the counselor there can be the risk of too much dependence on the counselor. In response to this, it is vital that the counselor set clear boundaries. These boundaries may need to be revisited. It is critical that counselors manage their reactions as well, by monitoring counter-transference related to client self-injury. If the counselor's counter-transference is not managed well, it is possible that he or she could be pursuing a personal goal rather than the client's goal (White et al., 2003).

In addition to maintaining ethical guidelines, one must be aware of the legal implications to working with this population. It can be very similar to working with suicidal clients. A clinician must recognize when additional help is needed (e.g., a physician, hospitalization, psychiatry). Counselors caring for clients are ethically and legally bound to obtain appropriate care if the client presents a threat to his or her own safety. With this population in particular, counselors need to continuously assess for self-harm and address the situation accordingly.

Case Example

Ana is a fourteen year-old female who has come to counseling for the first time. Ana reports that she is feeling overwhelmed. She states that she often feels tense and depressed. Ana's counselor is Nick.

Nick: "Ana, are you thinking about killing yourself?

Ana: "Oh no, I don't want to kill myself."

Nick: "Ana, are you currently or have you ever deliberately hurt yourself?"

Ana puts her head down and hesitates.

Nick reminds her that she is in a safe place and can be open with her answers.

Ana: “I hurt myself sometimes, when the pain is bad.”

Nick: “I appreciate your honesty. How do you hurt yourself? What do you do?”

Ana: “Sometimes I cut myself with a pocket knife.”

Nick: “Where on your body do you cut yourself?”

Ana: “Well, I usually cut my arms and sometimes my stomach.”

Nick: “How deep are these cuts?” “Do you care for them after?”

Ana: “I cut just enough to draw blood. Usually when I’m done I put a band-aid on. I don’t want anyone to see.”

Nick: “How long have you been cutting?”

Ana: “About two years.”

Nick: “How often for these two years has the cutting been taking place?”

Ana: “Once or twice a week depending on how bad the pain is.”

Next, Nick will explore this pain that Ana mentions and how Ana benefits from cutting. In other words, what purpose does the cutting serve for Ana? What does it mean to her and how does it help her? Nick will explore the feelings that Ana experiences right before she engages in the SIB, what she feels while cutting, and how she feels after she cuts. Other important areas for Nick to question will be who and what may target Ana’s SIB and where and at what times she engages in SIB.

These aspects of Ana's SIB help Nick to understand what Ana is experiencing through her SIB and why. This information aids Nick in better assisting Ana. It also allows Ana the opportunity to verbalize and express her feelings and begin to build a trusting relationship.

Case Example Continued

Nick: "Ana, we've talked a lot about your overwhelming feelings of a lack of control and your need to release the pain. You've shared that you gain this control by cutting. This gives you that release. You've also talked about what you feel like before you cut, tense and very depressed. It appears that cutting takes away those feelings. Am I correct so far?"

Ana: "Yes."

Nick: "Well, is that something you'd like to change? Would you like to release that tension and pain and gain control in a different way where you would not have to harm your body?"

Ana: "Yes, but I don't know how."

Nick: "Would you be willing to brainstorm some ideas with me of what you could do instead of cutting?"

Ana: "I can try."

Nick: "O.K. lets think about what cutting does for you and how you feel after you cut."

Ana: "I feel better. I feel more calm and like the pain has been lifted."

Nick: "O.K. What do you think might happen if you allowed the pain to stay, if you allowed yourself to experience it without immediately relieving it?"

Ana: "Wow, I don't know. I always try to get rid of it."

Nick: "Where might be a safe place for you to go with a person you feel comfortable with when you feel this way?"

Ana: "Well, I'm comfortable with my mom and my bedroom is a safe place. I can tell my mom when I feel like cutting."

Nick: "Maybe you can ask her to be with you during that time in your bedroom with you."

Ana: "Yeah, I can try that."

Nick: "What if your mom isn't around when you want to cut and you're not feeling particularly okay with staying with the feeling at that time? What behavior could you engage in that might also take away some of that pain and tension and produce a release along with that calm feeling?"

Ana: "Um…Well, I don't exercise often, but when I do, I get a good release from it."

Nick: "O.k. what specific exercise will you engage in when feeling the need to cut?"

Ana: "I could go walking."

Nick: "O.K. great. Now, you said you always cut in the bathroom, how can you avoid going into the bathroom when wanting to cut? What could distract you from going to that place in the house?"

Ana: "Well, the bathroom is upstairs. I could stay downstairs until someone is home that I can tell that I'm wanting to cut or I can leave and go for that walk."

Nick: "O.K. Ana. We've come up with some alternatives to cutting. One is that you will tell your mom how you are feeling and ask her to spend some time with you; another is that you'll go walking; and finally, you will avoid going into the bathroom."

Ana: "Right."

Nick: "How about if you try these alternatives for one week and next week when you come back, we can discuss what is and isn't working for you. Is that o.k. with you?"

Ana: "Yeah, I'll give it a try."

Nick: "O.K. Ana, you've been brave today in your willingness to attempt to give up cutting and explore other options."

In this specific session, Ana is at the point where she is ready to think about alternatives to SIB. Nick was respectful of her thoughts and feelings and empowered her by asking for her permission for the two of them to brainstorm possible alternatives to SIB together. This alone, can give Ana that sense of control that she is lacking. Nick also encourages Ana to allow herself to experience her feelings instead of immediately alleviating them. He takes into consideration that sometimes this may not be safe for Ana, so they talk about what she can do to alleviate the pain other than cutting. In trying these new behaviors, Ana may find healthier coping skills.

It will be important for Nick to continue empowering Ana, strengthening the therapeutic relationship, aid her in building and utilizing a vocabulary to express her feelings, and check in with Ana at each session to see if she has cut herself over the week. The sole purpose of the continuous assessment is not to scold or come down on the client for engaging in the SIB, but to assess danger and lethality in case additional services are needed in order to provide appropriate care.

This case study is a brief example of how the counselor and client work together to address the SIB. This process typically takes quite some time with these clients. Several, frequent sessions may be warranted before a client even considers alternatives to

the SIB let alone actually engage in them. Therefore, the treating clinician must be very patient.

Conclusion

Self-injurious behavior should be taken seriously and is not to be disregarded as an attention-seeking behavior or to be undermined because the wounds are self-inflicted. With 21 % of the clinical population engaging in SIB (Stone & Sias, 2003), it is critical that clinicians assess for SIB in each initial assessment along with follow-up counseling sessions with every client. The assessment procedure itself involves the opportunity for relationship and rapport building by allowing counselors to better understand clients and by inviting clients to verbalize and express feelings in a safe and non-critical environment.

Primary goals of treatment of SIB include creating a safe and structured environment promoting respect and the development of a trusting therapeutic relationship (White et al., 2002). Additional goals include developing a sense of identity, control, and verbalization skills to identify feelings, alternative coping skills, and broadening client supports. It is imperative that counselors are empowering, encouraging, supportive, available, and non-judgmental. Personal reactions must be managed (White et al., 2004) in order to not further stigmatize the SIB and to keep from encouraging secrecy of the behavior.

Counselors may have strong feelings when faced with clients who self-injure. It can be difficult and even taxing on the treating clinician who hears about and sees self-inflicted wounds. The utilization of close supervision and professional peer consultation

is essential in providing support for the counselor and enhancing clinical judgment, therefore, ensuring appropriate client care.

One of the most important things to acknowledge about SIB is that clients who present with this behavior are often suffering from deep, intense, emotional pain and know no other outlet for that pain (Levenkron, 1998). It is the counselor's job to validate and provide support for such painful feelings and to assist clients in learning to release and cope with such pain in healthier ways that are not self-harming. Most importantly, it is the development of a good therapeutic relationship that can provide clients who self-injure with a sense of trust, safety, support, and empowerment assisting them in gaining control and eventually replacing SIB behaviors with healthier ones.

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