A Manual of Best Practice for Counsellors Working With Adolescents Who Self-Injure

Judith (Judy) Polysou

B.H.Ec., University of British Columbia, 1978
Education Certificate, University of British Columbia, 1979

Project Submitted in Partial Fulfillment of

The Requirements for the Degree of

Master of Education

In Educational Counselling

The University of Northern British Columbia

April 2009

Abstract

Self-injury (SI) is the intentional harm of oneself in order to manage emotions and provide relief from unbearable stress. Methods of self-injury include cutting, burning, hitting, and hair pulling. Many counsellors are working with adolescent self-injurers but are struggling with how best to provide therapy. The role of counsellors may vary, depending on whether they are school or community-based. This project presents a manual focusing on adolescent self-injurers and their psychotherapeutic treatment. The manual presents and interprets information that is difficult for practicing counsellors to access into a succinct document. Topics addressed are the nature of adolescent self-injuring behavior, risk factors associated with SI, strategies for working with self-injurers within the public school system, assessment of the adolescent self-injuring client, and therapeutic treatment. Working with adolescent self-injurers is a challenging undertaking and this manual offers information and strategies to aid the counsellor in providing appropriate client care.

TABLE OF CONTENTS

List of Tables

List of Figures

Acknowledgements

I am grateful for the contributions many individuals have made throughout the development of this manual. During a conversation five years ago with a counselling colleague, Kirk Elliot, we were discussing the increasing number of self-injurers we were seeing in our practice and how best to meet their needs. As an aside, Kirk mentioned that self-injury would be an appropriate project topic and I thank him for starting me on my adolescent self-injury journey. My project supervisor, Dr. Corinne Koehn, has been incredible. Her experience, compassion, patience, understanding, knowledge, and editing skills are outstanding. My other committee members, Dr. Cindy Hardy and Dr. Peter MacMillan, contributed knowledge, were supportive, and reviewed my work in a very timely fashion. I thank my committee members for their efforts. Thank you to Marla Spike (school counsellor), Chris Molcak (high school principal), and Brain Pepper (district school superintendent), all School District #57 Prince George educators, for their time spent reviewing the chapter on working with self-injurers within the school setting. Mary Graham, with S.A.F.E BC, spent a great deal of time critiquing my project and assisted me in producing a more accurate and helpful document than I would have generated without her expertise. The contributions of my partner, Nick Polysou, cannot be overlooked. Nick is a great editor and skilled computer user—I thank him for his invaluable skills.

Dedication

This manual is dedicated to the many adolescents I have worked with over the past 30 years, as an educator, a counsellor, and a parent. Working with adolescents has taught me well and this teaching has been valuable in writing this manual. I also dedicate this manual to my family. While I developed this manual, Nick, Daniel, and Lauren gave up a great deal: camping trips, holidays, access to the computer, home-cooked meals, and the list goes on. In particular, my husband has been a trooper while dealing with computer glitches, editing woes, late nights, and my frustrations. If there is a patience medal, he has earned it.

Author's Note

This document is designed to provide information and suggestions for counselling practice. This manual is developed for use as a resource for counsellors/therapists and not as a replacement for skilled professional practice. Direction and professional experience are provided but the reader's judgment and consultation with other professionals are also required. It is essential that the client's safety and well-being take precedence at all times and that users of this manual understand that each client has different needs and recognize that not all elements of this manual are necessarily appropriate for all clients.

Chapter One: Introduction

An indication that self-injury (SI) has become a prevalent condition in the North American adolescent population abounds in the popular media. There is a proliferation of Internet websites focusing on SI. Television shows such as Oprah, Beverly Hills 90210, and Grey's Anatomy have had episodes focusing on SI. Nine Inch Nails, Eminem, and Pearl Jam are examples of rock music performers who include SI lyrics in their songs. Movies such as Thirteen and American Beauty have woven SI into their plots. SI has been featured in Canadian Living (Wysong, 2007), The Times (Kenrick, 2007), Teen People (Booth, 2004), and Girl's Life (Ryan, 2005). The media attention was one of the initial motivating factors for this project on adolescent SI.

While media coverage of SI has contributed to the development of this project, it was also inspired by an observation of counsellors that there is an increase in the incidence of adolescent clients exhibiting self-injuring behaviors. This project was also born out of secondary school counselling practice—in conversations with colleagues, it is evident that many school counsellors are struggling with how to effectively deal with the issue of adolescent self-injury. These conversations were broadened to include other mental health professionals in the community (physicians, private practice counsellors, psychiatrists, and government mental health providers) and the same issues were reported.

It seems that many mental health professionals are grappling with adolescent SI issues. Some questions are:

- Is the incidence of SI increasing?
- What are the safety issues surrounding SI?
- What are the parameters for confidentiality?

- How should SI be treated?
- Are there any differences between treating adolescent self-injurers and other self-injuring populations?

In conducting a review of the literature relating to adolescent SI, it appears that information is available for mental health professionals working with this population. However, access is problematic as these references are scattered and hard to locate, especially if the practitioner does not have access to information databases such as Academic Search Premier or PsychInfo.

The goal of this project is to provide the information required by front line mental health professionals to promote best practice for their adolescent self-injuring clients. To accomplish this goal, the project is presented in manual format. This includes chapters and several appendices to support counselling practice. This manual also contains information useful to school counsellors, who may not provide therapy to self-injuring adolescents, but play a key role in identifying, responding to, and supporting students who self-injure.

The knowledge offered in this project originates from several sources: empirical research, case studies, professional insight, and the author's experiences. Wherever possible, the source of the information presented is revealed.

Chapter Two is a discussion of the nature of adolescent SI. The discussion includes a definition of SI, incidence, and the differences between suicide and self-injury.

Chapter Three presents risk factors associated with SI. The presence of risk factors does not necessarily predict self-injurious behavior, however if one or several risk factors are present, SI is more likely.

Chapter Four addresses the issues the public school system faces when dealing with self-injuring students. Confidentiality and liability issues are discussed. So that the accuracy of the information was strengthened, this chapter and relevant appendices were reviewed by a school principal, school superintendent, and a school counsellor.

Assessment of adolescent self-injurers prior to the onset of treatment is the focus of Chapter Five. Many domains of an adolescent's world should be assessed. Each assessment domain is presented with a rationale for its inclusion and strategies to assist with assessment.

Chapter Six examines treatment approaches that can be considered when working with self-injuring adolescents. The approaches are provided in four groups: empirically supported treatments, treatment approaches without research support, other strategies, and treatments not recommended.

In addition to the school district employees who reviewed Chapter Four, the entire manual was reviewed by a layperson, Mary Graham, who was a self-injurer and has a vast amount of practical experience helping individuals who self-injure. Graham has also co-written a manual for self-injurers (Haswell & Graham, 2008). The intent behind seeking input from all external reviewers was to place the suggestions described in the manual under critical examination and make them available for critique. Discussions with a parent of a self-injurer informed the writing of this manual.

Throughout this manual the use of the words, "therapist" and "counsellor" are used interchangeably. Depending on the workplace, either term could be used. It is hoped that this SI resource facilitates effective counselling practice when therapists work with adolescent self-injurers.

Chapter Two: The Nature of Self-Injury as a Challenging Behavior

Self-injury (SI) is "the deliberate mutilation of the body or a body part, not with the intent to commit suicide but as a way of managing emotions that seem too painful for words to express" (Conterio & Lader, 1998, p. 16). SI is also referred to as self-mutilation, self-injurious behavior, self-inflicted violence, parasuicidal behavior, self-abuse, and deliberate self-harm. All terms are found in literature; however, self-mutilation is a term that self-injurers consider less acceptable. Parasuicide can be a confusing term as it often has a perceived link to suicide, a behavior that is not always comorbid with SI (Carlson, DeGeer, Deur, & Fenton, 2005; Connors, 2000; Conterio & Lader, 1998; Strong, 1998; Walsh & Rosen, 1988; White, Trepal-Wollenzier, & Nolan, 2002; Zila & Kiselica, 2001). This chapter presents SI information so that counsellors can gain understanding as to the nature of self-injurious behaviors.

Dr. Armando Favazza (1996), a significant contributor to the current understanding of self-injury, reports that incidents of self-injury have been observed throughout history among many cultures and religions. The first work that identified self-injury as a unique practice was that of Karl Menninger in 1938 (Favazza, 1996).

The American Psychiatric Association does not identify SI as a disorder in the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (*DSM-IV-TR*) (American Psychiatric Association [APA], 2000). Self-mutilating behavior is listed as one of the diagnostic criteria for Borderline Personality Disorder, a condition often associated with SI. The *Diagnostic and Statistical Manual of Mental Health Disorders-V (DMS-V)* is currently under consideration. A review of articles related to the *DSM-V's* development did not reveal any literature regarding either the inclusion or exclusion of SI as a separate disorder. A case

has been made for the inclusion of self-injurious behavior as a distinct disorder in the *DSM* (Muehlenkamp, 2005; Whitmarsh, Rosencrance, Lynch, & Mullette, 2006), whereas Conterio and Lader (1998) do not support the inclusion of SI as a separate disorder because they do not see SI diagnosis as helpful in the treatment of clients. With such contradicting arguments, the inclusion of SI as a disorder in the *DSM* is not without controversy.

The most common form of SI is cutting (Alderman, 1997; Conterio & Lader, 1998; Favazza & Conterio, 1988; Klonsky & Muehlenkamp, 2007; Ross & Heath, 2002; Selekman, 2006; Winkler, 2003). Other forms of SI include self-hitting, extracting hair, head banging, self-biting, self-burning, interfering with the healing of wounds, bone breaking, and the ingestion of sharp or toxic objects (Conterio & Lader, 1998). In rare situations, SI can also include eye removal, amputation of limbs, breasts, digits or genitals, or facial skinning (Conterio & Lader, 1998). Other acts, such as jumping off low bridges or balconies, can also be considered SI if the act is not meant to result in suicide and is used to help an individual cope with emotional difficulties (M. Graham, personal communication, March 9, 2009). Hitting a wall or object can also be self-injurious behavior, but some mental health professionals may inaccurately view such acts as anger management problems, not SI (M. Graham, personal communication, March 9, 2009).

Self-injury is separate from body modification or alteration (plastic surgery, tattooing, piercing, scarification) (Favazza, 1996; Levenkron, 1998; Walsh, 2006; Winkler, 2003). Rather than being a psychological syndrome, body modification is often sanctioned by society and may be viewed as youthful rebellion (Conterio & Lader, 1998). Self-injury is used as a way to cope with and relieve stress, whereas body modification is not. Self-injury is self-inflicted whereas body modification often is not. Body modification is often done for

beautification and self-expression while the goal of SI is psychological relief. Body modification is often done publicly and proudly displayed, whereas SI is usually done privately and shamefully hidden. It must also be recognized that while body modification is not considered a form of SI, body modification can cross the line and morph into SI if the practice becomes a coping mechanism for an individual (Conterio & Lader, 1998; Walsh, 2006).

SI Versus Suicide

Self-injurious behavior is different from suicidal ideation (Applewhite & Joseph, 1994; Carlson et al., 2005; Cavanaugh, 2002; Connors, 2000; Conterio & Lader, 1998; Favazza, 1996; Klonsky & Muehlenkamp, 2007; McDonald, 2006; Strong, 1998; Walsh, 2006, 2007; White et al., 2002). Zila and Kiselica (2001, p. 47) present an analysis of SI as a syndrome and compare SI and suicide. Table 1 summarizes the comparison offered by Zila and Kiselica.

Other evidence supporting SI as separate and different from suicide can be found in SI literature; Shaw (2002) uses the term "anti-suicide" in her work and Conterio and Lader (1998) state that paradoxically SI is usually life sustaining. Walsh (2007) asserts that SI forms (e.g. cutting, scratching, carving, self-hitting, and self-burning) tend to have a low degree of lethality, whereas suicide forms (e.g. firearms, suffocation, poison, and falling) have a high degree of lethality. SI often keeps the self-injurer functioning because the behavior provides emotional relief. Endorphins are released into the blood system when pain is inflicted and these endorphins may soothe the nervous system, ultimately reducing anxiety and depression (Alderman, 1997; Conterio & Lader, 1998; Favazza, 1996; Levenkron, 1998; Lukonski & Folmer, n.d.; Selekman, 2006; Strong, 1998). Evidence of suicide being different

from SI has been observed in the high school counselling office where it has often been stated by the client, "I don't think I would be alive if I didn't cut myself."

Table 1

Comparison of Suicide and Self-Injury

Suicide	Self-Injury
Wants to end life.	Does not want to end life.
Elicits a helping response from others and such a response reduces the possibility of further attempts.	Others often react with hostility and disgust, frequency does not diminish.
Individual's situation often improves when removed from stressful situations.	Individual continues SI despite change in the level of stress.
Intent is death.	Low lethality.
Following attempt there is no relief.	Following SI, there is relief.
Has thoughts of death and dying.	Little or no thoughts of death.

Although suicide and SI are different conditions, suicidal ideation and suicide attempts are sometimes found among the self-injuring population (Cooper, Kapur, Webb, Lawlor, Guthrie, Mackway-Jones et al., 2005; Favazza, 1996; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Nock, Joiner, Gordon, Lloyd-Richardson & Prinstein, 2006; Walsh, 2007). It cannot be understated that self-injuring individuals may be at risk of suicide (Walsh, 2007). When working with self-injuring clients, suicide must always be considered and the risk of suicide must be assessed.

Incidence of SI

The incidence of SI in the adolescent population is in question. In comparing youth and adult self-injurers, Hjelmeland and Groholt (2005) concluded that adolescents have a higher incidence of SI than adults and postulate that the reported difference is due to adolescents being more cognitively immature and having less experience dealing with problems. Galley (2003) reported that 4% of adolescents practice SI while Ross and Heath (2002) concluded that 13.9% of high school students practice self-injurious behaviors. In a community sample of adolescents, Lloyd-Richardson et al. (2007) found that in the past year 46.5% of youth reported having practiced self-injurious behavior but qualified this result by also indicating that only 28% reported moderate to severe SI. Among adolescents with some form of psychiatric illness, Winkler (2003) states that the incidence is 20%. When looking only at people of all ages who are hospitalized for mental illness, 40% to 60% practice SI (Winkler, 2003).

Although an increase in the incidence of SI is documented (Derouin & Bravender, 2004; Roberts-Dobie & Donatelle, 2007; Ross & Heath, 2002; White Kress, 2003), the reported incidence of adolescent SI (4% to 60%) varies depending on the methodology, sample, and date that the study was reported. A closer look at the literature suggests possible reasons for this variance. One explanation is the time of the study. Ross and Heath's study was published in 2002 whereas Lloyd-Richardson et al.'s study was published in 2007. Both research teams reported high rates of SI but the 2007 study concluded a far greater incidence among adolescents. It is possible that the time difference between the studies is a key factor; latter studies may report more adolescents engaging in SI as it has become more "normalized" by peers, the music industry, and the media. Events during the five-year period

between the two studies may have contributed to the increase in prevalence. Another factor that could explain a difference in results is the sample (high school, community, outpatient, or inpatient adolescents). Samples including outpatient or inpatient adolescents (clinical samples) report higher incidence of SI than in community or school populations (Nixon & Heath, 2009). The definition of SI (ranging from self-scratching and scab picking to cutting, burning, and bone breaking) could also influence study results. If superficial (not just moderate or severe) SI is included, prevalence is likely to be much higher. The age of the participants (early to late adolescence) in a study could influence prevalence; it is reported that younger adolescents practice SI less frequently than do older adolescents or young adults (Nixon & Heath, 2009).

No matter to which research or literature one refers, it is accurate to state that SI is a behavior with which many adolescents struggle. Evidence indicates that SI is a serious adolescent mental health issue and this is further compounded by reports that the incidence of self-injurious behavior is increasing (Carlson et al., 2005; Conterio & Lader, 1998; Roberts-Dobie & Donatelle, 2007; Walsh, 2006; White Kress, 2003).

The relative incidence of SI among males and females is in question. One reason for this is that most of the research conducted has focused on adult females in clinical settings. Literature that includes information on male self-injurers is lacking. Some authors have concluded that the incidence for both genders is similar (Alderman, 1997; Gratz, Conrad, & Roemer, 2002; Klonsky, Oltmanns, & Turkheimer, 2003; Marchetto, 2006; Muehlenkamp, 2005; Nock et al., 2006; Swadi, 2004; Tyler, Whitbeck, Hoyt, & Johnson, 2003; White et al., 2002). Other authors report that the behavior occurs more frequently among females than males (Conterio & Lader, 1998; Laye-Gindhu & Schonert-Reichl, 2005; Levenkron, 1998;

Ross & Heath, 2002; Shaw, 2002). One reason for this discrepancy in research results may be that adolescent males will not volunteer to participate in research studies after preliminary screening; male participation in such studies may require disclosure about emotions and a coping strategy (SI) that they may wish to keep private. Despite the discrepancy in the literature, evidence indicates that SI is an issue for both male and female adolescents.

Sample SI Case Illustrations

To help the reader understand the scope of adolescent SI, two hypothetical case illustrations that could surface in the public school system are presented. The case illustrations are based on experience but are not associated with any one client. Each case study represents a montage developed over years of experience.

Case Illustration One

Jason is 16 years old. He has passing grades at school but teachers report his attitude and lack of motivation prevent him from being more successful in school. He was removed from his mother's home by a government social worker when he was eight years old. Jason lives with his aunt who has sole custody of him. Jason suffered physical and sexual abuse while he lived with his natural mother and his mother's partner and currently has no contact with them.

Initial contact with the school counsellor was made as the result of a student reporting to the counsellor that Jason was cutting himself. The school counsellor brought Jason into his office to assess Jason's well-being. Jason admits to cutting himself on his wrists, arms, and thighs. Jason reports that cutting gives him needed relief. He always cuts in private but he often cuts on the Internet using a web camera.

The camera only shows his thighs while he cuts to ensure his anonymity. Jason says he is a loner with no close friends.

Jason admits to three previous suicide attempts. He tells his school counsellor that he has had recent suicidal thoughts and is considering suicide as the way to end his unfortunate situation and pain. Although no day has been determined, Jason has decided that he would kill himself by hanging himself in his aunt's basement and states that a rafter in the basement would work well.

Jason's safety and well-being are in jeopardy and the counsellor explained to Jason that he needs immediate medical care. Although Jason did not want the counsellor to call his aunt, the call was placed. Jason chose to remain in the office during the phone call. Jason's aunt immediately came to the school. On the counsellor's recommendation, Jason's aunt took him to the emergency ward of a hospital where he was admitted to an adolescent psychiatric unit. The counsellor followed up to ensure that the hospital visit occurred. While in hospital, a medication that Jason voluntarily and secretly discontinued was re-administered.

Jason has a counsellor with an outside community agency but his contact had become limited. Regular sessions were reestablished. Jason gave his permission for the school counsellor to contact his agency counsellor. The school counsellor reported Jason's situation from the school's perspective and said he will see Jason regularly to support him and monitor his mental health. Jason has agreed that this would be a helpful strategy.

Case Illustration Two

Jessica is 14 years old. Jessica is academically successful. She lives with both her natural parents. She would "pop in" to see her school counsellor sporadically just to visit. Over time, Jessica stated that she had something important to tell the counsellor but she could not talk about it. Her counsellor suggested she write it down if she wanted to share her thoughts. About two weeks later, Jessica came into the counsellor's office, dropped a note on the counsellor's desk, and left. The note explained how she had been raped by her cousin six months ago. Although her parents knew about the incident, they did nothing and told Jessica not to talk about it. The counsellor met with Jessica. Jessica was relieved to know that the counsellor was concerned and that a government social worker would be contacted. While an investigation was launched by the social worker and police, Jessica was placed in a group home. Jessica was very happy with this temporary outcome as she was away from the stress at home. The social worker arranged for out-of-school counselling for Jessica. Jessica continued to see the school counsellor, and her visits became more regular. With Jessica's permission, the school counsellor contacted her outside agency counsellor.

Several months after the disclosure was made, Jessica went to her school counsellor and told her she was cutting herself. She reported that the stress of the rape, her family's denial, and the move to the group home had culminated in her needing an outlet. Cutting was giving her the relief she needed. The counsellor assessed her risk of suicide and determined that it was very low. With Jessica's consent, the school counsellor called Jessica's outside agency counsellor to inform

her therapist of her cutting. Between Jessica, the outside agency therapist, and the school counsellor, a treatment strategy was developed. One aspect of the plan was for Jessica to see her school counsellor when she felt the urge to cut herself.

Jessica showed up at her school counsellor's office one day while classes were in session and was very distraught. She said she just left the girl's washroom where she had been contemplating cutting herself with her school mathematics compass. She chose not to cut herself and instead go to the school counsellor's office. Jessica and the counsellor determined that Jessica was able to make this positive choice because of her agency counselling sessions. One coping strategy developed was to see the school counsellor when her stress and anxiety became intolerable at school. Jessica proudly left the counselling office; she was able to get through a challenging situation without cutting herself.

Conclusion

Both case illustrations highlight some of the key aspects of this chapter on the nature of SI. One student struggled with suicidal ideation; the other did not. Suicide and SI are different and often are not comorbid, but can be. SI is an issue for both genders. In both cases, SI was practiced in early adolescence, the time when research indicates that most adolescents start self-injuring behaviors. The illustrations provide two of many possible situations a counsellor may face and allude to the risk factors related to the incidence of SI. Risk factors will be addressed in Chapter Three.

Chapter Three: Risk Factors Related to the Incidence of SI

Certain risk factors may be present in adolescents who practice SI. It must be noted that the risk factors discussed in this chapter are not all encompassing and do not necessarily predict self-injurious behaviors. Although there is a higher incidence of SI among clinical populations, it is occurring with increased frequency among populations without mental health diagnoses and that do not exhibit known risk factors (Klonsky, 2007; Walsh, 2007). Risk factors that may contribute to the incidence of adolescent self-injury will be presented in this chapter.

Childhood Trauma and Post Traumatic Stress

Past traumatic experiences are often present in the lives of those who practice SI (Derouin & Bravender, 2004; Marchetto, 2006; Shaw, 2002; Skegg, 2005; Zila & Kiselica, 2001). Many of these traumatic experiences relate to child abuse and subsequent post traumatic stress (Alderman, 1997; Cavanaugh, 2002; Conterio & Lader, 1998; Derouin & Bravender, 2004; Gratz & Chapman, 2007; Gratz, Conrad, & Roemer, 2002; Muehlenkamp, 2005; Nixon, Cloutier, & Aggarwal, 2002; Polk & Liss, 2007; Strong, 1998; Suyemoto & MacDonald, 1995; Swadi, 2004; Tyler et al., 2003; Walsh, 2006; White et al., 2002; Zila & Kiselica, 2001). Sexual abuse is one of the most significant forms of child abuse to influence self-injurious behavior (Strong, 1998). In more recently published literature (Croyle & Waltz, 2007; Heath, Toste, Nedecheva, & Charlebois, 2008; Klonsky & Muehlenkamp, 2007), the view of the relationship between child abuse and SI has been tempered. It is posited by these authors that practitioners cannot assume that a person who has endured child abuse is likely to self-injure nor that individuals without a history of child abuse will not practice SI. This assertion is made because much of the SI risk factor research conducted has studied clinical

samples exhibiting mental health issues and within such samples it is believed that a history of child abuse is more likely. Klonsky and Muehlenkamp, upon reviewing SI research, concluded that there is only a modest link between childhood sexual abuse and SI. It can be concluded that some abused children go on to self-injure while others do not, and that some individuals without a history of child abuse will practice SI.

Other traumatic experiences besides child abuse have been identified as risk factors. Strong (1998) identifies emotional abuse, emotional deprivation, physical neglect, and childhood loss as traumatic stressors that could contribute to the onset of SI. Connors (2000) and Frankel (2001) state that the traumatic event could be perceived by an outsider as a relatively minor one, but if the individual harbours significant negative feelings regarding the event, the event could be a factor contributing to SI. What a counsellor perceives as less significant trauma can actually have a profound impact on an adolescent and motivate an adolescent to self-injure as a coping mechanism.

The following hypothetical case illustration describes a situation where trauma unrelated to child abuse contributed to self-injurious behavior:

> *Melissa is 16 years old and is a student in grade 10. Recently her grades have been falling and her teachers have referred Melissa to her counsellor because she has been skipping school and not doing her academic work, leading to her being in jeopardy of failing classes. Over time, the counsellor discovered that when Jessica was seven years old, her mother was injured so seriously in the workplace that she can no longer work and draws a disability pension. When Melissa was 10 years old, her father was diagnosed with a chronic and debilitating condition. Melissa's father was treated and the condition is controlled with medication. Melissa is worried about*

her parents' long-term health and fears one or both parents could die. As her family endured two tragic challenges, Melissa spent a great deal of time with her immediate family and became isolated from her peers. While assessing Melissa's level of stress and depression, the counsellor learned that Melissa has been cutting herself since grade seven. Melissa describes herself as anxious, lonely, isolated, and stressed. She reports that she craves relief from her emotional turmoil and she has learned that when her stress builds to intolerable levels, cutting provides the relief she needs. Melissa feels stressed because of her parents' situations. Melissa has difficulty dealing with her emotions related to her family difficulties and her emotional dysfunction has carried over to other life situations, both socially and academically.

This illustration clearly demonstrates how traumatic childhood experiences could have an impact on an adolescent's coping abilities and increase the likelihood of an adolescent turning to SI for emotional relief.

Body Image Issues

A link between body image issues, including eating disorders, and SI has been reported in literature (Best, 2005; Castille, Prout, Marczyk, Shmidheiser, Yoder, & Howlett, 2007; Cavanaugh, 2002; Conterio & Lader, 1998; Favazza & Conterio, 1988; Gardner, 2001; Muehlenkamp, 2007; White et al., 2002; Zila & Kiselica, 2001). Muehlenkamp (2007) found that negative body regard can be related to male and female adolescent SI. To illustrate the link between negative body image and SI as a risk factor, a hypothetical case illustration is provided:

Although Laura is not overweight, Laura sees her peers as thinner and more attractive than herself. Laura thinks her body image explains why she is isolated from other girls. She would like to lose 10 to 15 pounds. Occasionally Laura decides that she is going to go on a "diet". When she goes on her diet, she tries to stop eating entirely. This sets Laura up for failure as she becomes so hungry that she "pigs out" in response to her intense hunger. Laura is now not only perceiving herself as overweight and ugly but also as a failure because she can't stick to her diet; the stress and anxiety created result in her cutting herself to relieve the tension and to escape her emotional turmoil.

From a review of the literature related to body image and the case illustration, it is apparent that adolescents with body image issues may exhibit self-injurious behaviors. It is also important to realize that if one issue exists (body image issues or self-injurious behavior), then the other issue may not be present. If either body image issues or self-injury is present, assessment is required to ascertain whether both conditions coexist.

Borderline Personality Disorder

Borderline personality disorder (BPD) is defined in the *DSM-IV-TR* (APA, 2000) as "a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity" (p. 685). Brown (1998) simply describes the condition as dysfunctions in emotions, behavior and cognition. The link between BPD and SI is well documented (Andover, Pepper, Ryabchenko, Orrico, & Gibb, 2005; Brown, 1998; Favazza & Conterio, 1988; Klonsky et al., 2003; McKay, Gavigan, & Kulchycky, 2004; Nock et al., 2006; Paris, 2005; Swadi, 2004; White Kress, 2003). Self-injury is mentioned only once in the *DSM-IV-*

TR and it is as a symptom of BPD. Much of the SI research and literature has focused on participants with a diagnosis of BPD (Klonsky & Muehlenkamp, 2007; Lukomski & Folmer, n.d.; Muehlenkamp, 2007; White Kress, 2003). White Kress reports that among people diagnosed with BPD, 75% are self-injurers. A review of the literature related to SI and BPD reveals that the incidence of SI is more frequent among adolescents in clinical and hospitalized populations with a diagnosis of BPD than in community samples.

Despite evidence linking SI and BPD, research indicates that over time superficial or moderate SI is occurring more frequently among individuals without symptoms of BPD than was previously reported (Muehlenkamp, 2005). Practitioners are cautioned to avoid considering BPD and SI together and instead to view the conditions as two unique problems (Muehlenkamp, 2005; Nixon et al., 2002).

In drawing conclusions from available research and literature related to SI and BPD, the following points can be made:

- Individuals diagnosed with BPD are likely to self-injure.
- SI is observed in populations that have not been diagnosed with BPD.
- Superficial/moderate SI is frequent in community samples with no BPD diagnosis.
- SI should be considered separately from BPD.

Anxiety, Despair, and Depression

Anxiety, despair, and depression are affective conditions that are often present among individuals who self-injure (Klonsky & Meuhlenkamp, 2007; Muehlenkamp, 2005; Nixon et al., 2002; Nixon, Cloutier, & Jansson, 2008; White Kress, n.d.). When these feelings are experienced by an individual, a situation can become overwhelming and result in turning to

SI for immediate emotional relief (Klonsky & Muehlenkamp, 2007). In studies of hospitalized and community self-injuring adolescents, it was found that participants reported coping with feelings of depression as the most frequent reason for turning to SI (Andover et al., 2005; Nixon et al., 2002; Nixon et al., 2008; Ross & Heath, 2002).

Disturbed Childhood Attachments

Disturbed childhood attachments have been cited as a SI risk factor (Carlson et al., 2005; Conterio & Lader, 1998; Derouin & Bravender, 2004; Gardner, 2001; Gratz & Chapman, 2007; Gratz et al., 2002; Heath et al., 2008; Levenkron, 1998; Selekman, 2006; Skegg, 2005; Swadi, 2004; Zila & Kiselica, 2001). Some factors that lead to attachment disturbances are:

- Childhood separation from a parent (Gratz et al., 2002),
- Loss of a parent, parental depression, marital violence (White et al., 2002),
- Divorced parents, incarcerated parents, parental alcoholism (Cavanaugh, 2002), or chronic physical or mental illness in the family (Castille et al., 2007), and
- Lack of parental handling and isolation from family (Zila & Kiselica, 2001).

Sexual Identity and Role Confusion

Zila and Kiselica (2001) identify repugnance toward sexuality, uncertainty regarding sexual identity, troublesome sexual feelings, adjustment problems with menarche, and confusion about emerging sexuality as possible issues related to SI. Difficulties with these issues can create intense negative affect and lead to SI as a way to address the overpowering stress.

Individuals who are gay, lesbian, bisexual or transgender are at greater risk of SI than are heterosexuals (Conterio & Lader, 1998; Skegg, 2005; Walsh, 2006). Skegg asserts that SI

often occurs around the time when individuals realize that they may not be heterosexual. Walsh has observed that youth not yet "out of the closet" often struggle with SI issues. A case illustration helps bring perspective to how sexual identity can be a SI risk factor:

> *Donald is 17 years old. Donald has told his school counsellor he is gay but has not disclosed this information to anyone else at school. He has decided that it is safer and easier for him to keep his sexual orientation confidential while he is a high school student. Donald is living away from his mother in a group home and endured a disturbed attachment to his mother as a child. To cope with his stress, Donald has turned to SI many times in his life. He began cutting himself when he was 10 years old. As Donald nears his high school graduation, he is becoming more optimistic about his future. He believes that he can start living his life as an outwardly gay man and the relief surrounding this perspective has contributed to his decision not to injure himself anymore. Donald thinks that one of the reasons he cut himself was because he found it necessary to repress his homosexuality.*

Substance Use

Substance use has been identified as a SI risk factor (Alderman, 1997; Castille et al. 2007; Conterio & Lader, 1998; Walsh, 2006; Winkler, 2003; Zila & Kiselica, 2001). Zila and Kiselica conclude that SI can be triggered by substance use because of impaired judgment. It appears that the link between substance use and SI is stronger for youth than adults (Skegg, 2005).

Contagion Effect

Peers, the media, music, and the Internet can influence an individual's SI behaviors. This influence is called the "contagion effect"; adolescents may imitate the behaviors to which they are exposed, including SI. Many authors of SI literature cite the contagion effect as a concern (Derouin & Bravender, 2004; Muehlenkamp, 2005; Nock et al., 2006; Roberts-Dobie & Donatelle, 2007; Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, & Helenius, 1998; Whitlock, Powers, & Eckenrode, 2006). The contagion effect can account for "outbreaks" of SI in school populations (White Kress, n.d.). Exposure to contagions increases the likelihood of adolescent SI. An in-depth review of the contagion effect is presented in Chapter Five.

Biological Factors

Not much is understood about the link between biological factors and SI. Neurotransmitters such as serotonin, dopamine, and opiates have been linked to SI (Nixon & Heath, 2009), but their relevance is not fully understood. Linking dopamine and opiates to SI has added strength to theories about the addictive nature of SI (Nixon & Heath, 2009); it appears that self-injuring individuals produce dopamine and opiates at different levels or develop different transmission pathways than non-self-injurers.

One biological factor important to mention relates to serotonin levels. Depression has been linked to disruptions of serotonin systems. Low serotonin levels have been linked to SI (Favazza, 1996; Levenkron, 1998; Muehlenkamp, 2005; Walsh, 2006). As one part of a research study, blood samples of adolescents self-reporting SI and an adolescent control group without self-injurious behaviors were compared (Crowell et al., 2008). A statistically significant difference between the two groups was reported with the self-injurious group

having significantly lower serotonin levels ($p < .001$ and $p < .05$ when the use of antidepressants was controlled for). Research of this nature has led to the use of selective serotonin reuptake inhibitors (SSRI's) in the treatment of SI (Nixon & Heath, 2009), although not without controversy. There appears to be a link between serotonin and self-aggression, but this link is not thoroughly proven or understood. This factor requires more research before conclusions can be drawn regarding the relevant links between neurotransmitters and SI.

Conclusion

The following is a summary of the risk factors identified in this chapter:

- Childhood trauma and post-traumatic stress,
- Body image issues,
- Borderline personality disorder (BPD),
- Anxiety, despair, and depression (negative affect),
- Disturbed childhood attachments,
- Sexual identity and role confusion,
- Substance use,
- Contagion effect (peers, media, music, and Internet), and
- Biological factors (neurotransmitters).

As the case illustrations indicate, it is common for several risk factors to be present in the lives of self-injurers. It is also important to realize that obvious risk factors may be absent in adolescents; researchers have concluded that the absence of risk factors is common in superficial/moderate SI.

Working with adolescents in the public school system offers challenges that are different from other counselling situations. Chapter Four provides information and strategies for individuals working with adolescents in a school environment.

Chapter Four: Working with Adolescents in a Public School Setting

The incidence of adolescent SI has increased to the point where self-injurious behaviors have become an issue that public schools need to address. Working with self-injuring students in the public school system has unique challenges that may not exist within non-educational support systems. Evidence of SI is often discovered at school by a staff member or a peer of a self-injurer. If SI is identified by a school staff member, the employee often reacts with panic, shock, and anxiety (Best, 2005, 2006a, 2006b). When evidence or disclosure of SI surfaces in a school, it is often perceived by the community that the school has an obligation to communicate with parents or guardians about their child's self-injurious behavior. School personnel will typically be concerned about the legal ramifications of not informing parents of a self-injurious incident. In addition to the school personnel's legal obligations, ethical considerations magnify the concerns created when SI is discovered at school. Whether or not counsellors must respect the confidentiality of students within the school system remains unclear, even though many students request confidentiality. Thus, a quagmire of issues difficult for school staff to traverse is created when self-injurious behavior arises within a school setting. The purpose of this chapter is to address these confusing challenges so that adolescent self-injurers can be supported appropriately within the public school system.

A scenario involving SI in the public school system illustrates a situation that a school could face:

> *Mr. Carson is an English teacher in a mid-sized urban high school. During his morning ninth grade class a female student raises her hand to request help. While helping at the student's desk, Mr. Carson notices that the student's oversized*

"hoodie" sleeve has slid up her arm; Mr. Carson can see several red, irritated, and shallow lacerations on the student's wrist.

The following is a list of questions the school staff may need to address when faced with this scenario:

- What should the teacher do?
- Is this SI?
- Whom should the teacher contact?
- To whom should the teacher refer the situation and student, if anyone?
- What are the student's rights in this situation?
- What are the parents'/guardians' rights?
- What is the legal responsibility of the school?
- What are the ethical issues that require consideration?
- Are there any procedures in place to which school staff can refer?

All of these questions are valid when situations of SI arise in a school and each one merits consideration. A possible reaction to the case study involving Mr. Carson follows:

Mr. Carson called the school counsellor asking her to meet with him during lunch break. The school counsellor met with Mr. Carson and gathered two pieces of information: the facts surrounding what Mr. Carson saw and how Mr. Carson was coping. Mr. Carson was distressed by what he saw and feared that the injuries were self-inflicted. The counsellor took some time to explain the nature of self-injury and to thank Mr. Carson for seeking help regarding the incident. The school counsellor

concluded the conversation by offering to talk with him again if he needed any further information or had additional concerns.

After the lunch break, the school counsellor brought the student into her office. The counsellor told the student that Mr. Carson had seen wounds on her wrist during class that morning. Although the school counsellor did not ask to see her wounds, the student volunteered to show them to her. The student confirmed that the wounds were self-inflicted. Throughout the session, it was ascertained that the student's parents were aware of her self-injurious behavior, she was receiving counselling from an outside agency, and she felt very sad and upset due to the stress created by a recent situation. The school counsellor obtained permission to speak with the student's parents and the outside agency providing her counselling. The student was given the option of staying in the school counsellor's office during the calls or to wait outside. She chose to be present during the calls. During the phone calls, the school counsellor related what had happened at school and offered support to both the family and outside agency counsellor. After the calls were made, the school counsellor worked with the student to develop alternate coping strategies that would work in her current and similar situations. The student agreed to see the school counsellor when she needed support, especially when she needed help to get her through a tough situation without hurting herself. The student accepted the offer of the school counsellor "touching base" with her on occasion to see how she was doing. The counsellor spoke to Mr. Carson to say that the situation was being addressed, to thank him for his efforts on behalf of the student, and to see how Mr. Carson was doing.

Within the realm of adolescent SI, this situation was relatively easy to address due to how the classroom teacher handled the situation, the school counsellor's knowledge about SI, the student accepting the school's help, the outside agency counselling already being in place, and the parents' awareness of the student's self-injurious behavior. What this situation illustrates is the value of the school counsellor as a supportive conduit for the adolescent, school staff, family, and outside agencies to work through when incidents of SI are identified. The value of staff education and support is also illustrated in the scenario. When adequate staff education is provided, the student is more likely to receive needed assistance in an appropriate way.

Staff Education Regarding SI

Research indicates that school staff members want education around the issue of adolescent SI (Best, 2006a, 2006b; Carlson et al., 2005; Roberts-Dobie & Donatelle, 2007). Other literature also supports staff education (Best, 2005; Froeschle & Moyer, 2004; Onacki, 2005). Most teachers do not possess the awareness and knowledge needed to intervene in situations of SI (Carlson et al., 2005). The shock, panic and anxiety among school staff identified by Best (2005, 2006a) can be appropriately addressed and reduced with staff training.

The two target staff groups that require education regarding SI are school counsellors and other staff members (administrators, teachers, and support staff). The needs of these two groups are different; school counsellors must deal with the self-injurer directly while other staff members need to understand the nature of SI, learn how to deal with their feelings around SI, learn how to support self-injuring students, and understand the importance of referring students to the appropriate school employee.

Staff education serves a two-fold purpose: to inform school employees about what to do should they identify a possible case of self-injury and to educate employees about the nature of SI so that understanding is fostered. A staff training session can occur within a staff meeting or during a professional development session. Teachers may not be the only staff members exposed to a possible case of SI. It is important to offer staff training to all school employees and volunteers: teachers, administrators, office support staff, custodians, youth care workers, bus drivers, and team coaches. A training session should provide information regarding the nature of SI and what to do if a case of SI is suspected. Appendix A provides a possible outline of staff training regarding student self-injury. This outline is meant to be a starting point that a school or school district can use to develop its own training approach; some school districts may opt for a standardized approach which all district schools could use as a reference. The person facilitating an information session on self-injury could be a school counsellor, school nurse, school psychologist, school social worker, or outside professional, depending on the expertise available to the school. No matter which individual(s) present information to a school's staff, presenters must have a sound understanding of the nature of adolescent self-injury and how to support adolescent self-injurers within the school system.

When self-injurious behaviors are identified in the public school system, the school counsellor often becomes the "conduit" through which the client, their family, staff members, and members of community support agencies work (Ross & Heath, 2003). School counsellors can educate themselves around the issues of SI by reading about SI and participating in training sessions designed for counsellors. Training for school counsellors needs to be more in depth than training for other school staff members as school counsellors must also be aware of treatment strategies, community resources, and how to assist those

who know the self-injurer (staff members, peers, and family members). It is the school counsellor's responsibility to access their own training and develop the skills needed to work effectively with the many possible stakeholders (adolescent client, peers, family members, school staff, medical professionals, and outside counsellors) identified when an incident of SI arises.

Treating self-injuring adolescents is a challenging task. Although self-injury is the observable behavior, there are often underlying issues that come to light during treatment. Many of these issues relate to past trauma, substance use, eating disorders, and suicide. In addition, several authors of SI literature assert that treating self-injurious behaviors is lengthy (Derouin, & Bravender, 2004; Galley, 2003; McDonald, 2006; Onacki, 2005; Strong, 1998; Winkler, 2003). It is argued that school counsellors usually do not have the time required to develop a suitable treatment plan and work with the student therapeutically on a long-term basis. In a school, counsellors work not just with students, but also with teachers, parents, and administrators. In addition to meeting the needs of these four user groups, school counsellors have large caseloads that limit the amount of time available for one-on-one work with students (Rutter, 2007). Further, school counsellors are not available for extended times during school holidays. The level of school counsellor training can vary from a teacher with no formal counselling training to a teacher with a Master degree in counselling. These school realities support the importance of referral to medical professionals and community agencies better designed to meet the therapeutic needs of self-injuring adolescents. Roberts-Dobie and Donatelle (2007) and Best (2005) conclude that it is not the role of the school counsellor to provide therapy for mental health problems. A great deal of literature supports the need for referral (Best, 2005; Froeschle & Moyer, 2004; Galley, 2003; Lukomski & Folmer, n.d.;

McDonald, 2006; Onacki, 2005; Robert-Dobie & Donatelle, 2007; Walsh, 2006). As referral is often required, counsellors must familiarize themselves with community resources that are most appropriate, and how to refer to them, so that students' mental health and medical needs are met (Roberts-Dobie & Donatelle, 2007). This aspect of effective school intervention should be a part of counsellor SI education. The identified need for referral does not underestimate the effectiveness of school counsellors. Mary Graham is a previous self-injurer who helps many self-injuring youth. Graham (personal communication, March 9, 2009) states that adolescents often report that the school counsellor is one of the most effective mental health providers—students know their school counsellor, a school counsellor is readily available, and a student can visit the counsellor's office as the need arises, even if it is only for 10 minutes.

Confidentiality

Confidentiality poses challenges for school personnel working with adolescents. As graphically presented in Figure 1, school counsellors often find themselves involved with sometimes opposing and unclear factors that contribute to the issues of confidentiality for adolescents in the school system.

The Canadian Counselling Association (CCA, 2007) addresses the issue of confidentiality in its Code of Ethics. Confidentiality is to be respected unless one or more of three conditions are involved (Section B2). The first is when there is client disclosure that indicates a "clear and imminent danger to the client or others" (CCA, p. 7). The second is when legal requirements demand that disclosure of confidential information is required. The third is "when a child is in need of protection" (CCA, p. 7). Although any of these conditions

can occur in a school environment, the first and third conditions are the confidentiality exceptions most likely to be issues when dealing with adolescent SI.

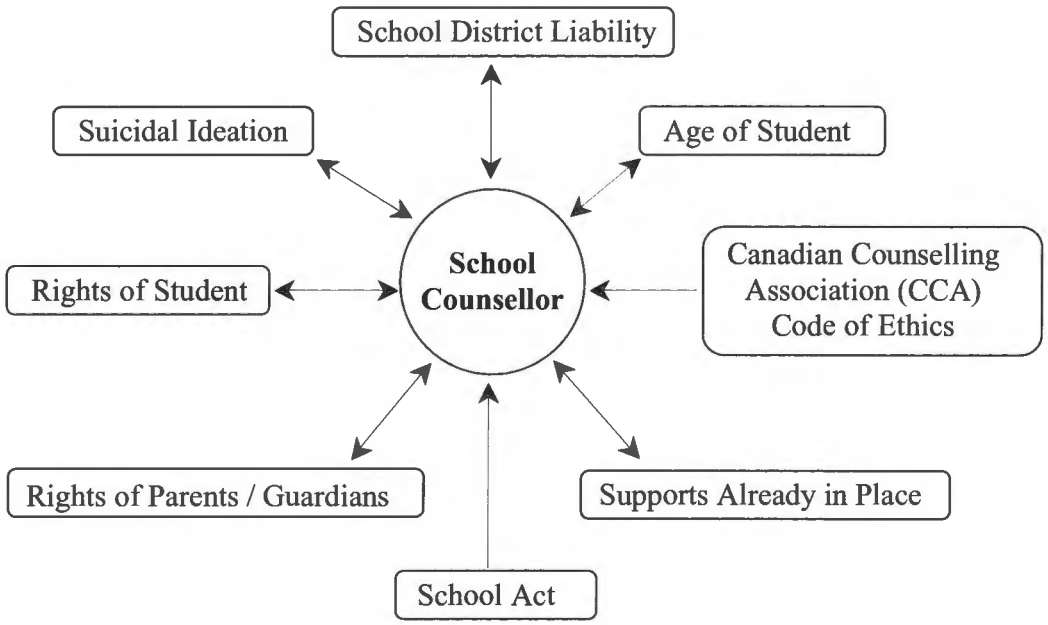

Figure 1. Factors for school counsellors to consider regarding confidentiality of adolescents practicing SI.

An example of "clear and imminent danger" surrounding adolescent SI is suicidal ideation. Although not all self-injurers are suicidal, suicidal ideation must be assessed when treating self-injurers. Within a school, the person to conduct a suicide assessment is often the school counsellor. If a counsellor has reason to believe that either suicide or a suicide attempt is a possibility, the counsellor is required to break confidentiality to access help necessary to maintain the student's safety. Accessing help can involve a gamut of possibilities, from calling a parent to taking the adolescent to the hospital.

When client safety is not at risk for adolescent self-injurers, confidentiality becomes murky. In reviewing the literature related to confidentiality, some authors conclude that parents or guardians have the right to be informed regarding their child's self-injurious behaviors (CCA, 2007; Frankel, 2001; Froeschle & Moyer, 2004; Galley, 2003; McDonald, 2006; Onacki, 2005). The CCA Code of Ethics qualifies its assertion by stating that "parental or guardian right to consent on behalf of children diminishes commensurate with the child's growing capacity to provide informed consent" (p.8). This aspect of the Code of Ethics suggests that adolescents may be able to make their own decisions around counselling for SI if the client's well-being is not in jeopardy. Applewhite and Joseph (1994) maintain that by the age of 14 years an adolescent is capable of making many competent decisions about mental health treatment, including confidentiality. The position regarding confidentiality presented by Applewhite and Joseph nurtures trust in the counselling relationship, gives the adolescent dignity, and protects the adolescent's interests. Best (2006b) and Nixon and Heath (2009) support respecting student confidentiality unless the student is in jeopardy. Walsh (2006) argues that if the behaviors assessed while interviewing the student are considered minor or have already been resolved, the behaviors need not be reported. Walsh goes on to state that if the behavior is significant and requires additional intervention, then parents need to be contacted. This summary of literature pertaining to adolescent SI and confidentiality illustrates how confusing the issue of confidentiality can be; everything from respecting confidentiality unless personal safety is in question to informing parents/guardians whenever an incident arises is advocated. This confusion reflects the quagmire of issues pertaining to adolescent SI in the school system.

An important confidentiality factor is the location at which self-injuring behaviors occur. For example, within the province of British Columbia (BC) public school system, the School Act (Revised Statutes of BC, Chapter 412, Part 1, Division 2, 1996) includes a statement that ensures a parent's right to information regarding a child's attendance, behavior, and progress in school. This brings into question confidentiality if a student is practicing SI at school. It can be interpreted from the School Act that parents are entitled to SI information if the behavior occurs on school property. Failure to inform parents may result in serious legal ramifications due to contravention of the BC School Act.

School counsellors and their schools need to develop procedures regarding the confidentiality of adolescents who practice self-injurious behaviors. It is suggested that the issue of adolescent confidentiality be addressed in school procedures before SI issues arise. My stance on adolescent SI, confidentiality, and the school system is that provided the student's safety is not in question and the behavior is not conducted at school, confidentiality should be respected. A therapeutic goal is often to work towards a point where the student is ready to tell parents/guardians about their self-injurious behavior. Although informing parents is usually not accepted by students at the beginning of a counsellor/student relationship, experience has indicated that students will eventually disclose their self-injurious behaviors to their parents. This strategy places the onus of disclosure on the student and allows the counsellor to respect the student's confidentiality.

If it is decided that parents/guardians need to be contacted, it is essential to remember that adolescent self-injurers do not like surprises (Malikow, 2006). Removing the element of surprise requires informing the student of the impending contact with parents and describing the actions that will occur. It also means giving the student options (Onacki, 2005). Giving

options allows the student to have some control throughout an intense situation while decreasing the chance of surprises. One choice is allowing the student to decide to stay in the room or wait outside while a phone call is made to parents/guardians or when parents come into the school to discuss their child's behavior (Galley, 2003). Letting the student choose the timing of contact is another way to let the adolescent self-injurer have some control. For example, a student may request that the counsellor wait until a parent/guardian is off work before making contact. Another choice is asking the student which parent/guardian to initially contact. Choice is also facilitated by asking the student whether there is another support person in addition to the parents/guardians that the student would also like involved; another relative, school staff member, or peer may be requested to provide support for the student.

Developing School SI Procedures

Not all adolescent SI cases are as easy to address as the one described earlier in this chapter. Often the student does not want help, parents are unaware of their child's self-injurious behaviors, the student wants the self-injurious behavior to remain confidential, and school staff members are repulsed by the behavior or fail to respond when evidence of SI is presented. Such challenging situations demonstrate the need for school procedures that bring clarity to murky SI situations that present to school personnel.

Further supporting the need for procedures, Best (2005) asserts that schools cannot wait for a tragedy to happen before addressing SI concerns. Kenrick (2007) powerfully states that the incidence of SI among the adolescent population should be "setting off alarm bells for teachers, parents and anyone who comes into contact with young people" (p. 23).

Despite a need for SI procedures in public schools, they are usually lacking (Roberts-Dobie & Donatelle, 2007). The absence of school procedures reflects a lack of understanding and knowledge around SI.

An example of school procedures is included to help schools develop their own approaches (Appendix B). It is understood that each school works within its own microenvironment and that each school is likely to have different needs and resources. Thus, the sample document presented is meant to be a starting point from which schools and/or school districts can develop their own procedures. The development of procedures related to SI is likely to require the input of school staff, school counsellors, school administrators, and school district staff (such as a superintendent, school board member, or district school psychologist). Once procedures have been established, it is more likely that all staff will be aware of how to appropriately handle an incident of SI.

The sample procedures in Appendix B encourage the use of the school counsellor as the conduit through which the school, community, and family connect. Many school counsellors have access to accurate SI knowledge through their professional development but also have professional training regarding how to provide support when sensitive and intense situations occur. It is understood that not all school counsellors have such background and it may be more appropriate to have a school psychologist, school nurse, or school social worker designated as the key individual.

Conclusion

Self-injuring students are often identified in the public school system. When an incident of SI is suspected, it is imperative that school personnel act appropriately. The school personnel's ability to act effectively hinges on the education of staff (teaching, non-

teaching, and counsellors) and volunteers and the development of suitable procedures. Paramount when an incident of SI is identified is the student's safety. The issue of confidentiality requires special consideration so that ethical and legal expectations are balanced with meeting the needs of the self-injuring student. Due to the nature of a school counsellor's professional role, providing adequate therapy in the school setting is likely not possible, although school counsellors can play an integral and supportive role. Referral of self-injuring students to an appropriate outside agency is strongly recommended.

With a sound background that includes an understanding of SI, the risk factors related to the behavior, the issues particularly relevant to adolescent self-injurers, and the school's role in responding to the behavior, client assessment can begin. Chapter Five offers a discussion of assessment procedures.

Chapter Five: Assessment of Self-Injuring Adolescents

The assessment of adolescent self-injurers prior to treatment is essential; treatment is likely to hinge upon the reasons a client practices SI. This chapter will present elements of SI to consider during assessment, the rationale for considering these elements in assessment, and strategies that can be used during assessment.

When an adolescent is self-injuring, safety must always be assessed. Although most self-injurers are not suicidal, suicide risk must still be determined (Harriss & Hawton, 2005; Harriss, Hawton, & Zahl, 2005). Depending on the level of self-injury (superficial or moderate versus major), serious unintended injury can occur, even leading to accidental death. Assessment can indicate that a referral to other health care or mental health providers (e.g. psychiatrist, physician, social worker, hospital emergency room) is needed. Assessment, therefore, serves four purposes: to determine the risks involved in the self-injurious behavior, to assess risk of suicide, to determine the need for referral, and to develop an appropriate treatment plan that meets the needs of the self-injuring client. While meeting the four purposes, an opportunity to nurture a strong therapeutic alliance is also created.

Validated assessment tools for adolescent SI are lacking (Walsh, 2007) and the *DSM-IV-TR* (APA, 2000) does not recognize SI as a disorder. The reality is that counsellors must assess self-injuring clients without many resources. Further, more counsellors are dealing with an increasing number of adolescents who self-injure, reflecting a growing need for information about assessment. The primary goal of this chapter is help fill this void by providing rationales for including a variety of domains (e.g. peers, family, substance use, and functions of SI) and offering assessment strategies particularly relevant to adolescent SI. For

the purposes of this chapter, it is assumed that counsellors have acquired basic counselling skills, including general assessment skills.

When assessing an adolescent client with self-injuring behaviors, a combination of tools should be considered (Appendices C and D). A multi-method approach using interviews, rating scales, and journaling can reveal many aspects of the client's world such as emotional experiences, the nature of self-reported behaviors, level and frequency of behaviors, suicide risk, inter-relational experiences, and mental health disorders. This information will increase understanding and provide direction during therapy. To assist with the organization of counsellor notes during the assessment phase of treatment, an "Assessment Record" has been developed (Appendix C) and suggestions for its use are included.

The Therapeutic Alliance

A strong alliance between the adolescent and counsellor is necessary to facilitate an informative assessment. Adolescents have an uncanny ability to detect counsellors lacking genuineness. Nixon and Heath (2009) encourage counsellors to use a "matter-of-fact, calm response . . . which focuses on listening to the youth's perspectives" (p. 146). Dealing with adolescent self-injury can generate strong emotions within the therapist. To support a strong alliance, counsellors must keep these emotions in check. Disgust, repulsion, frustration, and anger are examples of emotions a counsellor could experience and if the adolescent client senses such feelings, the therapeutic alliance may be compromised.

Assessment provides the opportunity to begin establishing a strong alliance. This can be done by encouraging a collaborative relationship. Some questions of the client that reinforce collaboration are:

- What do you want out of counselling?
- What changes are you hoping to achieve?
- What, if any, changes do you want to make in your self-injury?
- How will you benefit from changes in your self-injurious behaviors?

When communicating with an adolescent, the wording of probe statements and questions needs careful consideration. For example, Nixon and Heath (2009) consider a question like "Why do you self-injure?" unhelpful. Instead, they encourage the use of a statement like "Help me understand what is going on with you." (p. 147). Nixon and Heath assert that the "craftsmanship" of a counsellor is at the foundation of an effective and useful assessment.

An adolescent will not respond well to a barrage of questions. Asking a few probe questions and letting clients tell their stories is encouraged. Listening actively and empathically helps to develop a collaborative alliance and meet the needs of self-injuring adolescents.

It is relatively easy to understand what information is required during an assessment; it is more difficult to gather the relevant information in a way that builds a strong relationship. The success of assessment hinges on the quality of the therapeutic relationship and how the therapist communicates with the client.

Confidentiality

Confidentiality is always an important consideration in a client/counsellor relationship; however, confidentiality is more challenging to address when working with adolescents due to parent/guardian expectations, ethics, and legal obligations. Legally, the parent is the client, however ethically the client is the adolescent (Best, 2005, 2006b; Frankel,

2001; Froeschle & Moyer, 2004). There is great fear among adolescents that their parents/guardians will be informed of their self-injurious behavior (McVey-Nobel, Khemlani-Patel, & Neziroglu, 2006). SI is usually a private act and parents/guardians are often unaware of their child's behavior. Self-injuring adolescents may feel embarrassed about their behavior and want to keep the behavior confidential, especially where parents are concerned.

The confidentiality information presented in Chapter Four can be reviewed for further clarification regarding this important aspect of counselling adolescents who practice SI. In summary, respecting confidentiality hinges on the age of the adolescent (the older the adolescent client, the more likely confidentiality can be respected), severity of the SI (ensuring that the client's safety is not in jeopardy), the policies and ethics of organizations with which the counsellor is associated (certifying professional associations and employer policies), and legal responsibilities. It is recommended that whenever possible the confidentiality of the adolescent be respected. It is also suggested that an appropriate counselling goal is to work towards the client speaking with a parent or guardian about the self-injuring behavior.

The Assessment

SI assessment should not be conducted unless the counsellor has a strong understanding of SI (Zila & Kiselica, 2001). If assessment is inadequate, there is a risk of client harm. Harm could result from countertransference, judgment, criticism, a punitive stance, or subtle reinforcement of self-injuring behaviors (by giving a great deal of attention to the act of SI rather than the well-being of the client). The knowledge needed to work with self-injuring clients can be learned through a variety of sources: published literature

(Appendix E), consultation with colleagues and supervisors, and adolescent SI counselling training.

An important aspect of assessment is determining if the client is receiving service from any other mental health professionals. For example, adolescents can be simultaneously involved with a school counsellor, a community agency counsellor, and a social worker. If a client reveals that another professional is involved, it is recommended that a discussion with the client occur regarding continuing or terminating counselling. Seeking the names of professionals who are involved as well as consent to consult should be a routine aspect of counselling practice (Canadian Counselling Association, 2007; Schulz, Sheppard, Lehr, & Shepard, 2006). With consent, consultation can determine if additional counsellor involvement is in the best interests of the client. If other health care professionals are involved, an adolescent is often required to tell personal stories more than once. Pushing a client to reveal personal information when the client has already endured such disclosure with another practitioner may be unethical—it could result in client harm because of the resulting stress.

Appendix F provides a sample client consent form that can be used when contact with other professionals is required. To complete this form, client and guardian signatures are required. It is suggested that consent by a guardian may not be essential, depending on the client's age and situation. Some adolescent clients do not have a guardian because they are living independently. As well, an adolescent client may be able to solely give consent if it is determined that the client is capable (see Chapter 4); there is a vast difference between the capabilities of a client that is 13 years old and one that is 18 years old.

To conduct a thorough assessment, many domains of the client's world are worthy of inclusion. The key domains addressed in this chapter are:

- Safety and suicide risk,
- Seriousness of wounds,
- Family situation and functioning,
- History of self-injurious behavior,
- Details of recent SI, including triggers and antecedents,
- Mental health (self-esteem, depression, anxiety, stress),
- Substance use,
- Body image issues,
- Exposure to contagions (Internet, peers, media),
- Past history and trauma, including child abuse,
- Functions and meaning of SI, and
- Consequences of SI.

As each domain is presented on the following pages, both the rationale to support its inclusion and strategies to assist with the assessment are provided. It is important to recognize that there is no one best approach to use when conducting assessment (Nixon & Heath, 2009) and that the strategies offered are not necessarily the best nor the only ones that counsellors can use.

The Assessment Record (Appendix C) can be used to record and organize information gleaned from the client's conversations over several counselling sessions. Once completed, it portrays a detailed picture of the adolescent's world. The assessment tool should never be applied in one session in the form of a series of questions; most adolescents

would respond unfavourably to such an approach and the therapeutic alliance would likely be impeded. If an adolescent is bombarded by question after question, discouragement, frustration, and anger are possible emotions that can surface. This can lead to the adolescent client "shutting down" and cause damage to the client/counsellor relationship. Instead, the tool can be used to document relevant information disclosed by the adolescent client. To use the Assessment Record effectively, it should be considered as a method to record and organize client responses, not as an assessment script. It may take several sessions before all the information required for a thorough assessment has been disclosed.

Many agencies expect some form of assessment report be placed in a client's file and the Assessment Record may facilitate the writing of such a report by documenting and organizing information disclosed during the assessment. This assessment tool can also be used to develop treatment strategies and serve as a method of review by a supervisor or as a reference during agency team meetings (Nixon & Heath, 2009).

Walsh (2007) is an advocate of sound and thorough assessment and states that "the heart of a good assessment is 'in the details'" (p. 1066). Gathering the information suggested in this chapter will provide the details required to generate a comprehensive assessment that can be used to develop a treatment approach that meets an adolescent client's unique need.

Client Safety

Rationale. Of utmost concern is the safety of self-injurers. This includes the assessment of wounds resulting from SI. Medical intervention is required when wounds are serious or when the form of SI indicates possible serious risk. For example, when an adolescent has long gaping wounds that require stitches or when risk of infection is a concern, medical intervention is needed. Some self-injurers choose a serious form of self-

injury that can result in life-threatening injury. An example of this would be a person jumping from a height to cause injury while not wanting to attempt suicide.

Suicide assessment is a vital aspect of assessment. There is an increased risk of suicide among self-injurers (Harriss & Hawton, 2005; Harriss et al., 2005). Although most self-injurers are not suicidal, a thorough suicide assessment must be conducted.

Strategies. A visual inspection of wounds is sometimes a challenge. If a counsellor wants to see self-inflicted wounds, the counsellor should always ask for permission (Walsh, 2007). Some adolescents may volunteer to show a counsellor their wounds; other adolescents may be unwilling. Sometimes the wounds inflicted are on parts of the body where viewing is inappropriate (breasts, thighs, genitals). Dwelling on injury sites may bring attention to the self-injury rather than the functions of the injury and intervention. For these reasons, viewing wounds can be questionable and uncertain at best. The rule should be that if it is believed a wound needs medical treatment then such treatment must be accessed. If wounds are on an area of the body where viewing is inappropriate, it is likely that the wounds need medical attention due to the vulnerability of such locations (e.g. breasts and genitals).

Suicide assessment is an essential aspect of assessment. Assessment of suicide risk can be accomplished by using a suicide rating scale such as the *Beck Suicide Intent Scale* (Beck & Weishaar, 1990; Spirito, Sterling, Donaldson, & Arrigan, 1996), the *Beck Scale of Suicidal Ideation* (Cochrane-Brink, Phil, Lofchy, & Sakinofsky, 2000), Linehan's *Reason for Living* (Berman, Jobes, & Silverman, 2006), or the *Beck Hopelessness Scale* (Beck & Weishaar, 1990). Research conducted by Harriss and Hawton (2005) examined the effectiveness of *The Beck Suicide Intent Scale* in predicting suicide intent of self-injurers who presented to a hospital after an incident of SI. The authors conclude that this rating scale

is useful in gathering client information regarding suicide intent, particularly in the short term, but was not able to predict suicide in any one individual. Based on a review of literature, Berman, Jobes, and Silverman recommend *Beck's Scale for Suicide Ideation* and Linehan's *Reason for Living* because both instruments have been found to be reliable for adolescents. It is recommended that a rating scale be administered orally rather than in written form (clients are more receptive to an interview format) and that relying only on a rating scale for suicide prediction is poor practice because the scale may be inaccurate for any given individual, despite having statistical validity (Cochrane-Brink et al., 2000). The American Psychiatric Association (2003) has produced practical guidelines for assessment and treatment of suicidal clients. No matter what form of assessment applied, medical intervention should be accessed immediately if results indicate the client's safety is at risk.

Family Situation and Functioning

Rationale. Working with adolescents usually means working with families. A "family" can refer to anything from a two-parent nuclear family situation to a homeless adolescent living on the streets with other people in similar situations. Understanding the dynamic of a client's family through assessment can indicate familial challenges and strengths. Insight into the client's family situation can impact a treatment plan. For example, if the family lives chaotically and communicates poorly, working with the family system may be a priority.

Strategies. During assessment, family functioning, communication style, supports available, and family structure should be ascertained. Interviewing other family members can increase understanding of the client's family situation. Client and family input can inform treatment by developing an approach for the inclusion of the family. For example, if the

family situation is strained, the client and therapist may decide to work separately with the adolescent client and family in the initial stages of treatment so that stress is not compounded.

History of SI

Rationale. Learning about past adolescent SI practices can help a counsellor plan for future treatment. Walsh (2007) asserts that the longer an adolescent self-injures, the more difficult it is to treat. A counsellor may need to commit to a long term counselling relationship to address the client's needs if SI is a longstanding issue.

Strategies. Walsh (2007) recommends that the following historical information be ascertained during assessment:

- Onset,
- Types of SI,
- Tools used for SI,
- Duration of self-injuring episodes,
- Frequency of SI,
- Number of wounds during an episode of SI, and
- The amount of damage self-inflicted during an episode of SI.

Recent SI

Rationale. Knowing the history of a client's past SI information is helpful but it is not enough. It is argued that recent self-injuring behavior (within the last 2 months) can vary greatly from past practices. For example, a parent may discover that their child is self-injuring and then place many controls on the adolescent in the hopes that the SI will stop.

This could result in the adolescent hiding tools, self-injuring in more secretive locations than before, and self-injuring on areas of the body where parents cannot view the wounds.

Strategies. The historical information listed in the previous section can serve as a guide for accessing current client self-injuring information. While assessing recent SI practices, information about triggers and antecedents can be gathered. Triggers and antecedents are events in an adolescent's life that can motivate SI. A few possible examples are:

- Arguing with a parent, other family members, or peers,
- Doing poorly on a school assignment or test,
- A friend self-injuring,
- A relationship issue with a boyfriend/girlfriend,
- Viewing SI in the media or on the Internet,
- An addicted parent returning home under the influence of a substance, or
- Feeling lonely or abandoned.

Triggers and antecedents can provide valuable direction for generating new coping skills and SI alternatives during treatment.

Clients can be asked to keep a journal of their self-injuring practices in order to help the counsellor gather information (Appendix D). However, some adolescent clients do not respond well to journals. In such cases, the client's wishes should be respected and the use of a journal may need to be discontinued (Walsh, 2007). The self-injury journal is designed to document information while not requiring a great deal of time. Journals that require lengthy writing can frustrate youth so much that they will abandon their journal. For adolescents who

want to write more, an area to write notes is also provided. When reproducing the form, the notes page can be copied onto the back of the journal.

The sample of a SI journal provided in this manual is simply entitled "Journal" in order to help a client maintain privacy. If the sheet of paper were found by others, it would not be immediately apparent what the document is for, something adolescents appreciate. The name portion of the journal could be left blank until it is returned to the counsellor for discussion and filing. Anonymity would therefore be maintained if the adolescent were to misplace the document.

When the client returns to a counselling session with the completed journal, it is recommended that the journal be discussed to determine if it is an accurate and typical reflection of the client's self-injurious behaviors. For example, some adolescents may self-injure less than is typical because the behavior is being charted, and some may self-injure more, perhaps because frustration related to the journal is experienced. If it is ascertained that the adolescent is self-injuring more frequently when using a journal, its use should be immediately discontinued.

Mental Health

Rationale. It is helpful to learn about any past and current serious mental health issues. Previous or current mental health diagnoses and treatments (clinical or in-hospital) can shed light on the client's situation and provide valuable information regarding other practitioner involvement. Some relevant conditions that can be revealed during the mental health portion of the assessment are: anxiety, depression, emotional dysregulation, BPD, unmanageable stress, and poor self-esteem.

Strategies. Ask clients if they have been diagnosed or treated for any mental health issues, either currently or in the past. Based on experience, the answer to this is often yes. If diagnosis or treatment is identified, determine the nature of condition(s) diagnosed or treated.

It is recommended that any medications administered for mental health issues be documented for future reference. The use of prescribed medication is an indication of the severity of a mental health condition; enough medical concern was generated for pharmacological intervention.

Contacting other professionals involved in the adolescent's care can inform treatment. Any contact with other professionals requires written consent from the client and guardian(s). Appendix F provides an example of a consent form to use for interagency sharing of information. This form records the client's and guardian's consent to contact other counsellors, agencies, or health care providers when it is learned that other professionals are involved. The professional being contacted will require a copy of such a consent form prior to the release of information.

Substance Use

Rationale. Adolescents who misuse substances are more likely to self-injure than those who do not misuse substances (Nixon & Heath, 2009). Because substance use is a SI risk factor, it is important to assess. Nixon and Heath argue that substance abuse and SI are similar in that both can cause physical harm. In addition, there is evidence that SI has an addictive aspect similar to that of substance dependence (Nixon & Heath, 2009).

There is often a perception that street drugs are the most commonly misused substances among adolescents. A reality for adolescents is that alcohol is the most commonly misused substance and is used by 58% of British Columbia adolescents (Tonkin, Murphy,

Lee, Saewye, & The McCreary Center Society, 2005). Alcohol is a central nervous system depressant, produces a sense of euphoria, and is an addictive substance (Stevens & Smith, 2001). Considering that many self-injurers have depression issues, it stands to reason that some may turn to alcohol as a way of self-medicating. A further complication is that depression and suicidal symptoms may be aggravated when an individual is withdrawing from a substance, such as alcohol (Daley & Moss, 2002). The thorough assessment of all substance use, including alcohol, is essential.

Strategies. The Assessment Record (Appendix C) includes a chart that the therapist can use to effectively organize and document substance use. For an adolescent to openly discuss substance use, a strong therapeutic alliance is required so that the client feels the counsellor can be trusted. It is suggested that substance use be assessed later in the assessment phase when a trusting alliance is more firmly established.

Body Image Issues

Rationale. A link between poor body image and SI has been established (Muehlenkamp, 2007; Nixon & Heath, 2009; Walsh, 2006). It is believed that eating disorders such as anorexia and bulimia or negative body regard (Muehlenkamp, 2007) increase the risk of SI. Nixon and Heath assert that disordered eating helps relieve negative emotions in much the same manner as SI. During assessment, if poor body image or regard is an identified issue, then treatment should encourage body awareness and positive body regard (Muehlenkamp, 2007).

Strategies. An adolescent may not currently be dealing with an eating disorder, but may have struggled with one in the past, so it is important to assess current and past disordered eating and problematic body image issues. It is also useful to determine whether

the client has received previous treatment for any body image issues. If so, that therapist may be contacted to provide information, with the client's permission. When assessing body image issues, the following questions could be helpful:

- Have you ever been treated for body image issues or disordered eating? What did the treatment involve?
- Do you have an eating disorder such as anorexia, bulimia, or compulsive overeating? Have you had one in the past?
- Are you happy with your view of your body? If not, what is your concern? What aspects would you like to change if you could?
- Do you feel pressure to change your body image? Where does this pressure come from?
- What is your view of an ideal body image? From where does this view originate?
- Do you see body image or disordered eating as an issue for you? How?

Exposure to Contagions

Rationale. When an adolescent self-injures, the behavior is often introduced or supported in music lyrics, on television, in movies, on the Internet, and by peers who are self-injuring (Muehlenkamp, 2007; Roberts-Dobie & Donatelle, 2007; Whitlock, Lader, & Conterio, 2007; Whitlock et al., 2006). This phenomenon is called the SI contagion effect, referring to the direct or indirect influence exerted on an individual. This influence increases the likelihood of an individual practicing SI and is powerful during adolescence. A direct contagion occurs when the source of influence is known by an individual (e.g. a friend or classmate) and an indirect contagion results from accounts or word of mouth (Taiminen et al., 1998). Whether indirect or direct, the contagion is often not blatantly obvious and is more

likely to be subtle. For example, a song may not suggest that cutting should be attempted, but when relief is described in the lyrics, an individual may turn to cutting to manage stress or emotions.

Determining if contagion factors are contributing to the self-injuring dynamic during assessment can guide treatment; if they are a contributing factor, adolescents need to become aware of the impact of contagions on their behavior as well as learn how to cope with the influence of contagions.

Nock and Prinstein (2005) conclude from their research that male and female self-injuring adolescents often have peers who also self-injure; the authors coined this effect as the "positive reinforcement function" of SI. The researchers assert that if an adolescent perceives friends' SI behavior as a helpful coping mechanism, the adolescent is more likely to engage in the behavior. This standpoint is supported by McVey-Nobel et al. (2006) who note that self-injuring adolescents often cluster together. For adolescents practicing SI, such clustering may provide understanding, and a way to disclose their SI without fear of negative reactions. This may appear helpful, but more healthful coping options are often not encouraged in these peer relationships. McVey-Nobel et al. suggest that clustering leads to "copycat cutting". Walsh (2006) maintains that peers can be a contagion and that the contagion effect results from a desire among adolescents for group cohesiveness, which leads to a "special bond" among self-injuring peers.

Therapeutically, dealing with the influence of peers is challenging. Adolescents are trying to develop independence; they are unlikely to accept that they are mirroring the self-injuring behaviors of their peers as this implies dependence. Treatment is impeded when adolescent clients will not acknowledge the influence of self-injuring peers. The positive

aspect of adolescents searching for their adult independence is that once self-injuring adolescents come to accept that their behavior is influenced by peers, they may consider SI as less appropriate because they do not want to be perceived as following their peers.

Among adolescents, Internet use is common. In a review of research on SI and Internet use, Whitlock et al. (2007) found that 78% of adolescents use the Internet on a regular basis and of these users, more than half connect to the Internet daily. The reviewers also report that the prime reason most adolescents turn to the Internet is for social contact. Given the proliferation of adolescent Internet use, one can conclude that adolescents who self-injure are also frequent Internet users. Whitlock et al. (2006) reported almost 10,000 members on one SI Internet message board—the bulk of users of such sites being adolescents—and concluded that SI sites are a social contagion for some youth.

When adolescents visit SI sites on the Internet, the impact of such use can be negative. The virtual world offers an arena where anonymity can be assured and emotional attachments can be easily built or broken. The Internet also offers sites that glamorize, normalize, and promote SI while discouraging help from family and professionals. Some sites explain how SI can be performed, show pictures of SI, and encourage SI as an acceptable coping strategy. These sites can have a triggering effect on adolescents and bring about self-injurious behaviors.

Self-injuring adolescents often lack healthful and supportive relationships with peers, family members, or other adults. When a self-injuring adolescent turns to the Internet for relationships, these social connections can replace contact with "real" people and actually reinforce social problems in the adolescent's non-virtual world (Whitlock et al., 2007).

Use of the Internet can be addictive (Whitlock et al., 2007). As SI also has addictive aspects, counsellors could find themselves dealing with clients with two addictive conditions. Furthermore, counsellors may not be aware of a client's Internet use nor the complications that this use can generate for treatment and recovery.

In a study of Internet use conducted by Murray and Fox (2006), participants reported positive aspects of Internet SI sites; the majority of self-injurers reported less SI or no change in their self-injurious behaviors. However, the age of participants is worthy of note: the 95 participants in this study ranged from 12 to 47 years old with a mean age of 21.4 years. The study included both adolescents and adults and one could argue that adults may be able to use the Internet more prudently than can adolescents. Further research is needed regarding the difference between how adolescents and adults use and respond to self-injuring web sites.

Internet use among self-injurers is an important aspect of many adolescent lives. Web sites, message boards, YouTube, and chat rooms focusing on SI can negatively impact self-injuring adolescents. SI web sites are continually changing; they morph, are discontinued, and new ones are generated. In the resource section of this manual (Appendix E), a few valuable and reliable sites current at the time of publication are highlighted. Counsellors are encouraged to become aware of SI web sites, understand the impact sites can have on clients, and assess a client's use of the Internet and SI web sites. It is also suggested that when a client is accessing SI web sites that the counsellor monitor that access throughout treatment, not just at the beginning of therapy when initial assessment occurs.

Many music performers have produced songs that include messages about SI. When a Google search of "self-injury" songs was conducted on Aug. 18, 2008, over 73,000 hits were displayed. One of these sites was accessed and 217 self-injury songs were listed (Self-injury:

A struggle, n.d.). Among the musicians listed were Eminem, Indigo Girls, Korn, Linkin Park, Nine Inch Nails, Nirvana, and Pearl Jam, all popular within adolescent music culture. Such music can have a contagion effect, particularly with adolescents, because exposure to SI can increase the chance that an individual will adopt the behavior. In the counselling office, adolescents continue to inform me about performers from several music genres (rock, punk, grunge, rap, hip hop, alternative, indy) that include SI lyrics in their songs.

Some famous people have admitted to practicing SI. These include Angelina Jolie, Johnny Depp, Fiona Apple, and Princess Diana. Whitlock et al. (2007) report 14 pop icons who self-injure. SI has been included in movies such as Fatal Attraction, American Beauty, Secretary, and Thirteen. Television shows have featured episodes on SI: Beverly Hills 90210, DeGrassi, Grey's Anatomy, MTV's The Real World, Oprah, and Seventh Heaven. Role modeling of self-injuring behaviors by the media in movies and television shows coupled with famous performers admitting to SI is likely to normalize and glamorize SI. This exposure could increase the likelihood of an adolescent turning to SI.

The contagion effect generated by peers, the Internet, music, and the media cannot be overlooked when working with self-injuring adolescents. Counsellors should understand the subtle and not so subtle influences to which adolescents are exposed.

Strategies. Information about contagions can easily be gathered by asking exploratory questions. A few questions to facilitate this aspect of assessment are:

- How did you first become aware of SI?
- How did you learn that SI can be used as a coping strategy?
- Tell me about any friends you have who self-injure.
- What has the Internet taught you about SI?

- Have you heard about SI in music lyrics, movies or television? Tell me about it.

Past Trauma

Rationale. Many adolescent self-injurers have experienced trauma in the past. The trauma (e.g. child abuse, a death, divorce, parental substance abuse, family financial issues) can be profound or subtle, but if the adolescent perceives the event as traumatic then it needs to be addressed. A thorough assessment helps the counsellor to identify and inform an appropriate treatment plan.

A connection between abuse, particularly sexual abuse, and SI has been documented (Cavanaugh, 2002) and it is thus important to assess current or prior abuse.

Strategies. Many adolescents will not voluntarily and spontaneously disclose previous child abuse (Cavanaugh, 2002). When working with adolescents who have been abused, sensitivity is of the utmost importance. Youth will be more responsive and forthright in an atmosphere of trust, genuineness, empathic understanding, and collaboration. As with substance use, this crucial aspect of the youth's story should be left until later in the assessment so that the therapeutic alliance has had more time to develop.

The subject of child abuse needs to be addressed but finding the words to use with an adolescent client can be difficult. A useful approach is to tell the client that SI is sometimes linked to child abuse and knowing whether abuse has occurred (emotional, verbal, physical, or sexual) is helpful during treatment. Experience indicates that this "up front" approach works well with adolescents. Some questions that can be used during assessment are:

- Has anyone hit you or hurt you physically?
- Has anyone touched you on parts of you body that made you feel uncomfortable?
- Have you been forced or pressured into sexual contact with anyone?

Evidence of emotional or verbal abuse may surface during assessment when adolescents disclose information regarding their peer and family relationships. However, evidence of physical or sexual child abuse is often shrouded in many layers of shame, guilt, confusion, fear, embarrassment, and secrecy — disclosure of this information is not likely without using "pointed" questions.

Functions of SI

Rationale. Research indicates that there are several functions of SI. In a review of the empirical evidence, Klonsky (2007) identified seven reasons to explain why individuals will choose SI:

1. Affect regulation – SI leads to the alleviation of negative affect. When negative feeling become unbearable, SI provides relief.
2. Anti-dissociation – feelings are generated when self-injuring. This interrupts the dissociation by "shocking the system" into feeling again.
3. Anti-suicide – the effects generated by SI enable an individual to resist the urge to attempt suicide by replacing suicidal thoughts; SI is keeping the person alive.
4. Interpersonal influence – SI is done to influence or manipulate people in the self-injurer's world. Interpersonal influence can be viewed as a cry for help.
5. Interpersonal boundaries – the self-injurer sees the behavior as a way to assert one's identity or autonomy. SI helps the individual feel separated from others.
6. Self-punishment – SI is an expression of anger against oneself.
7. Sensation seeking – SI is seen as a way to generate excitement, much like extreme recreational pursuits such as skydiving.

Klonsky (2007) concludes that affect regulation is the most common function reported by individuals with or without BPD and by adolescents and adults. He also notes that self-punishment is a function reported more frequently among adolescents than other research populations, although this function is secondary to the affect regulation function.

Despite affect regulation being the most common function of SI, individuals injure themselves for various reasons. A counsellor cannot assume that a client self-injures for a particular reason; function(s) need to be assessed. Once function(s) have been identified, an appropriate treatment approach can be developed.

Nock and Prinstein (2005) identify a further reason to assess the function(s) of a client's SI. Their research led them to conclude that adolescents who self-injure to alleviate negative affect have feelings of hopelessness and suicide attempts are more likely than among adolescents who self-injure for other reasons. Therefore, during assessment a practitioner should be aware that SI practiced to reduce negative affect increases the likelihood of a suicide attempt.

Consequences of SI

There are consequences when a client self-injures. Some consequences can be generated within the individual. For example, along with a short-term intense feeling of relief, negative feelings such as guilt, shame, and disappointment can be experienced. Such feelings can be intensified if family members are aware of the self-injurious episode and this can, in turn, lead to intensifying one's negative feeling (e.g. an adolescent could feel that one's family has been let down).

When parents are aware of an adolescent's SI, the consequences can be intense. They may constantly monitor or frequently inspect their child for evidence of SI. They may react

powerfully and negatively, and impose punishment. Such negative consequences can be identified during assessment and inform treatment planning.

Not all consequences are perceived as negative. Some adolescents have peers who bestow status on self-injurers. SI induces emotional relief. Knowing about any perceived positive consequences of SI is helpful. If positive consequences are reported by a client, such consequences require exploration so that positive influences of SI can be minimized or replaced by acceptable alternatives. For example, other methods of generating emotional relief can be developed (such as exercise, talking to a friend, reducing faulty thinking, or journaling).

Conclusion

Developing and implementing an effective treatment plan requires comprehensive assessment. It includes many aspects of a client's world. In addition to generating a treatment plan, the assessment can reveal safety issues (risk of suicide or unintentional serious self-injury) and indicate the need for referral to other professionals.

Conducting an effective assessment requires a strong therapeutic alliance. Conversely, an assessment appropriately conducted will nurture a strong alliance. The counsellor needs to consider how questions and statements are worded, and present a therapeutic stance that is supportive and nonjudgmental.

Using a variety of assessment techniques is useful: interviewing, rating scales, and journaling are strategies that help a counsellor gather information related to the self-injurer's world.

There is no "cookie cutter" approach to assessment. Each self-injuring adolescent comes to counselling with unique characteristics and situations. Comprehensive assessment

provides a window into the adolescent's life and helps generate a treatment plan that meets the adolescent client's needs.

Following assessment, the treatment process can begin. Chapter Six describes treatment approaches to consider when working with adolescent self-injurers.

Chapter Six: Treatment

Treating adolescent self-injurers is challenging. Many practitioners and researchers assert that treatment is a long-term process (Derouin & Bravender, 2004; Hawton et al., 1999; Levy, Yeomans, & Diamond, 2007; McDonald, 2006; Suyemoto & MacDonald, 1995). Self-injuring clients can present with other mental health issues (e.g. suicidal ideation, eating disorders, trauma, BPD, and substance misuse issues). The condition is often shrouded in shame, embarrassment, and secretiveness. Self-injuring behavior may have an addictive aspect. These possible elements of adolescent self-injury treatment are evidence of the challenges that counsellors can face when working with this population.

There is no treatment panacea for adolescent self-injury (Nock & Prinstein, 2005). Evidence supporting the efficacy of particular treatment strategies is lacking (Hawton et al., 1999; Muehlenkamp, 2006; Nixon & Heath, 2009). In Muehlenkamp's meta-analysis (2006) of research related to SI treatment effectiveness it is reported that there is insufficient evidence to indicate that any one particular approach is more effective than other treatments. In addition to limited empirically supported evidence, some of the literature highlighting treatment approaches is based on case studies or practical experience. Despite the lack of empirical evidence supporting particular treatment approaches, therapists must rise to these challenges and provide the best care possible to meet the needs of their clients. The adolescent SI treatment approaches presented in this chapter are categorized as:

- Empirically supported therapies,
- Treatments without empirical research support,
- Additional strategies, and
- Treatments not recommended.

The use of the treatment approaches offered in this chapter depends on two factors: the skill and knowledge of the counsellor and the needs of the adolescent client. What works in one therapeutic situation may be ineffective in another situation.

The Beginning

Counsellor/Therapist Training and Experience

When working with adolescent self-injurers and their families, the degree of knowledge and experience of the therapist must be considered (Comtois, 2002; Hollander, 2008; McVey-Nobel et al., 2006). If a counsellor has limited theoretical and practical background working with self-injuring adolescents, the counsellor may not be able to provide adequate therapy. Counsellors working outside the limits of their professional skill would be unethical and client harm could be a possible outcome. For example, a therapist could unknowingly alienate an adolescent client by insisting on family therapy at the onset of therapy when this approach would be more effective later in the therapeutic process. Hollander states that the therapist should have several years of experience treating adolescent SI; this experience should include training in the area of SI, consultation with other professionals, and extensive work with adolescents. If expertise related to either SI or adolescents is lacking, a counsellor should consider referring adolescent self-injurers to more appropriate treatment situations until the necessary skills have been acquired.

Morrissette's literature review (2000) and Sutton and Pearson's research (2002) address the challenges school counsellors face in rural communities. It is assumed that many of these challenges also exist for other rural mental health professionals. Working with self-injurers can be stressful for any counsellor—if a counsellor is working in a rural community, the stress can be compounded for many reasons. The counsellor is often isolated from

professional support, supervision, and collaborative opportunities (Morrissette, 2000). The community can be physically isolated and a counsellor may be viewed as "from away", resulting in the closely-knit community not accepting the counsellor (Morrissette, 2000; Sutton & Pearson, 2002). The counsellor may struggle with unclear personal boundaries (Morrissette, 2000; Sutton & Pearson, 2002), making it difficult to establish and maintain separation between professional and personal life in small communities, something Morrissette describes as living in a "fish bowl". This is due to overlapping relationships, visibility, and scrutiny. For example, it is likely a counsellor could not go to a bank, post office, or grocery store without some community members being aware of the action. This lack of anonymity can result in many community members readily labeling a counsellor's "reputation", be it good or bad. Lack of mental health referral options place added demands on the counsellor and requires creativity and flexibility (Morrissette, 2000; Sutton & Pearson, 2002). A community with few counsellors and limited referral options can lead to stress from overwork (Morrissette, 2000). Professional development opportunities are limited and expensive to assess because this usually requires leaving the community. It is important that counsellors be aware of the added challenges generated by working and/or living in a rural community. Physical, emotional, and professional isolation gives rise to the added importance of self-care in rural communities to reduce the likelihood of burnout.

The Client

It is essential to establish which professionals are involved in the treatment of a self-injuring adolescent. Find out about the client's existing mental health diagnoses and treatments to assess the appropriateness of the counsellor's further involvement.

Another factor to consider at the beginning of therapy is the client's motivation for attending counselling sessions. When self-injurious behavior becomes evident to family members, counselling is often initiated by the adolescent's family. An adolescent may therefore be an unwilling participant, which can provide little motivation for behavioral change. In this situation, the value of continuing therapy must be determined by the client and therapist.

Therapeutic Boundaries

The establishment of client/therapist boundaries must to be addressed (Alderman, 1997; Conterio & Lader, 1998). Will client/therapist contact be restricted only to counselling sessions? Are client telephone calls to the therapist between sessions appropriate? Will emergency contact with the therapist be acceptable? What procedures should a client follow if personal safety is likely to be jeopardized? Clearly defining client and therapist roles and expectations assists in the development of the client/therapist relationship. It is particularly important for the client to have awareness of where support can be found if severe depression, suicidal ideation, or serious SI is pervasive and counsellor contact is not possible. For example, a client should be informed about how to access emergency care at a hospital.

Client Contracts. Some therapists may consider the implementation of safety rules that requires a client to commit to no SI while in therapy. This strategy is often referred to as a safety contract or a no harm contract. Several authors conclude that no harm contracts are ineffective and possibly dangerous (Alderman, 1997; Favazza, 1996; Mangnall & Yurkovich, 2008; Shaw, 2002; Walsh, 2006). Such an approach can "set a client up for failure"; when the client signs a contract and then self-injures, the client can experience intense guilt and a feeling of "letting the therapist down". Guilt and disappointment may lead to feelings of

inadequacy, undermining self-esteem. This can induce stress and to cope with the stress, the client may turn to SI because it is a well-established source of relief. This cycle of SI generated by no harm contracts can fuel self-injurious behavior, rather than reduce the incidence of SI.

Instead of a no harm contract, a contract that focuses on expectations and behaviors of the client and therapist is more useful (Alderman, 1997; Conterio & Lader, 1998). Such a contract can clarify therapeutic approaches, list the responsibilities of the client and therapist during treatment, list alternatives to SI that should be accessed, formalize boundaries and goals, and address emergency care procedures. Conterio and Lader refer to this strategy as a "treatment participation agreement" and they recommend that a contract of this nature be implemented and then reviewed and revised throughout treatment.

Assessment

Prior to the establishment of treatment goals and the onset of therapy, a thorough assessment of the client's situation is required (see Chapter Five). A comprehensive assessment indicates the issues that need to be addressed, brings attention to safety issues, and helps to determine the function(s) of the client's self-injuring behaviors—all valuable pieces of information for the treatment process.

Early Intervention

The younger the client and the earlier the SI is identified and treated, the greater the chance of treatment success (Conterio & Lader, 1998; Kenrick, 2007). This fact reinforces the efforts of those working with adolescent self-injurers: there is a greater likelihood of successful treatment with youth than with adults because the behavior may be less firmly entrenched and thus less difficult to surrender. Kendrick (2007) summarizes this point well

by stating, "If people don't learn to deal with stress as a teenager, how can they be expected to deal with stress as an adult? Perhaps it is time we looked at prevention at 15 rather than cure at 35" (p. 23).

Treatment Goals

Treatment goals are best established through collaboration between the client and the therapist (Muehlenkamp, 2006). Issues that the therapist might not consider important could be overwhelming to an adolescent client. For example, a self-injuring female adolescent may not want to address family communication, opting instead for ways to cope with how peers are negatively impacting her life. It stands to reason that adolescents will work towards a treatment goal if the goal is significant and relevant to their own situations.

The goals collaboratively established at the onset of treatment should be reviewed and adjusted throughout treatment. As therapy progresses, insight can result in the revision of treatment goals. For example, loneliness and isolation can surface as triggers for self-injuring behaviors and development of strategies to cope with these emotions and to decrease loneliness and isolation would become important.

The Therapist and the Therapeutic Relationship

The therapeutic relationship has been identified as an effective therapeutic strategy on its own (Nafisi & Stanley, 2007). A grounded theory study conducted by Huband and Tantam (2004) explored the effects of treatment interventions with 10 women. The researchers concluded that a long-term relationship with a therapist who is competent and neither under-concerned nor overprotective is most helpful in treating SI. In her meta-analysis of adolescent and adult empirically supported treatments, Muehlenkamp (2006) asserts that a strong therapeutic relationship is the greatest single therapeutic technique for

successful treatment. In light of published research, it is sound therapeutic practice for the counsellor to concentrate efforts on nurturing a strong therapeutic alliance when treating adolescent self-injurers.

Therapist characteristics that are conducive to working with self-injurers have been identified by researchers and practitioners. The effective counsellor:

- Provides validation, understanding, support, and respect (Muehlenkamp, 2006; Nafisi & Stanley, 2007).
- Uses a collaborative approach that avoids power struggles (Muehlenkamp, 2006; White et al., 2002).
- Recognizes that SI is an effective way to cope with acknowledged pain/emotions (Muehlenkamp, 2006; Nafisi & Stanley, 2007; Skegg, 2005).
- Commits to long-term therapy that requires perseverance, creativity and flexibility (Huband & Tantam, 2004; Muehlenkamp, 2006).
- Is not under/over protective (Huband & Tantam, 2004).
- Understands and manages countertransference and emotions (Deiter, Nicholls, & Pearlman, 2000; Trepal, Wester, & MacDonald, 2006; White, Trepal-Wollenzier & Nolan, 2002).
- Considers cultural and social norms (Skegg, 2005).
- Makes use of ongoing clinical supervision/consultation (Deiter et al., 2000; White et al., 2002).
- Ensures balance in life as working with self-injurers is stressful (Deiter et al, 2000).
- Works from a not-knowing stance and lets client educate the therapist (Zila & Kiselica, 2001).

Countertransference warrants further consideration. Corey (2005) states that countertransference occurs when therapists see themselves mirrored in clients, identify too strongly with clients, or seek to meet their own needs through clients. Gardner (2001) simply states countertransference as "the psychotherapist's unconscious reaction to the patient" (p. 106). Countertransference is likely when working with individuals who self-injure and can result in strong feelings and reactions including panic, fear, misunderstanding, anger, helplessness, pessimism, guilt, and disgust (Whitmarsh et al., 2006). Many clinicians who work with self-injuring adolescents warn of countertransference and encourage its control (Favazza, 1996; Hollander, 2008; Swadi, 2004; White Kress, 2003).

Countertransference is likely to be more powerful and harder to overcome when working with adolescents due to how difficult SI is to understand and treat in the adolescent population (Gardner, 2001). Counsellors may be particularly vulnerable to countertransference when working with adolescent clients because of feelings that arise when witnessing the effects of SI on a young person. Counsellors need to self-analyze, identify, and control their negative feelings towards SI if a positive therapeutic relationship is to develop.

In schools, SI might be identified by teachers or other school staff who have little understanding of the behavior. School employees often experience a great amount of emotional upheaval upon the discovery of a self-injuring student. Students are likely to sense the negative feelings that teachers and other staff experience. It is not just counsellors/therapists, but also other school professionals who are involved, who need awareness and control of their negative feelings (e.g. frustration, repulsion, and anger) in order for countertransference to be reduced.

If a journal is being used during either assessment or treatment, the journal should only be referred to for a portion of any session. If an entire session were to focus only on a journal of self-injuring behaviors, the adolescent may think that is all you are interested in (M. Graham, personal communication, March 10, 2009). The focus of treatment should be on positive change and not on self-injurious behavior. If the focus was on SI, the behavior could be reinforced by such attention—the client may think that they need to self-injure to have something to talk about.

Working with Families

Treating a self-injuring adolescent usually entails dealing with the adolescent's family. When a family member is practicing SI, an array of intense emotions may be present. Some possible emotions are confusion, fear, anger, frustration, hurt, pain, embarrassment, guilt, and helplessness—all strong emotions that can interfere with an adolescent's recovery and give the family a sense of upheaval. Dealing with family aspects of SI are challenging because the adolescent often has little or no control over family behaviors and decisions. Therefore, when an adolescent shows up at a counsellor's office, the family's struggles also surface—communication difficulties, conflict, and unclear expectations are some family stressors the adolescent can experience (Derouin & Bravender, 2004).

When a family operates chaotically and communicates poorly, family group involvement, particularly at the start of therapy, may not be appropriate. Working with the family together may place the adolescent in the middle of a great stressor, create emotional tension, and generate more problems than solutions (the adolescent could "shutdown", turn to SI for emotional relief, or rebel during and after sessions) (Hollander, 2008). The client and

the family both need help, but that help may need to be given in separate sessions until progress has been made and all members are ready to cope with family sessions.

Many people have never heard about SI and if they have, it has usually not been considered as a possible issue in their family. Families must be provided with information about SI. Frequent questions are:

- Is our family member safe?/How can our family member be kept safe?
- Why is this happening?
- How can this be stopped?
- How can we help?
- Is this our fault?
- Is our family member crazy?
- What do we tell other people (other family members, the school, friends)?

These challenging questions can be addressed by providing family education, training and SI resources (Trepel et al., 2006). Books written to provide family support are available (Hollander, 2008; McVey-Nobel et al., 2006; Penner, 2008). Prior to providing a printed reference, ensure that the book has information that is accurate and comes from an appropriate perspective (see Appendix E for an annotated resource list). For example, Penner's book presents SI information from a Christian perspective, yet there is little indication that this perspective is offered by viewing the book's front and back covers. If a Christian perspective does not fit with the spiritual and cultural practices of a family, this book would not be useful. A counsellor needs to be familiar with publications before they are recommended to clients and their families.

Appendix G provides SI facts and answers to frequently asked questions and is a "take away" resource for family members. Adolescent SI is overwhelming for a family and even if accurate information has been provided in the counselling office, the family may find a reference for later perusal helpful.

Treatment Approaches

Hawton et al. (1999) and Muehlenkamp (2006) have reviewed the empirical research relating to adolescent SI treatment approaches. The conclusion emerging from both reviews is that there is insufficient statistical evidence to state that any one treatment approach is more effective than is any other. Regardless of the intervention used, effective treatment requires a strong a strong therapeutic alliance, adequate therapist skill and knowledge (regarding SI treatment, adolescent treatment, and the approach used), collaboration between the client and therapist, and a focus on meeting the needs of the client. Despite the lack of definitive research results, some approaches show promise and their use should be considered (Muehlenkamp, 2006).

Empirically Supported Therapies

Cognitive Behavioral Therapy. Reviews of the research indicate that cognitive behavioral therapy (CBT) shows the greatest promise in addressing self-injuring behaviors and emotional regulation (Fortune & Hawton, 2005; Muehlenkamp, 2006; Portzky, & van Heeringen, 2007; Slee, Arensman, Garnefski, & Spinhoven, 2007; Tillotson, 2008). CBT approaches are structured, directive, active, and time-limited (Corey, 2005). The focus of CBT approaches is on faulty thinking and how it impacts emotions (feelings) and behaviors. Treatment goals include learning new skills (e.g. anger management and distress tolerance), ways of thinking (with attention to faulty thinking/cognitive distortions), and coping

strategies that can replace self-injurious behaviors. At their foundation, CBT treatments identify and address a client's rigid, faulty and automatic thoughts and beliefs, resulting in positive emotional and behavioral changes.

CBT techniques are structured. Clients are often asked to journal thoughts, emotions and behaviors (Appendix D). Along with journaling, homework assignments, developing alternative ways of thinking, role-playing, and learning new coping skills are other aspects of CBT.

Included in this manual is a CBT-based counselling strategy that has been used with self-injuring clients (Appendix H). This resource, based on my clinical experience, was developed to help adolescents generate insight into the thoughts, emotions, and behaviors that result in SI. Once the relationship between thoughts, emotions and behaviors and SI is established, faulty thinking can be addressed. Faulty thoughts, also called cognitive distortions, are those that the client believes are unconditionally true without evidence to support the beliefs.

To address faulty thinking, the therapist defines the concept of faulty thinking for the client. Next, faulty thinking that occurs in the client's world is identified as it arises during therapy. Because faulty thoughts and beliefs are often deeply ingrained in the client's world, it takes time and effort to change such thoughts and requires the therapist to challenge false thinking when it arises. For example, a client may state that SI is the *only* way to deal with stress. To address this faulty thought, the therapist may ask the client to suggest ways to deal with stress besides SI. When the client generates alternatives, the client is asked again if SI is the *only* way to deal with stress. At this point, the client will often agree that the thought is faulty and can correct the statement by saying something like, "I choose to self-injure when I

am stressed, but I see that there are other ways to cope." At this point, the client may be ready to try alternate coping strategies that are more healthful. After some practice at identifying and labeling faulty thinking, the adolescent client can become adept at identifying and correcting faulty thinking.

Although Aaron T. Beck was the first to identify cognitive distortions (Corey, 2005), Burns (1980) has expanded on his work. Burns refers to the example of faulty thinking highlighted in the previous paragraph as "all-or-nothing thinking". The client is asserting that SI is the *only* way to cope with stress. In addition to all or nothing thinking, other examples of faulty thinking or cognitive distortions presented by Burns are:

- Overgeneralization: One negative situation can be applied to many other situations. Example: "Because I failed this test, I know I'm going to fail them all."
- Jumping to conclusions: Without evidence to support a negative interpretation, a conclusion is made. Example: "I failed the test therefore the teacher doesn't like me."
- Should, must or ought statements: Because people say they should do something, they feel guilty when it is not accomplished. Example: "I should be a better friend."
- Extreme labeling: Making an extreme overgeneralization when an error is made. Example: "I am a failure."
- Catastrophizing (magnifying) or minimizing: The importance of something is negatively exaggerated when the person is unsuccessful or minimized when the person is successful. Catastrophizing example: "I failed math and now I will never amount to anything." Minimizing example: After getting a raise at

work, the client says, "It was not no big deal, everybody eventually gets a raise."

- Personalization: Self-blame for events that the person is not responsible for.

  Example: "It is my fault that my parents fight so much."

Dialectical Behavior Therapy (DBT). DBT is a therapeutic approach that has its roots in CBT. Hollander (2008, p. 72) describes DBT as "the best treatment" for SI and "more successful than other forms of psychotherapy or medication". This assertion is tempered by conclusions in literature reviews where it is noted that research focusing on adolescent SI treatment is limited and includes small samples in unique situations such as hospitalized female patients (Hawton et al., 1999; Meuhlenkamp, 2006). Based on the empirical research available, Hawton et al. and Muehlenkamp conclude that DBT is a treatment worthy of consideration. Comtois (2002) did not limit her literature review to adolescents, but her conclusions about efficacy are similar. Other practitioners and researchers also support the use of DBT (Brown & Bryan, 2007; Chapman, Gratz, & Brown, 2006; Gratz, 2007; Nock, Teper, & Hollander, 2007). Although definitive conclusions about the efficacy of DBT for SI cannot be drawn, DBT is a promising treatment option.

DBT was originally developed by Linehan to treat female suicidal patients with BPD (Hollander, 2008; Nixon & Heath, 2009). It emerged out of Zen Buddhism, CBT, problem solving therapy (PST) and skills training (Meuhlenkamp, 2006). Unlike CBT, which focuses on changing thoughts, emotions, and behaviors, DBT is an attempt to validate the client's suffering while motivating change (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). From this tenet emerged the dialectical approach, a core aspect of DBT that addresses not just the disorder, but also the whole person by accepting the client's painful situation while

motivating change (Lynch et al., 2006). Meuhlenkamp describes simultaneous change and acceptance as a therapeutic balancing act. With this approach, SI is not considered a character flaw or a sign of weakness; instead, the problem is emotional dysregulation and DBT helps the client develop the skills to cope with their emotions (Hollander, 2008). DBT is used during individual and group sessions. Group counselling focuses on skill development and individual counselling focuses on the client's unique situation. DBT skills are also taught to the client's family.

Some DBT strategies include stimulus control, cognitive restructuring, mindfulness, emotion regulation, distress tolerance, problem solving, validation, modeling, and phone consultation.

Adolescents often have a strong urge to self-injure when emotional stress is overwhelming. Stimulus control is often beyond a client's perceived abilities. To curb the influence of a stimulus (trigger) leading to SI, clients develop insight during therapy regarding which stimuli generate self-injurious behavior and then identify healthful coping methods. These alternative coping methods are practiced in therapy and are applied outside of the counselling office. Their failure or success is reviewed in future counselling sessions. Effective strategies are encouraged and ineffective ones are modified or changed, strengthening stimulus control.

Cognitive restructuring focuses on self-defeating thinking, how that thinking is impacting emotions and behaviors, and how that thinking can be changed. Faulty thinking or distorted beliefs are common among adolescent self-injurers. For example, an adolescent may believe that because of failing grades in school, self-injury is justified. Minimizing this faulty thought could become a therapeutic goal. The client actively works towards

understanding that faulty thoughts are self-defeating and negatively impact feelings and behaviors. Another example of addressing faulty thinking is to reduce the client's use of "extreme" words such as "always", "never", or "must". For example, a client could believe that rejection by peers is *always* happening. Other examples of faulty thinking are:

- "I am weak and can't resist the urge to cut myself."
- "Nobody cares that I am hurting myself."
- "When I fail, it shows others that I am a failure."
- "When I feel rejected, I have to cut myself."
- "Everybody thinks I am a loser."

Mindfulness is "the quality of awareness that an individual contributes to the present situation" (Lynch et al., 2006, p. 463). Although mindfulness is found in other therapeutic approaches, this skill is considered essential in DBT. To be conscious of the present reality involves an individual "letting go of attachments and becoming one with current experience, without judgment or any effort to change 'what is'"(Lynch et al., 2006, p. 463). This is accomplished by teaching the client behavioral skills of "observing, describing, and participating fully in one's actions and experiences, in a nonjudgmental and one-mindful manner (i.e., attending to one thing at a time), with a focus on effective behavior" (Lynch et al., 2006, p. 463).

Mindfulness requires a shift from trying to control such things as thoughts and emotions to rather controlling the attention given to those thoughts and emotions. Unlike other behavioral interventions that strive for change in behaviors, mindfulness encourages acceptance; acceptance of what is being experienced without trying to change or avoid the experience (Lynch et al., 2006). Nonjudgmental acceptance of emotions teaches the client to

see emotions as just "being there", not as being fearful, threatening, or debilitating. The outlook generated by mindfulness culminates in the client experiencing emotions nonjudgmentally and enables the client to experience but not act on emotions.

In addition to supporting thought appraisal and emotion regulation, mindfulness also teaches the client how to reduce literal belief in rules. An example of a "rule" is a belief that if I am failing in school, I am a hopeless failure. Such beliefs can lead to thoughts that perpetuate dangerous situations (e.g. suicidal ideation, SI). The client learns that literal beliefs are not literally true.

Adolescent self-injurers often show deficits in emotional regulation (Gratz & Chapman, 2007; Heath et al., 2008). If emotions are not appropriately regulated, they can become intense and intolerable and adolescents can turn to SI as a way of managing these feelings. Individuals who regulate their emotions effectively recognize that emotions are present but they are capable of dealing with them in a healthful way.

Mindfulness is a skill that can address emotional regulation. Developing and using mindfulness allows the adolescent to accept emotions as natural feelings that "just are" rather than regarding emotions as good, bad, or incapacitating. The outlook generated by mindfulness culminates in the client experiencing emotions nonjudgmentally and enables the client to accept the emotions but not act on them.

All individuals struggle with uncomfortable events or thoughts while dealing with distressful life experiences. However, when adolescent self-injurers have such experiences, they often become overwhelmed and incapable of dealing with the stress, culminating in self-injury to cope (Nock & Mendes, 2008). Furthermore, self-injurers often perceive events that other people would consider minor to be intense and debilitating. Developing distress

tolerance skills enables the adolescent to accept stress as part of life's experiences. Distress tolerance allows the client to recognize emotional stress, but also enables the client to view the stress as tolerable and manageable.

Developing distress tolerance entails putting distress into manageable perspective. This begins with the therapist teaching a client that distress is a "normal" aspect of life experience—something that all individuals need to manage. Managing life's inevitable stressors becomes a therapeutic goal. For example, when an adolescent has a verbal "fight" with a parent, this distressful incident can trigger SI. Through therapy, a client can learn that uncomfortable and stressful situations are sometimes inevitable but can be managed using coping skills that do not involve SI. An adolescent in the situation described may decide to call a trusted aunt to talk through the stressful situation. Feeling empowered to deal with inevitable distress without resorting to SI becomes the new perspective.

Adolescent self-injurers who learn problem-solving skills are empowered to cope with challenging situations. The steps involved in problem solving are taught and then applied to the client's life experiences. Later in this chapter, detailed problem-solving information is provided when PST is addressed.

Another cornerstone of DBT is validation, a skill that focuses on therapist acceptance of client behaviors, thoughts, or feelings (Lynch et al., 2006). Skills related to validation are active listening and empathy (Brown, 1998). The therapist can provide further validation by nurturing an appropriate therapeutic alliance that includes genuineness. The appropriate client/therapist relationship is identified as essential of DBT (Muehlenkamp, 2006).

DBT recognizes the value of therapist modeling of skills with which clients are deficient. The client can see and learn various ways to react appropriately to intense emotions

when the therapist models the skills required: acceptance of intense emotions, talking through a difficult situation, and identifying and altering irrational or faulty thoughts are a few skills a therapist can model in the counselling office.

Phone consultation is an essential aspect of DBT and is particularly valuable for crisis management. Further, the client is also encouraged to seek coaching from the therapist or another team member outside of treatment sessions, an approach that reinforces the client accessing useful resources when needed (Nock et al., 2007).

The difficulty a therapist faces in learning the intricacies of DBT must be considered. DBT includes many treatment strategies, requires an understanding of the philosophy supporting the approach, and requires long-term commitment to the therapy (typically one year). Learning all the skills required to use DBT effectively requires a great deal of time, commitment, and financial expense (Walsh, 2006)—requirements that not all therapists can access.

DBT is a treatment approach that relies on dialectical philosophy, emotional awareness and acceptance, mindfulness, emotional regulation, distress tolerance, validation, problem-solving skills culminating in client change. The bulk of these goals are accomplished by encouraging mindfulness skills. The resource section of this manual includes annotated DBT resources (Appendix E).

Problem Solving Therapy. PST is another treatment approach based of CBT used in the treatment of adolescent SI (Hawton et al., 1999; Muehlenkamp, 2006; Raj, Kumaraiah, & Bhide, 2001). Based on a review of six studies using PST, Hatcher (2002) reports that PST improves depression, hopelessness and personal problems for self-injurers. Other authors

report some optimism for this approach; however, there is insufficient research available to support its use (Hawton et al., 1999; Muehlenkamp, 2006).

Problem-solving deficits and SI go hand in hand (Haines &Williams, 2003; McAuliffe et al., 2006; Nock & Mendes, 2007). PST can address this deficit as it identifies and resolves problems using the problem-solving process. The problem solving process involves the following steps (McNamara, 2004):

1. Define the problem,
2. Review potential causes of the problem,
3. Identify alternatives to resolve the problem,
4. Select an alternative to resolve the problem,
5. Plan the implementation of the alternative (action plan),
6. Implement the plan, and
7. Evaluate the solution to determine if it has resolved the problem.

Like DBT, PST is time-limited, structured, and skills oriented. PST concentrates on remedying cognitive and behavioral functioning. This approach regards the client as having poor problem-solving skills and thus the goal of PST is to resolve the client's problem(s) by teaching coping skills and problem-solving skills (Muehlenkamp, 2006).

For PST to be used effectively, Muehlenkamp (2006) recommends a multifaceted approach that includes cognitive, interpersonal and behavioral aspects. Similar to DBT, this approach also requires a strong therapeutic alliance and collaboration.

Manual-Assisted Cognitive-Behavioral Therapy (MACT). MACT is a cognitive-behavioral therapy that combines PST, DBT and CBT. The skills taught focus on managing emotions and negative thinking. Lukomski and Folmer (n.d.) identify MACT as an effective

approach while Muehlenkamp (2006) reports that it has *potential* as a treatment approach. Klonsky and Muehlenkamp (2007) conclude that MACT can significantly reduce SI and delay SI acts over a 12-month post-treatment period. Leyshon (2005) reports that MACT has the same efficacy as "treatment as usual" (medical care and long term counselling) over 12 months.

The difference between MACT and other CBT treatments is that the former includes a manual based on the principles of CBT for clients to use at home. An advantage of this approach is cost effectiveness (Leyshon, 2005). A client working at home with a manual and attending a few therapy sessions is inexpensive when compared to usual treatment approaches which often require a great deal of one-on-one contact with counselling and health care professionals. Treatment manuals that adhere to the MACT approach are referenced in Appendix E.

Pharmacological Treatments. Using medications to treat SI is controversial. Because other mental health conditions (e.g. depression, anxiety, obsessive compulsive disorder, bipolar disorder, BPD) can be comorbid, SI clients are sometimes treated with medication. Medications include selective serotonin and serotonin-norepinephrine reuptake inhibitors (SSRIs). Some SSRIs are fluoxetine (e.g. Prozac), sertraline (e.g. Zoloft), paroxetine (e.g. Paxil), fluvoxamine (e.g. Luvox), citalpram (e.g. Celexa), and descitalopram (Lexparo) (Walsh, 2006). Prescribing medications for youth is controversial because there is evidence that SSRIs can increase problem behaviors such as suicidal ideation (Walsh, 2006). Depending on the comorbid disorder, other medications that are considered are antipsychotics, anticonvulsants, alpha2-adrenergic drugs, and opiod antagonists (Nixon & Heath, 2009). Reviews of pharmacological treatments have lead authors to conclude that

there is no empirical evidence to support their use specifically for SI (Hawton et al., 1999; Klonsky & Muehlenkamp, 2007) but evidence does support their use for comorbid mental disorders.

Psychodynamic Therapy. Psychodynamic approaches are based on psychoanalytic psychotherapy. Empirical evidence supporting the use of psychodynamic therapy is limited and the evidence that exists identifies only modest support for the approach (Klonsky & Muehlenkamp, 2007; Skegg, 2005). Rather than treating SI specifically, the psychodynamic approach has been used to treat comorbid conditions or symptoms such as BPD, poor self-image, and relationship difficulties (Klonsky & Muehlenkamp, 2007). Applying psychodynamic/psychoanalytical approaches to the treatment of adolescent SI requires a high degree of psychoanalytic knowledge and skill. In addition, this approach requires a great deal of time. Adolescents often do not want to commit to such a time-demanding treatment. Further attention must also be given to the commitment of the therapist; the therapist must be able to commit to the self-injuring client for the duration of therapy (usually one to two years). Information regarding psychodynamic treatment of SI is difficult to access. For information on the psychodynamic approach for SI, the reader can refer to Gardner (2001) and Levy et al. (2007).

Promising Treatments without Empirical Support

Group Therapy. Group therapy can be used with many theoretical approaches (e.g., DBT). No matter which treatment perspective is utilized in group therapy, caution is encouraged. This caution relates to the contagion factor that is well documented in SI literature (Carlson et al., 2005; Conterio & Lader, 1998; McDonald, 2006). Placing adolescent self-injurers together for group psychotherapy is risky because any discussion

surrounding SI behaviors could stimulate further SI. Group participants could also learn about forms of SI that they are unfamiliar with and open the door to more self-injurious behaviors. It is possible for participants to progress from moderate to major SI when exposed to the practices of other self-injurers. Allowing the contagion effect to occur in group therapy would be dangerous, unethical, and counterproductive.

Some authors state that group therapy is not successful with adolescent self-injurers (Lukomski & Folmer, n.d.; Zila & Kiselica, 2001); however, the authors do not provide a rationale for their claims. Perhaps the contagion effect contributes to the reticence about group therapy. From his experiences treating self-injuring clients, Walsh (2006) concludes that group discussions around SI antecedents and behaviors can have a triggering effect on participants.

If group therapy is used with self-injuring adolescents, it is suggested that the focus of the group be on skill development (e.g. distress tolerance, coping skills, communication, and emotional regulation) rather than on group processing (Favazza, 1996; Walsh, 2006). This is precisely what DBT does and may be one of the reasons to explain why DBT is identified as a promising treatment approach. Structure, skill building, and avoiding emotionally stressful situations are suggested elements of adolescent group work (Hollander, 2008).

When group therapy is an aspect of treatment, the sessions must begin with clear rules about the discussion of self-injurious behaviors; any talk of SI should be prohibited (Conterio & Lader, 1998; Walsh, 2006) no matter what treatment approach is used. This rule keeps group work focused on skill development, not SI behaviors. SI needs to be discussed with clients, but to avoid the contagion effect and triggering conversation, this should be conducted during individual therapy.

Family Therapy. There is no empirical evidence assessing the effectiveness of family therapy for SI (Nixon & Heath, 2009). Family dysfunction is often one of the factors contributing to adolescent SI and the family situation may actually reinforce and maintain adolescent SI (Conterio & Lader, 1998). In a case of family dysfunction, family therapy throws an adolescent into a situation that is stressful and emotion laden. It is widely accepted that emotional dysregulation is a significant issue for self-injurers (Gratz & Chapman, 2007; Heath et al., 2008; Klonsky, 2007; Laye-Gindhu & Schonert-Reichl, 2005) and family therapy requires adolescents to utilize skills they often do not have (Hollander, 2008). It is suggested that family therapy may be most effectively used after individual therapy has improved emotional regulation skills (Crowe & Bunclark, 2000; Hollander, 2008).

Instead of family therapy, an alternative way of including family members in the therapeutic process can be considered. One possible alternative is to facilitate parental/family guidance sessions that provide information, teach family members needed skills, and encourage the development of characteristics such as emotional management, flexibility and caring, and communications strategies that improve family dynamics. A second alternative is to establish a group for parents of self-injurers in which SI information and communication skills training is facilitated.

Working with adolescents usually means working with families. Meeting the needs of a client and family members requires careful consideration of what is in the best interests of the client. This is best done collaboratively with the client. Family therapy may be delayed until the client has first had an opportunity to participate in individual therapy.

Bibliotherapy. Providing reading materials for self-injuring adolescents and their families can be an aspect of treatment. Non-fiction books, self-help books, and even videos

can be used. Suggesting a video for the client, the client's family, or both to watch is a strategy that can be effective in encouraging communication, either in a session or between family members. An example of a video that has been used during SI treatment is *Pay It Forward* (2000). This video highlights the power one child has when he makes a difference in the lives of other people. This video is suggested for viewing to illustrate the concepts of empowerment, determination, and self-motivation and can be suggested for family viewing. Appendix E includes a list of printed and electronic resources appropriate for adolescents and parents.

Additional Perspectives

Although they are not psychotherapies, two perspectives that can help when working with adolescent self-injurers are the feminist approach and narrative restructuring. Based on anecdotal evidence, I believe these strategies warrant consideration.

Feminist Approach. Feminist therapy is a treatment approach that focuses on the impact of oppression, politics, multicultural issues, and socialization on women (Corey, 2005). Within a feminist framework, SI is seen as a way to break women's silence in an oppressive society. SI and cultural standards of "feminine beauty" are linked in feminist therapy. Cultural expectations of what a woman "is" can lead to SI as a source of empowerment and a way to regain bodily control (Walsh, 2006). To treat SI from a feminist perspective requires the analysis of gender, power and social influences to understand the emotional distress and behavioral dysfunction of clients (Brown & Bryan, 2007). Personal distress, not psychopathology, is at the heart of treatment. SI is viewed as a way to repel the oppression the client faces and a way to address powerlessness. Two references that highlight feminist therapy and SI are Brown and Bryan (2007) and Shaw (2002).

In counselling practice with adolescents, feminist issues often arise. For example, a female adolescent will state that weight loss is imperative to achieve a desirable body image. This distress related to body image can be one of the contributors to the client's self-injurious behaviors. A discussion regarding the factors that motivate a woman to pursue a body image that is culturally defined can give the client new perspective, possibly generating insight into how distorted the objective of weight loss can be.

Another example relates to sexuality. Some female adolescent clients have been hurt in relationships. They report that they feel pressured into sexual involvement to maintain their relationships with their partners. Because female adolescents sometimes think that they "need" a partner to fit into their adolescent social network, they become involved in undesired sexual contact in order to keep their partners. The confusion and possible partner rejection surrounding this dilemma can contribute to distress and SI. In counselling, talking about social pressures, healthful relationships, autonomy, and empowerment can provide insight that results in the adolescent feeling capable of making decisions based on personal values and beliefs instead of cultural and social pressures.

Narrative restructuring. Information or research regarding narrative therapy and SI is absent. A search of books, journal articles, and computer web sites did not locate any information. This dearth of literature could be due to how recently the narrative postmodernist approach was developed. Despite the absence of empirical evidence, I have found narrative restructuring to be helpful in the treatment of adolescent SI.

Once a therapeutic alliance has been established, adolescents like to tell their stories. Storytelling and the construction of healthful alternative stories is a narrative approach to which adolescents may respond well. A major technique in the use of narrative restructuring

is questioning to gain an understanding of the client's experiences; however, it has been observed that adolescents do not like to be bombarded with questions. The skill of the therapist in asking questions is therefore likely to be a pivotal aspect in the delivery of narrative treatment strategies.

Asking questions is not enough. The therapist must also listen nonjudgmentally and with an open mind. While listening to a story, the therapist is searching for evidence of success or competence. When successful glimmers are shared by the adolescent, the therapist presents them as evidence of the client's capability. Client empowerment results when the new perspective is presented.

SI can be viewed as an external coping mechanism used to deal with internalized problems. The narrative approach externalizes the problem by labeling the problem so that the problem is the problem, rather than the client. To facilitate the externalization of the problem, the problem is labeled using a word(s), often a noun. A student may identify the problem as "depression" and therapy can then focus on the depression, not the client. The therapist may ask a question such as "When depression takes over, what does it look like?" The important aspect of externalizing the behavior is to allow the adolescent client to choose the word(s) that accurately label the problem. Self-injuring behavior can be a symptom of another problem and the client may focus on a problem other than SI and choose to label it accordingly. For example, an adolescent may view body image as an issue and choose to label the problem "the skinny model". In therapy, the skinny model can then be investigated through narrative questioning.

I have found narrative strategies are helpful because:

- There is no blame placed on the client,

- The approach nurtures self-esteem and client empowerment when the problem is the problem, rather than the client,
- A goal is to discover exceptions that highlight success and contradict the problematic story, and
- Negative and problem focused stories can be reconstructed into alternative stories of competence when exceptions are identified and presented.

Interventions Not Recommended

In addition to the cautions expressed earlier in this chapter around group therapy, family therapy, and the risk involved in the use of no-harm contracts, other treatments have been identified as unsuccessful (Lukomski & Folmer, n.d.: Whitmarsh et al., 2006; Zila & Kiselica, 2001). These include physical restraint, hypnosis, faith healing, relaxation therapy, and electroconvulsive therapy.

Huband and Tantum (2004) conducted a grounded theory study that examined women's perceptions of which treatment interventions were of value. Women reported that relaxation techniques worsened SI because relaxation reduced self-control and diminished personal fortitude to fend off SI urges. Based on the research, the authors state that supporting this technique would be considered unethical.

Termination Issues

Deciding when to terminate treatment is difficult. The absence of self-injurious behavior should not be considered the only benchmark to indicate that treatment should end; when an adolescent surrenders self-injuring behaviors, other problems are likely to remain because SI is usually a symptom of other difficulties in the adolescent client's life. For example, child abuse, substance misuse, eating disorders, self-esteem issues, inadequate

communication skills, peer pressure, or family dysfunction could be difficulties identified during treatment. Therefore, therapy is likely required to continue even when the client's self-injurious behaviors have ceased.

It is recommended that the decision to terminate treatment is a collaborative decision between the client and counsellor. Termination should occur in such a manner that the client does not feel abandoned. Long before termination occurs, the client should be aware of the coming event. Adolescents do not like surprises; termination should be planned. In addition to removing the element of surprise, planned termination helps the client feel supported.

Prior to termination, continued wellness must be considered. It is possible that the client could relapse into a cycle of SI when experiencing overwhelming distress. A plan should be developed in the event that self-injurious behaviors return. The client requires access to resources that provide support and help to maintain the client's safety. This can include how to access medical care (physician or hospital), how to initiate further counselling, encouraging the client to communicate with family members when the need to self-injure surfaces, and how to access printed resources (Appendix E).

Terminating treatment should also involve family members if the client accepts this strategy. Including the family in the termination plan is recommended if there is family involvement. Inviting the family to a termination session can open the door to ways the family can continue to support the adolescent once treatment ceases.

It is helpful to formalize the termination plan in writing so that the client has a "take away" document to review. Such a plan should highlight healthful coping strategies the client has identified throughout therapy, resources to access, and what do if the urge to self-injure returns.

Borrowed from narrative therapy, an effective way of supporting the client beyond the termination of therapy is by sending the client a letter several weeks after the last session. The letter can again summarize the treatment process experienced by the adolescent. Such a letter shows continued support, reminds the client about what was accomplished, and generates self-reflection so that the client can monitor progress beyond treatment.

Conclusion

In synthesizing information regarding adolescent SI treatment, one predominant theme is at the forefront, that of a multifaceted approach that includes several treatment approaches and skills training (e.g. anger management, emotional regulation, problem-solving, coping techniques, and modeling) (Zila & Kiselica, 2001). Zila and Kiselica assert that no one approach can serve the client's treatment needs.

Several other themes also emerge when therapeutic treatments are reviewed:

1. A strong therapeutic alliance is essential and is considered a significant treatment strategy on its own.
2. Therapist/client collaboration is important.
3. SI is a multi-dimensional behavior and therefore treatment should address the family system, peer influences, societal issues, and the cultural context.
4. Treatment is usually long-term.
5. No one treatment is most effacious in the treatment of SI, although several show promise.
6. Clients are heterogeneous and each self-injuring client has unique treatment needs.
7. Assessment should inform treatment.

8. To be effective, the therapist must have competence working with SI, adolescents, and the treatment approaches used.

References

Alderman, T. (1997*). The scarred soul: Understanding and ending self-inflicted violence.* Oakland, CA: New Harbinger.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders-IV-TR* (4th ed., Text Revision). Washington, DC: Author.

American Psychiatric Association. (2003). *Practical guideline for the assessment and treatment of patients with suicidal behaviors.* Washington, DC: Author.

Andover, M., Pepper, C., Ryabchenko, K., Orrico, E., & Gibb, B. (2005). Self-mutilation and symptoms of depression, anxiety, and borderline personality disorder [Electronic Version]. *Suicide and Threatening Behavior, 35*, 581-591.

Applewhite, L., & Joseph, M. (1994). Confidentiality: Issues in working with self-harming adolescents [Electronic Version]. *Child and Adolescent Social Work Journal, 11*, 279-294.

Beck, A., & Weishaar, M. (1990). Suicide risk assessment and prediction. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 11*(2), 22-30.

Berman, A., Jobes, D., & Silverman, M. (2006). *Adolescent suicide: Assessment and intervention* (2nd ed.). Washington, DC: American Psychological Association.

Best, R. (2005). An educational response to deliberate self-harm: Training, support, and school-agency links [Electronic Version]. *Journal of Social Work Practice, 19*, 275-287.

Best, R. (2006a). Deliberate self-harm in adolescence: A challenge for schools [Electronic Version]. *British Journal of Guidance and Counselling, 34,* 161-175.

Best, R. (2006b, September). *Educational response to deliberate self-harm in adolescence.* Paper presented at the conference of the British Educational Research Association, London, England.

Booth, S. (2004). Cutting clubs: What's the latest and most shocking "friendship" ritual? Teen People looks at how a growing number of kids are bonding with their peers by slicing themselves with razor blades. *Teen People, 7* (1), 98. Retrieved December 27, 2005, from Infotrac database.

Bowman, S., & Randall, K. (2006). *See my pain!: Creative strategies and activities for helping young people who self-injure* (2nd ed.). Chapin, SC: YouthLight.

Brown, L., & Bryan, T. (2007). Feminist therapy with people who self-inflict violence [Electronic Version]. *Journal of Clinical Psychology: In Session. 63*, 1121-1133.

Brown, M. (1998, August). *The behavioral treatment of self-mutilation.* Paper presented at the Self-mutilation, Treatment, and Research Symposium, Congress of the World Association of Social Psychiatry, Vancouver BC, Canada.

Burns, D. (1980). *Feeling good: The new mood therapy*. New York: Avon.

Canadian Counselling Association. (2007, January). *Code of Ethics*. Ottawa, Ontario, Canada: Author.

Carlson, L., DeGeer, S., Deur, C., & Fenton, K. (2005). Teachers' awareness of self-cutting behavior among the adolescent population [Electronic Version]. *Praxix, 5,* 22-29.

Castille, K., Prout, M., Marczyk, G., Shmidheiser, M., Yoder, S., & Howlett, B. (2007). The early maladaptive schemas of self-mutilators: Implications for therapy [Electronic Version]. *Journal of Cognitive Psychotherapy: An International Quarterly, 21*, 58-71.

Cavanaugh, R. (2002). Self-mutilation as a manifestation of sexual abuse in adolescent girls [Electronic Version]. *Journal of Pediatric Gynecology, 15,* 97-100.

Chapman, A., Gratz, K., Brown, M. (2006). Solving the puzzle of deliberate self-harm: The experimental avoidance model. *Behavior Research and therapy, 44*, 371-394. Retrieved June 20, 2007, from ScienceDirect database.

Cochrane-Brink, K., Phil, D., Lofchy, J., & Sakinofsky, I. (2000). Clinical rating scales in suicide risk assessment [Electronic Version]. *General Hospital Psychiatry, (22)*, 445-451.

Comtois, K. (2002). A review of interventions to reduce the prevalence of parasuicide. *Psychiatric Services, 53,* 1138-1144. Retrieved October 22, 2006, from PsycInfo database.

Connors, R. E. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* Northvale, NJ: Jason Aronson.

Conterio, K., & Lader, W. (1998). *Bodily Harm: The breakthrough healing program for self-injurers.* New York: Hyperion.

Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway-Jones, K., et al. (2005). Suicide after deliberate self-harm: A 4-year cohort study [Electronic Version]. *American Journal of Psychiatry, 162*, 297-303.

Corey, G. (2005). *Theory and practice of counseling and psychotherapy* (8th ed.). Brooks/Cole-Thompson Learning: Belmont, CA.

Crowe, M., & Bunclark, J. (2000). Repeated self-injury and its management [Electronic Version]. *International Review of Psychiatry, 12,* 48-53.

Crowell, S., Beauchaine, T., McCauley, E., Smith, C., Vasilev, C., & Stevens, A. (2008). Parent-child interactions, peripheral serotonin, and self-inflicted injury in adolescents [Electronic Version]. *Journal of Consulting and Clinical Psychology, 76,* 15-21.

Croyle, K., & Waltz, J. (2007). Subclinical self-harm: Range of behaviors, extent, and associated characteristics. *American Journal of Orthopsychiatry, 77,* 332-342.

Daley, D., & Moss, H. (2002). *Dual disorders: Counseling clients with chemical dependency and mental health illness* (3rd ed.). Centre City, MN: Hazelden.

Deiter, P., Nicholls, S., & Pearlman, L. (2000). Self-injury and self- capacities: Assisting an individual in crisis [Electronic Version]. *Journal of Clinical Psychology, 56,* 1173-1191.

Derouin, A., & Bravender, T. (2004). Living on the edge: The current phenomenon of self-mutilation in adolescents. *The American Journal of Maternal/Child Nursing, 29*(1), 12-18. Retrieved October 14, 2006, from Ovid database.

Favazza, A. R. (1996). *Bodies under siege: Self-mutilation and body modification in culture and psychiatry.* Baltimore: Johns Hopkins University Press.

Favazza, A., & Conterio, K. (1988). The plight of chronic self-mutilators [Electronic Version]. *Community Mental Health Journal, 24*(1). 22-30.

Focus Adolescent Services: What is self-injury? (n.d.). Retrieved February 13, 2009, from www.focusas.com

Fortune, S., & Hawton, K. (2005). Deliberate self-harm in children and adolescents: A research review. *Current Opinion in Psychiatry, 18,* 401-406. Retrieved January 3, 2009, from Ovid database.

Frankel, J. (2001). A witness breaks his silence: The meaning of a therapist's response to an adolescent's self-destruction [Electronic Version]. *American Journal of Psychoanalysis, 61*(1), 85-99.

Froeschle, J., & Moyer, M. (2004). Just cut it out: Legal and ethical challenges in counseling students who self-mutilate. *Professional School Counselling, 7,* 231-235. Retrieved October 16, 2006, from PsycInfo database.

Galley, M. (2003). Student self-harm: Silent school crisis. *Education Week, 23*(14), 1-15. Retrieved June 10, 2007, from Academic Search Premier database.

Gardner, F. (2001). *Self-harm: A psychotherapeutic approach.* New York: Taylor and Francis.

Gratz, K. (2007). Targeting emotional dysregulation in the treatment of self-injury [Electronic Version]. *Journal of Clinical Psychology: In Session, 63,* 1091-1103.

Gratz, K., & Chapman, A. (2007). The role of emotional responding and childhood maltreatment in the development and maintenance of deliberate self-harm among male undergraduates [Electronic Version]. *Psychology of Men and Masculinity, 8*(1), 1-14.

Gratz, K., Conrad, S., & Roemer, L. (2002). Risk factors of deliberate self-harm among college students [Electronic Version]. *American Journal of Orthopsychiatry, 72,* 128-140.

Haines, J., & Williams, C. (2003). Coping and problem solving of self-mutilators [Electronic Version]. *Journal of Clinical Psychology, 59,* 1097-1106.

Harriss, L., & Hawton, K. (2005). Suicidal intent in deliberate self-harm and the risk of suicide: The predictive power of the Suicide Intent Scale [Electronic Version]. *Journal of Affective Disorders, 65,* 225-233.

Harriss, L., Hawton, K., Zahl, D. (2005). Value of measuring suicidal intent in the assessment of people attending hospital following self-poisoning or self-injury. *British Journal of Psychiatry, 186*, 60-66. Retrieved November 15, 2008, from http//bjp.rcpsych.org/cgi/content/full/186/1/60

Haswell, D., & Graham, M. (2008). *Overcoming self-abuse: Step by step to success* (5th ed.). Hamilton, Ontario, Canada: S.A.F.E. BC.

Hatcher, S. (2002). Review: Problem-solving treatment after deliberate self-harm improves depression, hopelessness, and personal problems. *APC Journal Club, 136*, 64. Retrieved February 21, 2009, from Academic Search Premier database.

Hawton, K., Townsend, E., Arensman, E., Gunnell, D., Hazell, P., House, A., et al. (1999). Psychosocial and pharmacological treatments for deliberate self harm. *Cochrane Database of Systematic Reviews,* Issue 4. Art. No.: CD001764.DOI:10.1002/ 14651858.CD111764.

Heath, N., Toste, J., Nedecheva, T., & Charlebois, A. (2008). An examination of nonsuicidal self-injury among college students [Electronic Version]. *Journal of Mental Health Counselling, 30,* 137-156.

Hjelmeland, H., & Groholt, B. (2005). A comparative study of young and adult deliberate self-harm patients. *Crisis: The Journal of crisis intervention and suicide prevention, 26,* 64-72. Retrieved June 15, 2007, from EBSCOhost database.

Hollander, M. (2008). *Helping teens who cut: Understanding and ending self-injury.* New York: Guilford Press.

Huband, N., & Tantam, D. (2004). Repeated self-wounding: Women's recollection of pathways to cutting and of the value of different interventions [Electronic Version]. *Psychology and Psychotherapy: Theory, Research and Practice, 77*, 413-428.

Kenrick, J. (2007, February 16). 'If I didn't self-harm, I'd probably kill myself'. *Times, 4724* (Educational Supplement), 20-23. Retrieved October 19, 2007, from LexisNexis database.

Klonsky, E. (2007). The functions of deliberate self-injury: A review of the evidence [Electronic Version]. *Clinical Psychology Review, 27,* 226-239.

Klonsky, E., & Muehlenkamp, J. (2007). Self-Injury: A research review for the practitioner [Electronic Version]. *Journal of Clinical Psychology: In Session, 63*, 1045-1056.

Klonsky, E., Oltmanns, T., & Turkheimer, E. (2003). Deliberate self-harm in a nonclinical population: Prevalence and psychological correlates [Electronic Version]. *American Journal of Psychiatry, 160,* 1501-1508.

Laye-Gindhu, A., & Schonert-Reichl, K. (2005). Nonsuicidal self-harm among community adolescents: Understanding the "whats" and "whys" of self-harm [Electronic Version]. *Journal of Youth and Adolescence (34),* 447-457.

Levenkron, S. (1998). *Cutting: Understanding and overcoming self-mutilation.* New York: W. W. Norton.

Levy, K., Yeomans, F., & Diamond, D. (2007). Psychodynamic treatments of self-injury [Electronic Version]. *Journal of Clinical Psychology: In Session, 63*, 1105-1120.

Leyshon, S. (2005). Deliberate self-harm [Electronic Version]. *Primary Health Care, 15,* 8.

Lloyd-Richardson, E., Perrine, N., Dierker, L., & Kelley, M. (2007). Characteristics and functions of non-suicidal self-injury in a community sample of adolescents [Electronic Version]. *Psychological Medicine, 37,* 1183-1192.

Lukomski, J., & Folmer, T. (n.d.). Self-mutilation: Information and guidance for school personnel. *Guidance Channel Online.* Retrieved April 16, 2006, from http://www.guidancechannel.com/default.aspx?index=1328&cat213

Lynch, T., Chapman, A., Rosenthal, M., Kuo, J., & Linehan, M. (2006). Mechanisms of change in dialectic behavior therapy: Theoretical and empirical observations [Electronic Version]. *Journal of Clinical Psychology, 62,* 159-480.

Malikow, M. (2006). When students cut themselves [Electronic Version]. Condensed from *Tennessee Education 34,* 31-34. *The Education Digest, 17*(8). 45-50.

Mangnall, J., & Yurkovich, E. (2008). A literature review of deliberate self-harm [Electronic Version]. *Perspectives in Psychiatric Care, 44*(3), 175-184.

Marchetto, M. (2006). Repetitive skin-cutting: Parental bonding, personality and gender [Electronic Version]. *Psychology and Psychotherapy: Theory, Research and Practice, 79,* 445-459.

McAuliffe, C., Corcoran, P., Keeley, H., Arensman, E., Bille-Brahe, U., DeLeo, D., et al. (2006). Problem-solving ability and repetition of deliberate self-harm: A multicentre study [Electronic Version]. *Psychological Medicine, 36,* 45-55.

McDonald, C. (2006). Self-mutilation in adolescents [Electronic Version]. *Journal of School Nursing, 22,* 193-200.

McKay, D., Gavigan, C., & Kulchycky, S. (2004). Social skills and sex-role functioning in borderline personality disorder: Relationship to self-mutilating behavior [Electronic Version]. *Cognitive Behavior Therapy, 33*(1), 27-35.

McNamara, C. (2004). The seven steps of problem-solving [Electronic Version]. *Administrator. 23*(5), 3.

McVey-Noble, M., Khemlani-Patel, S., & Neziroglu, F. (2006). *When your child is cutting: A parent's guide to helping children overcome self-injury.* Oakland, CA: New Harbinger Publications.

Morrissette, P. (2000). The experiences of the rural school counsellor. *Professional School Counselling, 3,* 197-208. Retrieved March 4, 2009, from Academic Search Premier database.

Muehlenkamp, J. (2005). Self-injurious behavior as a separate clinical syndrome [Electronic Version]. *American Journal of Orthopsychiatry, 75*, 324-333.

Muehlenkamp, J. (2006). Empirically supported treatments and general therapy guidelines for non-suicidal self-injury [Electronic Version]. *Journal of Mental Health Counseling, 28,* 166-185.

Muehlenkamp, J. (2007). Body regard and risk for self-injurious behavior in a sample of clinical and non-clinical adolescents (Doctoral dissertation, Illinois University, 2005). UMI Dissertation Services.

Murray, C., & Fox, J. (2006). Do Internet self-harm discussion groups alleviate or exacerbate self-harming behavior? *Australian e-Journal for the Advancement of Mental Health, 5*(3), 1-9. Retrieved March 17, 2007, from www.auseinet.com/journal/vol5 iss3/ murray.pdf

Nafisi, N., & Stanley, B. (2007). Developing and maintaining the therapeutic alliance with self-injuring patients [Electronic Version]. *Journal of Clinical Psychology: In Session, 63,* 1069-1079.

Nixon, M., Cloutier, P., & Aggarwal, S. (2002). Affect regulation and addictive aspects of repetitive self-injury in hospitalized adolescents [Electronic Version]. *Journal of American Academy of Child and Adolescent Psychiatry, 41*, 1333-1341.

Nixon, M., Cloutier, P., & Jansson, M. (2008). Nonsuicidal self-harm in youth: A population-based survey [Electronic Version]. *Canadian Medical Association Journal. 178,* 306-12.

Nixon, M., & Heath, N. (Eds.). (2009). *Self-injury in youth: The essential guide to assessment and intervention.* New York: Routledge.

Nock, M., Joiner, T., Gordon, K., Lloyd-Richardson, E., & Prinstein, M. (2006). Non-suicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry Research, 144,* 65-72. Retrieved October 14, 2006, from ScienceDirect database.

Nock, M., & Mendes, W. (2008). Physiological arousal, distress tolerance, and social problem-solving deficits among adolescent self-injurers [Electronic Version]. *Journal of Consulting and Clinical Psychology, 76,* 28-38.

Nock, M., & Prinstein, M. (2005). Contextual features and behavioral functions of self-mutilation among adolescents [Electronic Version]. *Journal of Abnormal Psychology, 114,* 140-146.

Nock, M., Teper, R., & Hollander, M. (2007). Psychological treatment of self-injury among adolescents [Electronic Version]. *Journal of Clinical Psychology: In Session, 63,* 1081-1089.

Onacki, M. (2005). Kids who cut: A protocol for public schools [Electronic Version]. *Journal of School Health, 75,* 400-401.

Paris, J. (2005). Understanding self-mutilation in borderline personality disorder [Electronic Version]. *Harvard Review of Psychiatry, 13*, 179-185.

Penner, M. (2008). *Hope and healing for kids who cut.* Grand Rapids, MI: Zondervan.

Polk, E., & Liss, M. (2007). Psychological characteristics of self-injurious behavior [Electronic Version]. *Personality and individual differences, 43*, 567-577.

Portzky, G., & van Heeringen, K. (2007). Deliberate self-harm in adolescents. *Current Opinion in Psychiatry, 20,* 337-342. Retrieved January 3, 2009, from Ovid database.

Province of British Columbia (1996). *British Columbia School Act; Revised Statutes of British Columbia, Chapter 412.* Victoria, British Columbia, Canada: Queen's Printer. Retrieved March 15, 2009, from www.bced.gov.bc.ca/legislation/schoollaw/revised statutescontents.pdf

Raj, A., Kumaraiah, V., & Bhide, A. (2001). Cognitive-behavioral intervention in deliberate self-harm [Electronic Version]. *Acta Psychiatrica Scandinavica, 104*, 304-345.

Roberts-Dobie, S., & Donatelle, R. (2007). School counsellors and student self-injury [Electronic Version]. *Journal of School Health, 77,* 257-264.

Ross, S., & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents [Electronic Version]. *Journal of Youth and Adolescence, 31*, 67-77.

Rutter, M. (2007). Group supervision with practicing school counsellors [Electronic Version]. *Guidance and Counselling, 21,* 106-167.

Ryan, S. (2005). The silent scream: Sari Grossman, now 16, is creative, funny and very smart. So smart, in fact, that it's hard to understand why she decided to cut her arms and legs on a daily basis. An inside look at the heartbreaking world of girls whose emotional pain has lead to torture themselves. *Girl's Life, 12*(1), 68-73. Retrieved December 27, 2005, from Infotrac database.

S.A.F.E. in Canada: Your resource for self-abuse prevention, support, education, and resources. (n.d.). Retrieved February 13, 2009, from www. safeincanada.org

Schulz, W., Sheppard, G., Lehr, R., & Shepard, B. (2006). *Counselling ethics: Issues and cases.* Ottawa, Ontario, Canada: Canadian Counselling Association.

Selekman, M. (2006). *Working with self-harming adolescents: A collaborative, strengths-based therapy approach.* New York: W. W. Norton.

Self-injury: A struggle. (n.d.) Retrieved August 18, 2008, from http://self-injury. net

Self-injury: You are not the only one. (n.d.). Retrieved February 13, 2009, from http://crystal .palace.net/~llama/psych/injury.html

Shapiro, L. (2008). *Stopping the pain: A workbook for teens who cut and self-injure.* Oakland, CA: New Harbinger Publications.

Shaw, S. (2002). Shifting conversations on girls' and women's self-injury: An analysis of the clinical literature in historical context [Electronic Version]. *Feminism and Psychology, 12,* 191-219.

Skegg, K. (2005). Self-harm [Electronic Version]. *Lancet, 366,* 1471-1483.

Slee, N., Arensman, E., Garnefski, N., & Spinhoven, P. (2007). Cognitive-behavioral therapy and deliberate self-harm [Electronic Version]. *Crisis, 28*(4), 175-182.

Spirito, A., Sterling, C., Donaldson, D., & Arrigan, M. (1996). Factor analysis of the Suicide Intent Scale with adolescent suicide attempters [Electronic Version]. *Journal of Personality Assessment, 67*(1), 90-101.

Stevens, P., & Smith, R. (2001). *Substance Abuse Counseling: Theory and Practice* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.

Sutton, J., Jr. & Pearson, R. (2002). The practice of school counseling in rural and small town schools. *Professional School Counseling, 5,* 266-277. Retrieved March 4, 2009, from Academic Search Premier database.

Strong, M. (1998). *A bright red scream: Self-mutilation and language of pain.* New York: Penquin.

Suyemoto, K., & MacDonald, M. (1995). Self-cutting in female adolescents [Electronic Version]. *Psychotherapy: Theory, Research, Practice, Training, 32,* 162-171.

Swadi, H. (2004). Self-mutilation among adolescents and youth: Some clinical perspectives [Electronic Version]. *New Zealand Family Physician, 31,* 374-377.

Taiminen, T., Kallio-Soukainen, K., Nokso-Koivisto, H., Kaljonen, A., & Helenius, H., (1998). Contagion of deliberate self-harm among adolescent inpatients. *Adolescent and Child Psychiatry, 37,* 211-21-7. Retrieved October 14, 2006, from OVID database.

Tillotson, K. (2008). Is cognitive behavior therapy useful for people who self harm? [Electronic Version]. *Mental Health Practice, 11*(5), 28-31.

Tonkin, R., Murphy, A., Lee, Z., Saewye, E., & The McCreary Center Society (2005). *British Columbia Health Trends: A retrospective, 1992-2003.* Vancouver, British Columbia, Canada: McCreary Center Society.

Trepal, H., Wester, K., & MacDonald, C. (2006). Self-injury and postvention: Responding to the family in crisis [Electronic Version]. *The Family Journal: Counseling and Therapy for Couples and Families, 14,* 342-348.

Tyler, K., Whitbeck, L., Hoyt, D., & Johnson, K. (2003). Self-mutilation and homeless youth: The role of family abuse, street experiences, and mental disorders [Electronic Version]. *Journal of Research on Adolescence, 13,* 457-474.

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

Walsh, B. (2007). Clinical assessment of self-injury: A practical guide [Electronic Version]. *Journal of Clinical Psychology: In Session, 63,* 1057-1068.

Walsh, B. & Rosen, P. (1988). *Self-mutilation: Theory, research, and treatment.* New York: Guilford.

White, V., Trepal-Wollenzier, H., & Nolan, J. (2002). College students and self-injury: Intervention strategies for counselors [Electronic Version]. *Journal of College Counseling, 5,* 105-113.

White Kress, V. (n.d.). Adolescents who self-injure: Implications and strategies for school counsellors. Retrieved March 7, 2008, from http//www.findarticles.com/p/articles/mi_m0KOC/is_3_7aj_11478735/print

White Kress, V. (2003). Self-injurious behaviors: Assessment and diagnosis [Electronic Version]. *Journal of Counseling and Development, 81,* 490-496.

Whitlock, J., Lader, W., & Conterio, K. (2007). The Internet and self-injury: What psychotherapists should know [Electronic Version]. *Journal of Clinical Psychology: In Session, 64,* 1135-1143.

Whitlock, J., Powers, J., & Eckenrode, J. (2006). The virtual cutting edge: The Internet and adolescent self-injury [Electronic Version]. *Developmental Psychology, 42,* 407-417.

Whitmarsh, L., Rosencrance, J., Lynch, M., & Mullette, J. (2006). Adolescent self-mutilation: Research review and case presentations. Retrieved April 16, 2006, from http://www.njcounselling.org/NJCA-Journal/subpages/whitmarsh.html

Winkler, K. (2003). *Cutting and self-mutilation: When teens injure themselves.* Berkeley Heights, NJ: Enslow.

Wysong, P. (2007, September). Bodily harm: Understanding self-injury. *Canadian Living, 32,* 105-110.

Zila, L., & Kiselica, M. (2001). Understanding and counseling self-mutilation in female adolescents and young adults [Electronic Version]. *Journal of Counseling and Development, 79*(1), 46-52.

Appendix A

Adolescent Self-Injury: A Staff Education Session

Goal: School staff will understand the nature of adolescent self-injury (SI) and what their role is in the identification and support of self-injurers.

1. Explain what behaviors are considered self-injurious.

   -cutting, self-burning, self-hitting, breaking bones

2. Explain why a student may self-injure.

   -to deal with emotional pain

   -many self-injurers have had a traumatic experience

   -often have body image issues

   -tension builds up and is relieved by SI

   -self-soothing behavior

   -may be introduced and/or reinforced by peers (contagion effect) and/or media (TV, web sites, movies, popular music)

3. Explain the difference between self-injurious and suicidal behaviors.

   -a suicidal person feels helpless and hopeless and is looking for a way to end these feelings

   -a person who self-injures is looking for a way to relieve the tension and thus sees SI as a way to cope and stay alive.

4. Explain what is not SI (body modification).

   -tattooing and body piercing are socially accepted and not considered SI unless the behavior becomes compulsive and is used to relieve tension.

5. How to respond to and support a self-injurer.

   -calm, patient, respectful, nonjudgmental, optimistic

   -do not normalize or minimize the behavior

   -provide some flexibility in school assignments, as self-injurious students may be academically overwhelmed.

6. What should be done if possible self-injurious behavior is suspected or identified.

   -refer to school procedures, if they exist

   -seek the help of a designated person in the school. This person is often the school counsellor.

   -ensure that the student is assessed to determine the extent of the SI and risk of suicide.

   -support the student.

7. Discussion and questions

Appendix B

Recommended School Procedures Regarding Incidents of Self-Injury

School District:

School Name:

Procedures:

1. The counsellor will have a conversation with the school principal about how incidents of self-injury (SI) are handled in the school so that administrative input and approval are included.
2. All school staff/volunteers will be given the opportunity to participate in a training session related to adolescent SI so that all employees and volunteers have an understanding of SI issues.
3. The school counsellor will ensure that adequate education has been accessed so that he/she can deal appropriately with incidents of adolescent SI. This includes knowledge related to SI and community SI resources available. The trained school counsellor is the person that students, staff, volunteers and family members can access when an incident of SI occurs.
4. When an incident of SI is suspected by a school staff member or volunteer, the school counsellor will be informed.
5. The school counsellor will seek information from the staff member related to the suspected SI.
6. With discretion and in a confidential manner, the school counsellor will interview the student to determine if SI is involved.

7. If it is assessed that SI has occurred, the counsellor will also assess if the student's safety is at risk. If student safety is at risk, the school counsellor will inform parents/guardians and access appropriate community resources to support the student. This may include immediate and appropriate medical care provided by a physician or hospital emergency department.
8. If the counsellor assesses that the self-injuring student's safety is not at risk, the school counsellor will respect the student's confidentiality when it is requested by the student. The school counsellor will continue to monitor the student.
9. While working with a self-injuring student, the counsellor will encourage the student to develop healthful alternatives to SI, inform their parents/guardians of their behavior, and access appropriate community SI support.
10. The school will support the student, community agencies, health care providers, family, and peers involved when an incident of SI arises.
11. Through the entire process while working with a student practicing SI, the school counsellor will consult with other counselling colleagues, school administration, the school nurse, school district psychologists, and outside agencies to provide the best course of action possible for the student.

Appendix C

Assessment Record

Demographic Information

Client _____

Date of birth _____ Age _____

Mailing address _____

_____

Phone _____ Cell _____

Email address _____

Physician _____ Phone _____

Other health care providers _____ Phone _____

_____ Phone _____

Social worker _____ Phone _____

Legal issues _____

_____

Family Information

Legal guardian(s) _____

_____

_____

Parent(s) _____

_____

_____

Siblings (ages) _____

Other individuals living in home _____

Other information (separations, divorce, group home, foster care . . .) _____

School Information

School attending _____ Grade_____

Previous schools attended_____

School subjects/marks _____

Favourite subject/Why _____

Most disliked subject/Why _____

Other information:

Friends/Peers

Best friend(s) _____

Friends at school _____

Boyfriends/Girlfriends (history) _____

Activities with friends _____

Other information:

_____

_____

_____

Mental Health

Previous or current mental health conditions (depression, anxiety, suicide . . .)/Describe (when, how often, how it was treated, ongoing): _____

_____

_____

_____

_____

_____

Client's description of his/her mental health

_____

_____

_____

_____

_____

Does the client have another counsellor/therapist? _____Who _____

Client consent to contact other counsellor/therapist _____

Results of suicide assessment _____

_____

_____

Prescribed medications (name, dose, frequency, reason for prescription) _____

Other information:

Past Trauma

Past traumatic events (death, violence, parental substance abuse, divorce . . .)/Describe

Child Abuse (physical, sexual or emotional) _____

Other information: _____

Internet Use

Regular access to the Internet _____

SI web sites frequently accessed _____

_____

_____

Other information: _____

_____

_____

_____

Substance Use

Record of substance use:

Substance	Onset of Use	Currently Used/ Amount	Frequency of Use
Alcohol			
Tobacco			
Marijuana			
Amphetamines			
Depressants			

Cocaine			
Ecstasy			
Other (Include any prescription medication misuse)			

What client thinks about his/her substance use; is it seen as a problem/damage to health or lifestyle _____

_____

_____

_____

Family history of substance use _____

_____

_____

_____

Other information: _____

_____

_____

Body Image Issues

Client considers self:

____ Underweight ____ Average ____ Overweight

Describe _____

_____

_____

History of disordered eating (anorexia, bulimia, compulsive overeating)/Describe _____

_____

_____

Concerns about body image/Describe _____

_____

_____

_____

Other information: _____

_____

_____

Self-Injurious Behavior

Age at onset _____

Frequency_____

_____

_____

_____

Types of self-injury (cutting, picking, burning, self-hitting . . .) _____

_____

_____

_____

Type(s) of self-injury most frequently used _____

_____

Duration of a self-injuring episode _____

_____

_____

Time of day when SI usually occurs _____

_____

_____

Places where self-injury occurs _____

_____

_____

Number of wounds per episode _____

_____

_____

Area(s) of body _____

_____

Extent of injury _____

_____

_____

Medical care required _____

_____

Tool(s) used to self-injure _____

_____

Triggers/antecedents _____

_____

_____

_____

_____

Reducers of client's self-injury (being with friends, going for a walk, writing . . .) _____

_____

_____

_____

_____

Friends who self-injure/Describe _____

_____

_____

_____

Self-injure alone or with others/Who _____

_____

_____

Access to self-injury websites/Which ones/How often _____

_____

_____

_____

Consequences of self-injury _____

_____

Others aware of self-injury _____

Recent changes in self-injury/What _____

Functions (purposes) of self-injury/How SI helps the client _____

Other information: _____

Notes:

Appendix D

Journal

Name: _____ Week: _____

Date	Approximate Time Spent Self-Injuring	Location	Triggers	Feelings	Extent of Injury	Consequences

Notes:

Appendix E

Selected and Annotated SI Resources

Professional Reference Books

Bowman, S., & Randall, K. (2006*). See my pain!: Creative strategies and activities for helping young people who self-injure* (2nd ed.). Chapin, SC: YouthLight.

- A reference for practitioners working with children/adolescents who self-injure.
- Includes background information, assessment questions, and activities to use with individuals or small groups.
- Includes a spiritual component with references to God and the value of prayer, an approach that some adolescent clients may not find helpful.

Favazza, A. (1996). *Bodies under siege: Self-mutilation and body modification in culture and psychiatry.* Baltimore: Johns Hopkins University Press.

- Author is considered one of the pioneers in the study and treatment of SI.
- Provides historical, cultural, and sociological perspectives of SI.
- Includes information on the treatment and diagnosis of SI.

Nixon, M., & Heath, N. (Eds.). (2009). *Self-injury in youth: The essential guide to assessment and intervention.* New York: Routledge.

- A comprehensive resource for the clinician edited by two Canadian SI researchers with clinical experience.
- Contains a great deal of in-depth information, all focusing on youth.
- In addition to the two editors/authors, the book also contains the writings of many prominent researchers and clinicians (e.g., Lloyd-Richardson, Nock, Prinstein, Klonsky, Muehlenkamp, and Toste).

- Edited resource is of value to those requiring information beyond that presented in this manual.
- Information presented is based on empirical evidence.
- Can be viewed as one of the most current and definitive references available for practitioners working with self-injuring adolescents.

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

- A reference book for clinicians.
- Does not focus specifically on adolescents, however a great deal of information is relevant to adolescent SI issues (e.g. a chapter on dealing with self-injurers within the school system).
- Walsh's book indicates that he has vast experience and sound SI background.
- Thorough, well-presented, and informative.

Professional journal articles

A detailed list of journal articles can be found in this manual's reference list. The following articles provide valuable SI information that, once read, would provide the reader with sound background regarding SI and its treatment.

Best, R. (2006). Deliberate self-harm in adolescence: A challenge for schools. *British Journal of Guidance and Counselling, 34,* 161-175.

- Presents the results of a research study that accessed SI knowledge and attitude of high school teachers and school-related professionals.

Froeschle, J., & Moyer, M. (2004). Just cut it out: Legal and ethical challenges in counseling students who self-mutilate. *Professional School Counselling, 7,* 231-235.

- Provides background information on SI.

- Offers best practice for schools.
- Investigates legal and ethical considerations pertaining to SI and the school system.

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

- A study (n=633) that results in a vast amount of adolescent SI information.
- One of the few studies conducted using adolescent participants that are not hospitalized or in outpatient treatment.
- Results indicate why adolescents self-injure.
- Makes intervention recommendations.

Klonsky, E. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27,* 226-239.

- Review of empirical research related to the functions of SI.
- Concludes that affect-regulation is a significant function of SI but also recognizes support for other functions.
- Includes the review of research using adolescent participants.

Klonsky, E., & Muehlenkamp, J. (2007). Self-Injury: A research review for the practitioner. *Journal of Clinical Psychology: In Session, 63*, 1045-1056.

- Provides accurate and useful background information regarding SI.
- Includes the functions of SI and treatment approaches.
- Published in a journal volume entirely allocated to the topic of SI.

Muehlenkamp, J. (2006). Empirically supported treatments and general therapy guidelines for non-suicidal self-injury. *Journal of Mental Health Counseling, 28,* 166-185.

- Muehlenkamp has been a major contributor to the understanding of adolescent SI.
- Although not focused specifically on adolescent SI, the author offers treatment approaches and strategies that are useful for adolescents.
- Suggests cognitive behavioral approaches as she reports they have the most empirical support.

Nock, M., Teper, R., & Hollander, M. (2007). Psychological treatment of self-injury among adolescents. *Journal of Clinical Psychology: In Session, 63,* 1081-1089.

- Focuses on the use of dialectical behavioral therapy.
- Provides an in-depth counselling case study.
- Published in a journal issue that is devoted to SI.

Roberts-Dobie, S., & Donatelle, R. (2007). School counselors and student self-injury. *Journal of School Health, 77,* 257-264.

- Research regarding the issue of SI from a school counsellor's perspective.
- Authors conclude that the school counsellor's role is that of a liaison, and encourage counsellors to refer students to appropriate community resources.

Ross, S., & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents . *Journal of Youth and Adolescence, 31*, 67-77.

- A research article that is referenced by many authors in SI literature and research.
- Canadian study conducted by two knowledgeable and well-qualified researchers and clinicians.

Walsh, B. (2007). Clinical assessment of self-injury: A practical guide *Journal of Clinical Psychology: In Session, 63*, 1057-1068.

- Presents factors that require assessment.

- A case study is presented to illustrate how assessment can be conducted.
- One of several articles presented in a journal issue focusing on SI.

Whitlock, J., Lader, W., & Conterio, K. (2007). The Internet and self-injury: What psychotherapists should know. *Journal of Clinical Psychology: In Session, 64,* 1135-1143.

- Summarizes the possible impact of Internet sites on self-injuring behavior.
- Review of research.
- Provides recommendations for clinicians.
- Published in a journal issue that is devoted to SI.

Zila, L., & Kiselica, M. (2001). Understanding and counseling self-mutilation in female adolescents and young adults. *Journal of Counseling and Development, 79*(1), 46-52.

- Provides female adolescent SI information.
- Article is often sited in other SI references.
- Offers treatment alternatives and suggests treatments to avoid.

Reference Books for Parents

Hollander, M. (2008). *Helping teens who cut.* New York: Guilford Press.

- Written in a less technical way than the professional books highlighted in this appendix.
- Hollander is a psychotherapist with vast experience working with self-injuring adolescents.
- This book lacks citations, an aspect of the publication that parents may find desirable because it may be perceived as "readable".
- The resource helps parents understand SI and assists them in accessing appropriate

treatment for their self-injuring child.

- Resource is focused on Dialectical behavior therapy (DBT).

McVey-Noble, M., Khemlani-Patel, S., & Neziroglu. F. (2006). *When your child is cutting: A parent's guide to helping children overcome self-injury.* Oakland, CA: New Harbinger Publications.

- Written by three practicing psychologists and all have a great deal of counselling experience.
- Provides accurate SI information, presents treatment options, and suggests ways for parents to support a self-injuring child.
- Readable and not lengthy, both advantages for many parents who want accurate information that is succinctly presented.

Self-Help References

Haswell, D., & Graham, M. (2008). *Overcoming self-abuse: Step by step to success* (5th ed.). Hamilton, Ontario, Canada: S.A.F.E BC.

- S.A.F.E.is an acronym for Self-Abuse Finally Ends.
- A manual-assisted cognitive behavioral workbook.
- Designed as a 10-module program. Could be used with therapy.
- Recommended for group meetings, but the concerns about group therapy in this manual should be referred to prior to the establishment of group sessions.

Shapiro, L. (2008). *Stopping the pain: A workbook for teens who cut and self-injure.* Oakland, CA: New Harbinger.

- A manual-assisted cognitive behavioral workbook for adolescent self-injurers.
- Could be used on its own or in conjunction with therapy.

- Has a useful section on faulty thinking (cognitive distortions) and how to change them.

Winkler, K. (2003). *Cutting and self-mutilation: When teens injure themselves.* Berkeley Heights, NJ: Enslow.

- A reference book for adolescents written by a journalist.
- Would be of value in a school library as it is written specifically for teens.
- Not a large volume, an aspect of the book that is likely to appeal to adolescents.

Internet Resources

Warning: Some Internet sites can promote SI by acting as triggers for the behavior. Extreme caution must be used to ensure that the site accessed is appropriate and encourages the healthful cessation of SI. Stress, guilt, and more SI could be outcomes if a website "pushes" cessation without encouraging healthful alternatives.

Note: Websites are constantly changing. Although access to these websites was available at the time of writing (Feb. 13, 2009), some sites may be discontinued.

Self-injury: You are not the only one – http://crystal.palace.net/~llama/psych/injury.html

- Offers accurate SI information.
- Does not appear to have any contagion factors.
- Appears not to have been updated since 2002.
- Authored by Deb Martinson, a person who claims to have worked extensively with self-injurers.
- Includes some interesting aspects such as quotes, self-assessment and a questionnaire.

Focus Adolescent Services: What is Self-injury? – www.focusas.com

- An online information referral service provided by Focus Adolescent Services, an organization located in Salisbury, Maryland.
- Established for teens and their families.
- Self-injury is one of the topics highlighted on the site.
- Information is accurate.

Self-injury: A struggle – http://self-injury.net

- Appears to be moderated by a 24 years old female university student.
- This is an example of a site that could have a triggering (contagion) effect as it has quotes from self-injurers and provides an extensive list of self-injury song lyrics.
- This site should be accessed with reservations. There is value in visiting the site to see what youth can be accessing online, however this site should not be recommended to adolescent self-injurers, as it could be a trigger.

S.A.F.E. in BC – http://ca.geocities.com/safebc

- A Canadian site with reliable and accurate information.
- Provides accurate information for the self-injurer and loved ones.
- Not likely to have a triggering (contagion) effect, although the site warns of this possible outcome.
- Provides resources available in Canada, in particular Ontario and British Columbia.
- S.A.F.E. is an acronym for Self-Abuse Finally Ends and was originally coined by the founders of S.A.F.E. Alternatives in Illinois, U.S.A.

Appendix F

Agency/Counsellor/Medical Care Contact and Release of Information

Consent Form

PLACE ON BUSINESS LETTERHEAD

(This is the minimum information required on a consent form and

agencies may need to add details to meet their mandate.)

Agency and/or counsellor requesting contact _____

Client _____ Date of birth _____

I (We) hereby give my (our) consent for _____

to contact and share _____ with

_____. The information provided

will be held in confidence, shared with the client and/or guardian(s), and used only for

treatment purposes.

Client Signature _____ Date_____

Guardian(s) Signature(s) _____ Date _____

_____ Date_____

Witness _____ Date_____

Appendix G

Frequently Asked Questions –Self-Injury

When someone you care about is intentionally injuring himself/herself, it can be confusing and scary. These answers to frequently asked questions will provide you with some accurate information regarding self-injury (SI).

1. What is self-injury (SI)?

SI is a behavior individuals may turn to when experiencing emotional difficulty. A person will intentionally harm an area(s) of the body. Some methods of SI are cutting, burning, hair pulling, self-hitting, scratching, and bone breaking. Cutting is the most common form of SI.

2. Where on the body do individuals self-injure?

Typically, injury can be done on arms, thighs, breasts, genitals, abdomen, or ankles. Injury is not restricted to these areas. The area of SI is often a place that is easily covered by clothing so that the injury site is not obvious to others.

3. Why do individuals self-injure?

There is no one reason to explain why people self-injure. A common aspect of the behavior is that the individual is experiencing overwhelming emotional difficulties. When SI occurs, the individual experiences intense emotional relief. Individuals who practice SI sometimes have trauma in their backgrounds. Examples of trauma could be child abuse, the death of a loved one, separation from a caregiver, a caregiver who misuses substances, family dysfunction, or isolation from others. SI can also occur with no history of trauma.

4. Does a self-injuring person require hospitalization?

Usually not. If a person's safety is in jeopardy, hospitalization is sometimes considered to ensure the self-injurer's safety. If SI is severe or if there is evidence of other psychological

conditions (examples are borderline personality disorder, obsessive-compulsive disorder, depression, or anxiety), a physician may recommend hospitalization to stabilize the self-injurer and to conduct a thorough psychological assessment over several days or weeks. Otherwise, a person can usually be treated in the community without hospitalization.

5. Is SI a way to get attention?

Usually not. SI is often a secretive and private act rather than an attention getting act. Evidence of SI is usually hidden. It is helpful to view SI as a way to cope, not as a way to get attention.

6. How common is self-injury?

Among adolescents, research indicates that 4% to 14% of adolescents use SI as a coping mechanism. The variance in this reported prevalence is due to how SI is defined and the participants in the research study. For example, SI is more prevalent among adolescents hospitalized due to mental health issues than in adolescent community populations.

7. Is SI the same as suicide?

No, SI and suicide are very different. Suicidal individuals want to remove the emotional pain permanently. SI is a way to generate emotional relief so that the person can continue living. It is important that a skilled professional assesses the risk of suicide because some self-injuring individuals do attempt suicide. Safety considerations should be of the utmost concern and need to be evaluated prior to the onset of treatment.

8. Is SI an addictive behavior?

Yes, research indicates that it is. It is addictive from both a psychological and physiological perspective. Because SI provides instant emotional relief, an individual can become addicted to the relief the behavior offers. When an individual self-injures, research indicates that the

behavior releases naturally produced neurotransmitters (serotonin, dopamine, and opiods). These natural compounds are similar to those released with other addictive behaviors such as alcohol or drug misuse and can be equally addictive.

9. How can self-injurious behaviors be stopped?

An individual cannot be forced to stop SI. If this is attempted, the individual usually continues the behavior, but the individual becomes more secretive when self-injuring to avoid detection. It is recommended that a self-injurer not be forced to terminate SI without first developing other more healthful coping strategies. Trying to take away SI without treatment can be dangerous because the individual is losing a way of coping with stress without it being replaced with a better coping method. The longer the behavior has been used as a coping mechanism, the more difficult it is to terminate. Treating SI usually requires professional help (for example: physician, counsellor, therapist, mental health professionals).

10. Does a self-injuring person require medication?

There is no medication identified to treat SI; however, medication may be prescribed for other conditions that can occur at the same time. Some of these conditions are depression, anxiety, obsessive-compulsive disorder, and borderline personality disorder.

11. How long does treatment take?

The length of treatment depends on many variables. One of the most significant is the length of time for which an adolescent has self-injured. Although it is not always the case, the longer a person has been self-injuring, the longer the treatment required. Some other variables are the frequency of SI, and the presence of other mental health issues (such as disordered eating, borderline personality disorder, depression, and post traumatic distress).

12. How can I (we) get help for SI?

Safety must be the first consideration. If a self-injurer's safety is at risk (for example, the person requires wound care, has suicidal thoughts), the individual needs immediate medical care. This can be accessed in a hospital emergency room or doctor's office. Once safety is addressed, seeking mental health support should be considered. If the adolescent self-injurer is attending school, one place to start is with the school counsellor. Although school counsellors often do not have the time required for long-term treatment, they can refer a client to appropriate community resources. A school counsellor will offer support to the client and family and advocate for the youth's health and learning in the school system. A physician is also another starting point. If the adolescent has a social worker, this person can link an adolescent with an appropriate counsellor.

13. What should I (we) look for in a counsellor?

A counsellor/therapist working with adolescents who self-injure should have:

a) A great deal of experience working with adolescents,

b) An understanding of SI (for example: what SI is, the functions of SI, risk factors, assessment, and treatment approaches), and

c) Practical experience working with self-injuring clients.

14. What SI resources are available?

Ask the counsellor, medical professional, or agency providing support for recommended resources. There are self-help manuals, books for self-injurers, books for parents, and websites that can provide sound information. There is also inappropriate information available that can actually trigger SI, so it is important to assess reliable resources, especially when using the computer.

The following is a limited list of printed resources you can consider accessing. These books can be obtained from a bookstore or an on-line book supplier. If a book is not available in a bookstore, it can be ordered by the store. A list of on-line book suppliers can be generated by conducting a "Google" search using the book's title.

Alderman, T. (1997). ***The scarred soul: Understanding and ending self-inflicted violence.*** Oakland, CA: New Harbinger. ISBN:1-57224-079-2

Conterio, K., & Lader, W. (1998). ***Bodily Harm: The break through healing program for self-injurers.*** New York: Hyperion. No ISBN provided.

Haswell, D., & Graham, M. (2008). ***Overcoming self-abuse: Step by step to success* (5th ed.)**. Hamilton, Ontario, Canada: S.A.F.E. BC. No ISBN provided.

To access this resource, phone Mary Graham at 289-389-2337.

Hollander, M. (2008). ***Helping teens who cut: Understanding and ending self-injury***. New York: Guilford Press. ISBN: 978-1-59358-426-3

McVey-Nobel, M., Khemlani-Patel, S., & Neziroglu, F. (2006). ***When your child is cutting: A parent's guide to helping children overcome self-injury.*** Oakland, CA: New Harbinger. ISBN-13: 978-1-57224-437-5

Shapiro, L. (2008). ***Stopping the pain: A workbook for teens who cut and self-injure.*** Oakland, CA: New Harbinger. ISBN-13: 978-1-57224-602-7

Appendix H

What's Going On? – A Cognitive Behavioral Strategy

This is a cognitive behavioral strategy, which addresses faulty thinking and develops awareness of the link between behaviors, emotions, and thinking.

Purpose/Goals:

a) To bring attention to faulty thoughts and beliefs that lead to the adolescent client using SI as a coping strategy.

b) To establish a starting point for the confrontation of the client's faulty beliefs so these beliefs can be minimized.

c) To challenge the adolescent to change unrealistic, rigid, and automatic thoughts and beliefs by developing and reinforcing more healthful ones.

Materials:

"What's Going On?" worksheet, "Difficult/Unpleasant Feeling Words" reference sheet, Thoughts/Emotions/Behaviors sheet

Method:

1. Review the two-page document "What's Going On?" with the client so that he/she understands how to complete the "assignment". Encourage the client to expand on the feelings section to get a broader array of emotions than adolescents will typically report; encourage "richness" (more than one word answers) in their responses. You may want to provide a copy of the "Difficult/Unpleasant Feeling Words" reference sheet to help the client identify feelings. Giving this as a homework assignment works well if the client agrees and if you are certain the client is not likely to self-injure because of completing the form outside the counselling office. It is suggested, however, that you avoid using the word "assignment"

with the client because many adolescents have academic and school issues and automatic negative thoughts can be generated when school-oriented words are used.

2. When the client returns to the next session, review the information recorded by the client.

3. Refer to the Thoughts/Emotions/Behaviors triangle with the client. Summarize the recorded information by clustering the information the appropriate aspects of the triangle. It is now possible to view the interconnections between the trigger, thoughts, emotions and behaviors. The arrows used to build the triangle graphically illustrate this point. If one aspect of the triangle is impacted, the other aspects will also change.

4. Explain to the client that in future counselling sessions ways to change faulty thoughts and beliefs will be explored in order to help change other parts of the triangle.

5. Typically, at this point faulty thoughts and beliefs begin to surface. The insight generated by this activity can provide direction so that the client and therapist can work collaboratively to replace distorted thoughts with ones that are healthful so that emotions and behaviors become more healthful as well.

What is going on? – A Cognitive Behavior SI Strategy

Choose a time when you turned to SI as a way to get through a challenging situation.

What was the "trigger"? _____

Behavior – Provide detail of the event: where were you, who was with you, what time was it, how did you self-injure, how long did the self-injuring episode last, what were the positive and negative consequences of the behavior?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thoughts – What were you thinking just prior to the behavior? What were the thoughts that led you to SI? It might help to start with "I was thinking that . . ."

_____

Feelings – What negative feelings were you experiencing just prior to injuring yourself? Use feeling words and describe your feelings as much as possible. How strong were the feelings you had? You may want to refer to the attached feelings word list. There are many more feelings than those listed, but they might help you get started. Try to identify your feelings with words other than afraid, angry or sad.

Difficult/Unpleasant Feeling Words:

Terrified	Anxious	Hateful
Frustrated	Scared	Sore
Disappointed	Nervous	Enraged
Depressed	Worried	Resentful
Embarrassed	Threatened	Unsure
Numb	Tortured	Disillusioned
Tense	Desperate	Dominated
Alone	Victimized	Incapable
Rejected	Heartbroken	Vulnerable
Ignored	Humiliated	Hopeless
Betrayed	Alienated	Terrified
Overwhelmed	Unhappy	Alienated
Ashamed	Offended	Grief
Guilty	Panic	Pessimistic
Disgusting	Frightened	Hateful
Powerless	Worried	Shy
Lost	Pained	Pathetic
Inadequate	Distant	Edgy
Tired	Uncertain	Unsupported
Inferior	Lost	Wronged
Bored	Useless	Injured
Lifeless	Empty	Tormented

Trigger: