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Legal and Ethical Issues in the Treatment of Self-Injurious Behavior: *Risk Management Considerations for Professional Counselors*

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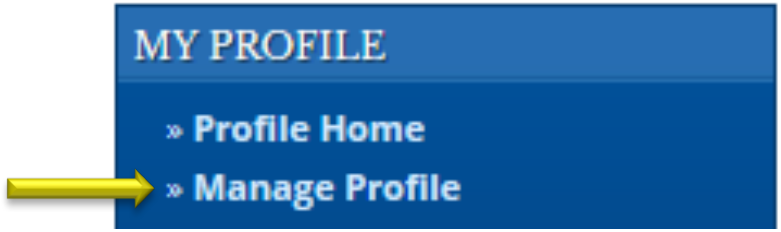

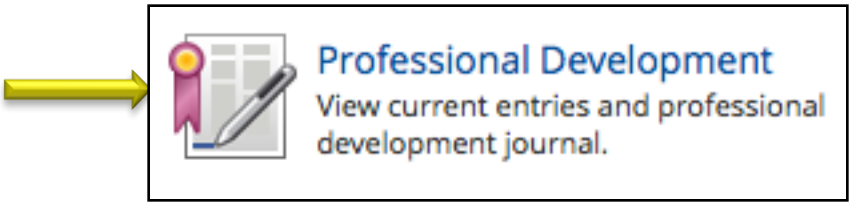

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Presentation Objectives

- Discuss potential client motivations for engaging in self-injurious behavior
- Review potential legal and ethical considerations in working with clients who self-injure
- Discuss strategies for minimizing risk when working with clients who self-injure.

WHAT IS SELF-INJURY?

Poll Question #1

- True/False: I have worked with a client who engaged in self-injurious behavior

What is Self-Injury?

- Self injury is defined as "**a volitional act** to harm one's own body **without intention to cause death**." (Yaryura-Tobtas, Nezirogula, & Kaplan, 1995).
- Self injury is "an **act that is done to oneself**, **performed by oneself**, physically violent, **not suicidal**, and intentional and purposeful." (Alderman, 1997).
- Acts of self-injury are discrete, intentional acts of harm.

What is Self-Injury?

- **Examples of SI include:**
  - self-cutting
  - self-burning
  - self-hitting
  - self-scratching
  - interference with wound healing.
- **Typical Injury Sites Include:**
  - the arms and wrists
  - legs
  - abdomen
  - head / neck
  - chest or genitals

Statistics

- Peak incidence occurs from 14 to 25 yeas of age (Diclemente et al., 1991; Herpertz, 1995; Pattison & Kahan, 1983;).
- 60% report they do not feel any pain during acts of self-mutilation such as cutting and burning (Bohus et al., 2000).
- Co-morbidity – self-mutilation occurs in 70 to 80% of clients who meet the DSM criteria for Borderline Personality Disorder. (Bohus et al., 2000).

Poll Question #2

- True/False: Everyone who engages in self-injury has Borderline Personality Disorder

Prevalence Estimates

- About 1% to 4% percent of the general population *(Briere & Gil, 1998).*
- About 21% of hospitalized adult inpatients *(Briere & Gil, 1998).*
- 40-60% of patients in adolescent inpatient settings *(Darche, 1990; DiClemente et al, 1991).*
- 13% of the general population of adolescents *(Ross & Heath, 2002).*

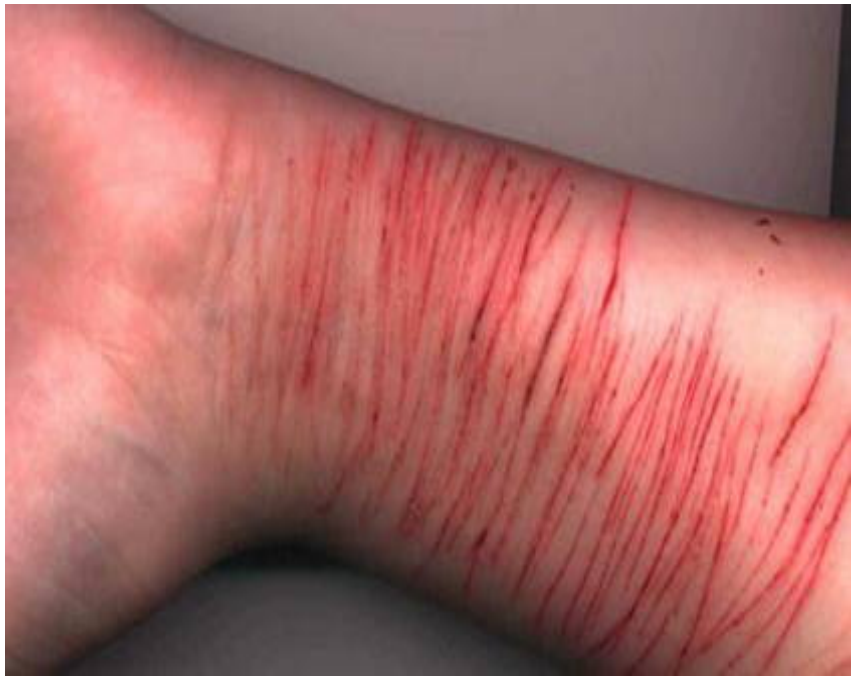
Note: It can be difficult to accurately assess the prevalence of self-injury as some episodes of SI, especially those that result in medical attention, may be incorrectly identified as a suicide attempt.

TRIGGER WARNING:
SEVERAL OF THE FOLLOWING SLIDES CONTAIN GRAPHIC IMAGES OF SELF-INJURY.

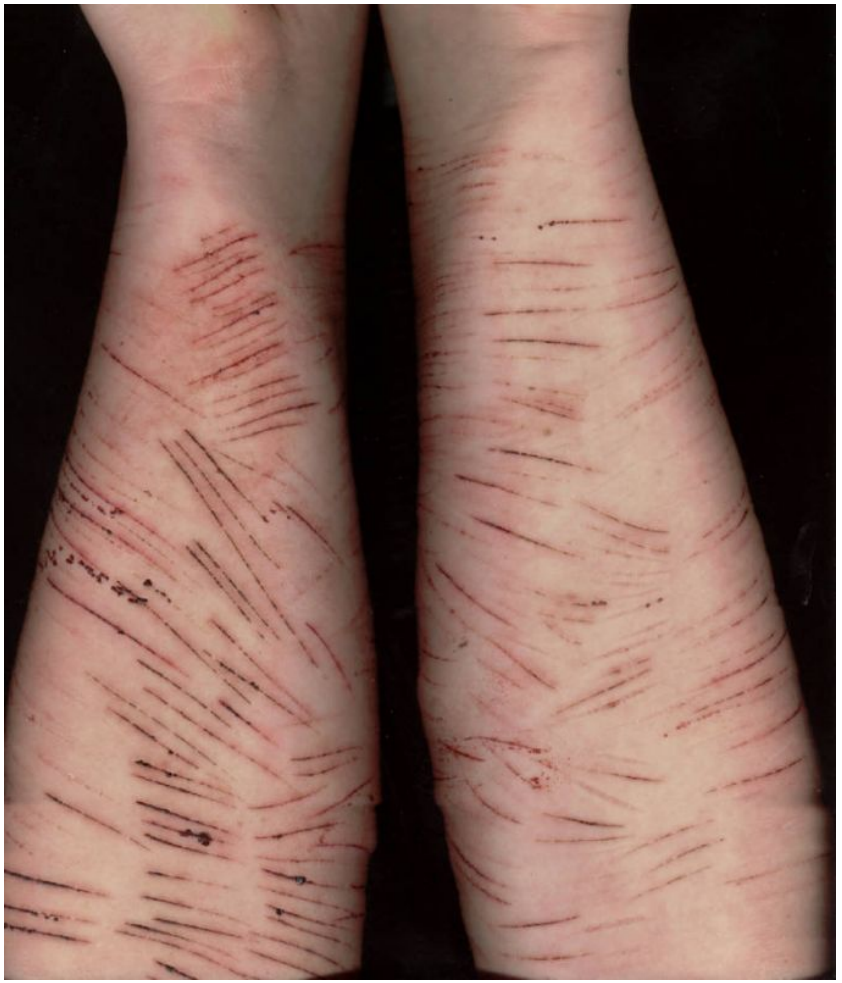
ALL IMAGES HAVE BEEN OBTAINED VIA THE INTERNET AND DO NOT REPRESENT ANY CURRENT OR FORMER CLIENTS OF THE PRESENTER.

Examples of Self-Injury

Superficial, highly repetitive cutting



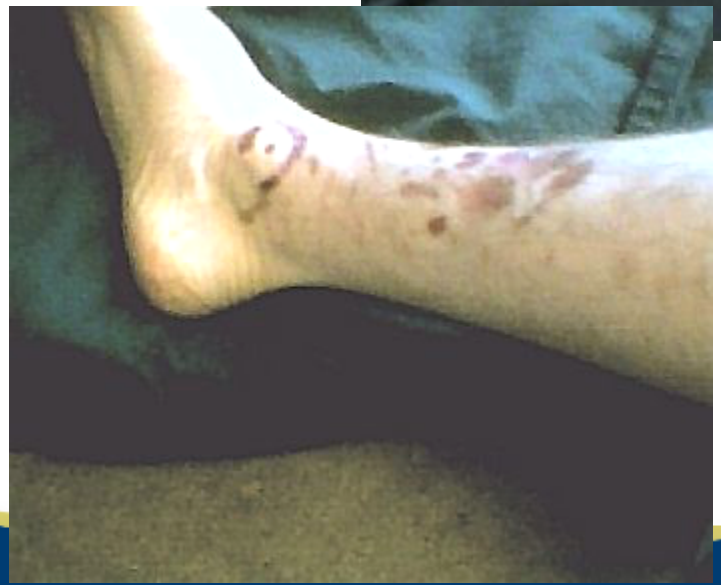
Often comorbid with OCD and/or eating disorders



Examples of Self-Injury

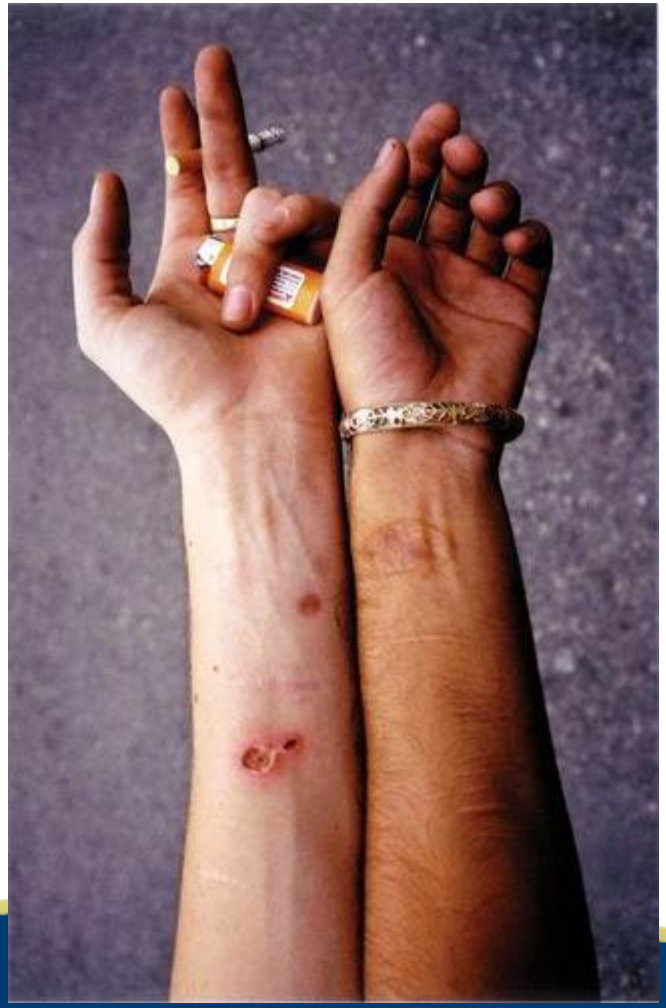
Significant tissue damage

Word carving; especially common among teens



Skin burning

Examples of Self – Injury

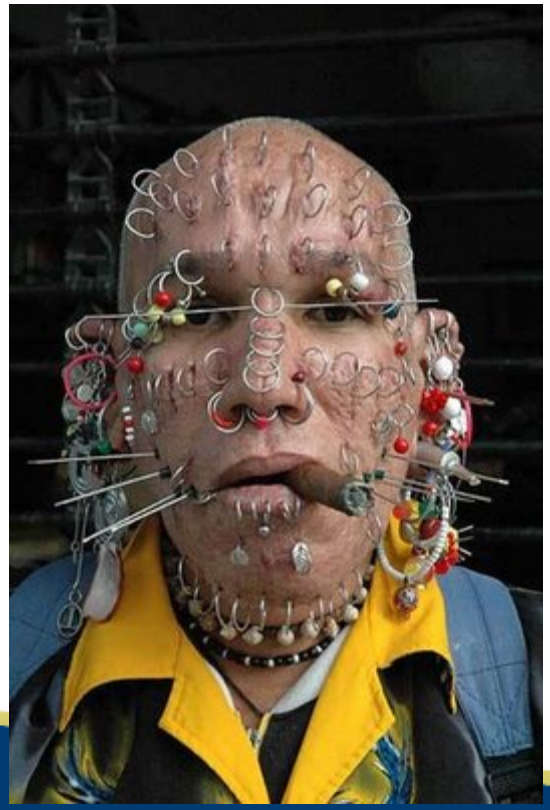


Poll Question #3

- True/False Body Modification (e.g., tattoos, piercings) are a form of self-injury

Not Self-Injury

Body modification is not considered to be a form of self-injury



Reasons Associated with Self-Injurious Behavior

- Automatic Negative Reinforcement: Engaging in SI to remove some unpleasant emotion or sensation.
- Automatic Positive Reinforcement: Engaging in SI to bring about a pleasant or desirable emotion or sensation.
- Social Negative Reinforcement: Engaging in SI to escape or avoid undesirable consequences.
- Social Positive Reinforcement: Engaging in SI to achieve a desirable event or response.

(Nock & Prinstein, 2004)

Poll Question #4

- True/False: Individuals most often engage in self-injury for reasons associated with automatic reinforcement.

Predictors of SI

1. History of sexual abuse*
2. Family violence/physical or marital abuse*
3. Sexual assault/rape
4. Physical illness/surgery at a young age
5. Perfectionism
6. Eating disorders
7. Dissatisfaction with the body
8. Loss of a parent/recent loss
9. Familial self injury
10. Peer conflict and intimacy problems
11. Impulse control problems
12. Parental alcoholism or depression
13. Anxiety and depression

* = *best predictors* *(Briere & Gil, 1998; Favazza & Rosenthal, 1993; Walsh & Rosen, 1988)*

RISK MANAGEMENT

Risk Management Considerations

- Self-Injury is often comorbid with mental health diagnoses (e.g., depression, anxiety, borderline personality disorder) and suicidal ideation (Andover et al., 2005; Hawton et al., 2002).
- Comprehensive assessment of SIB is an important consideration for counselors who work with this population (Hoffman & Kress, 2010).

Risk Management Considerations

- Clients who engage in SIB often have many complex issues which may increase their overall associated risk.

- Clients who engage in SIB may present with a developmental and personal contexts that can contribute to the emergence and maintenance of the behavior (Klonsky & Muehlenkamp, 2006).

Risk Management Considerations

- The possible health risk associated with SIB can contribute to counselors feeling overwhelmed when working with this population (Dieter & Pearlman, 1998).

- One of the most complex risk management issues is that clients who engage in SIB may not view the behavior as problematic and may not want to stop (Kress & Hoffman, 2008).

- Clients who present with severe SIB or those who use SIB to cope with dissociation and trauma-related recall may build up a tolerance to the pain associated with SIB (Matsumoto et al., 2005). Those who develop a tolerance to the pain may engage in more damaging SIB in order to achieved the same effects.

Poll Question #5

- True/False: Assessment of self-injury is usually an ongoing process.

On-Going Risk Assessment of SIB and Suicide

Risk assessment should be on-going

- Risk levels may change over time
- Contributing factors may not be fully understood or addressed during initial assessment
- On-going risk assessment should be integrated into the intervention plan

Risk Assessment and SIB

Risk is Higher if:

- There is a past history of suicide attempts or ideation
- Co-occurring mental health considerations, severe trauma or abuse, substance abuse or significant eating disorder
- The frequency/intensity of SIB is high
- The client is between the ages of 13-19.

Risk is Lower if:

- No expressed suicidal ideation
- No co-occurring mental health issues or mental health issues currently stabilized
- SI is of a mild or superficial nature

Risk Assessment and Evaluation Considerations

Evaluation and Risk Assessment of SIB (Hoffman & Kress, 2010)

- **Severity of Physical Injury**
  - Be aware of scope of practice (i.e., medical evaluation is outside the scope of practice of counseling professionals)
  - Obtain consent to speak with client's GP.
  - Ensure that client is aware of potential risks associated with SIB (e.g., staph, MRSA)
- **Sharing of Cutting Implements**
  - Have clients ever shared cutting implements?
  - Clients should be informed of risk of sharing cutting implements.
  - Counselor should thoroughly document that such a discussion took place with a client.

Risk Assessment and Evaluation Considerations *(continued)*

- **Development and Course of the SIB**
  - Counselors must understand the etiology of SIB: when it began; whether the client has ever abstained from the behavior; and the current frequency of the behavior.
  - Does the client engage in appropriate wound care after an episode of SIB?
  - Has the client ever experienced any medical complications (e.g., stitches, infections, surgery) as result of the SIB?
  - Types of tools used to self injure
  - Efforts to abstain from SIB; ability to control impulse to engage in behavior.

Risk Assessment and Evaluation Considerations *(continued)*

- **Do Family or Friends Know about the Self-Injury?**
  - Evans et al. (2004) found that only 20% of teens reported that they disclosed their SIB to family or friends.
  - If others are aware of the SIB, the counselor should determine how they found out about the behavior (e.g., the client told them, a parent discovered the wounds).
- **Presence of Other High Risk Behaviors**
  - SIB in teens is associated with being sexually active, using condoms inconsistently, and sharing cutting implements.
  - Teens who engage in SIB are also more likely to use drugs, alcohol, and tobacco.

General Risk Assessment Suggestions

- Risk assessments should include consideration not only for the severity of the SIB but also for the client's current level of impulsivity and past history of impulsive behavior.

- Counselors must recognize that risk assessment is an on-going process, and changes in life situation can elevate risk, at which point the risk of suicide should be assessed more frequently (Hoffman & Kress, 2010).

Legal Considerations SIB and Suicide

- The law does not address the duty to protect clients who engage in SIB as directly as it does suicidal behaviors (Vesper, 1996; Walsh, 2008).

- Safety issues related to suicide should be addressed, and a suicide assessment completed, particularly on clients who regularly engage in SIB (Muehelnkamp & Kerr, 2010).

Adolescent Considerations: SIB and Suicide

- Counselors who work with adolescents must consider clients' confidentiality rights while simultaneously appreciating the right of parents to be apprised of their children's clinically-relevant developments (Hoffman & Kress, 2010).
- Counselors likely have a responsibility to notify adolescents' parents of the SIB even when SIB might not pose an imminent risk to the client (Kress et al., 2006).
- Judicial decisions have historically protected parental rights related to accessing information about their children (Isaacs & Stone, 1999).

Adolescent Considerations: SIB and Suicide

- Private information should be shared in a way that empowers the client. Involving the adolescent in the disclosure process will likely lead to better treatment outcomes.

- Providing the SIB is not life-threatening and does not need immediate intervention, when approaching the topic of disclosing SIB to parents, counselors should work with the adolescent to draft a plan for disclosure (Hoffman & Kress, 2010).

- From a treatment perspective, informing parents of the client's SIB can lead to increased family counseling, which is an important component of comprehensive treatment plan to address SIB (Trepal et al., 2006).

LEGAL AND ETHICAL CONSIDERATIONS IN THE TREATMENT OF SIB

General Ethical and Legal Considerations in the Treatment of SIB

- Client Welfare
  - Respecting client's dignity & promoting client's well being
- Countertransference
  - Counselor reactions to clients
- Counselor Competence
  - Practicing within professional boundaries
  - Recognize limits of competence
- Informed Consent
  - Clients' ability to participate in treatment decisions

Client Welfare

- Primary responsibility of counselors is to respect the dignity and to promote the welfare of clients (ACA, 2014, A.1.a, Standard A.1; Welfel, 2002)

- Autonomy: freedom and dignity;
  - Clients make own decisions related to personal welfare
  - Clients assist in establishing treatment decisions & goals

- Nonmaleficence: "do no harm" principle;
  - Self-injury may prevent suicide by serving as a coping strategy
  - Counselors can do harm by personal attempts to keep clients safe; therefore, attempts to control clients should be avoided

Client Welfare

- Counselors must balance principles of autonomy and nonmaleficence in decisions about client's treatment
- Counselors must determine if passive action & respecting client's treatment decisions *(i.e., autonomy)* could cause significant harm to client *(i.e., nonmaleficence)*
  - **If a client does not want to stop self-injuring, is this okay? When would it not be okay?**
- When harm outweighs autonomy, appropriate actions must be taken

Countertransference/ Counselor Reactions

- According to Favazza (1998), " the treatment literature on self-injury is basically one of countertransference" (p. 265).
- Countertransference is defined as *incompletely recognized reactions towards a client*
- Client SIB can be very activating and frightening - counselors may pursue their personal agendas as opposed to client generated goals.
- The issue of countertransference is one of the most critical client-welfare related considerations when working with SIB.

Countertransference/ Counselor Reactions

- Counselors are ethically obligated to manage and monitor their personal reactions and to avoid actions that seek to meet their personal needs at the expense of clients' needs (ACA, 2014, standard A.5; AMHCA, 2010, standard A.1.a)

- Research (e.g., Deiter & Perlman, 1998; White et al., 2003) has underscored the impact of negative counselor attitudes on the treatment process.

- Extreme reactions to SIB will likely limit the counselor's ability to maintain a therapeutic relationship with the client (Connors, 2000) and may affect the client's views on mental health treatment in general.

Common Counselor Reactions to SIB

- Horror
- Helplessness
- Frustration
- Anger
- Disgust
- Sadness
- Countertransference

Reactions may interfere with ability to make treatment decisions and ability to be helpful and ethical

Countertransference and SIB

- One potential response to SIB is an attempt to *contract for safety*. In other words, clients are told that they need to stop self-injuring.

- A no-harm contract typically contains a statement where a client agrees to abstain from self harm for a specified period of time. The no-harm contract generally also contains contingency plans if the client feels the urge to engage in SIB and includes terms of the counselor and client relationship (Hyldahl & Richardson, 2010).

Countertransference and SIB

- **No-Harm Contracts**
  - Benefits
    - May symbolize the counselor's concern for the client's well-being (Range et al., 2002).
    - The no-harm contract emphasizes the common goal of treatment for counselor and client (Lee & Bartlett, 2005).
  - Limitations
    - There is no evidence that the use of the No-Harm contract will reduce client SIB or minimize potential counselor liability (Walsh, 2006).
    - The use of the no-harm contract might inadvertently lead the client to believe that the counselor is only concerned with protecting him/herself against legal action (Range et al., 2002)
    - The no-harm contract might inadvertently silence the client; they may feel discouraged, embarrassed, or ashamed if they do break the contract, and thus may not disclose when they do engage in SIB (Lee & Bartlett, 2005).

Counselor Competence and Risk

- Counselors are to practice within boundaries of competence, determined on basis of education, training and experience (ACA, 2014, Standard C.2.a)

- Clients who engage in SIB require skilled counselors who are educated about the etiology & functions of self-injury, as well as appropriate interventions

Achieving and Maintaining Competence

- Attaining Competence
  - Education / Graduate Training
  - Credentialing / Licensure
- Maintaining Competence
  - Continuing Education
  - Seeking Supervision / Consultation

Considerations Related to Competence and Risk

- Consider severity of current & potential medical complications secondary to SIB & know limits of competence, particularly related to medical information
  - e.g., Risks of sharing razor blades in order to prevent transmission of disease (Dallam, 1997)

- Make referrals & consult when necessary
  - Counselors must demonstrate competency in self-injury, or to refer clients to counselors who are competent to work with this population (White et al., 2003)

Supervisor/Educator Competence Considerations

- Education on the topic of self-injury has been suggested as a means of promoting effective clinical practice (Zila & Kiselica, 2001). Supervisees providing service to those who self-injure require not only patience, but knowledge and skill. If a supervisee has not had adequate preparation and training he/she may feel overwhelmed when confronted with a client who self-injures. Researchers have suggested that systematic training related to self-injury can clear misconceptions and help prevent the stigma often associated with self-injury (White et al., 2002).

49

Supervisor/Educator Ethical / Legal Considerations:

- If there is concern that the client has infections or is engaging in self-injury of a severe and chronic nature, the client should immediately be referred to a physician for a medical assessment.

- Is the counselor competent to counsel the client?

- Are you competent to supervise the counselors work on this issue? If not, is there consultation available?

50

Supervisor/Educator Ethical / Legal Considerations:

- Supervisors have the responsibility to monitor both the well-being of the client, as well as the development and performance of the supervisee.
- Supervisors must be cognizant of both the session content, and the supervisee's responses to the client.
- Supervisors need to be aware of potential liability concerns (i.e., direct liability and vicarious liability)

51

Informed Consent

- Counselors must obtain informed consent from clients regarding goals, techniques and potential risks & benefits involved in the counseling process (ACA, 2014, Standard B.1)

- Confidential information should only be disclosed when in best interest of client (Welfel, 2002)

- So that there are no miscommunications, counselors should be exceptionally clear in providing informed consent related to duty to protect clients

Informed Consent, SIB, & Suicide

- Counselors have a legal & ethical duty to protect clients from acting on suicidal intentions
- SIB should ONLY be thought of as suicidal if client indicates intent to die (Favazza, 2001)
- Always assess risk of suicide, but clients who self-injure generally need NOT be considered suicidal unless they express intent to die (Simeon & Favazza, 2001)
- Again, be very clear when providing informed consent

Ethics & Social Media

- **A study of online SI message boards found:**
  - The most frequent type of exchange was provision of informal support (28.3% of all posts)
  - Individuals also frequently discussed triggers for self-injury (19.5% of all posts).
  - Concealment of self-injury and its effects accounted for 9.1% of all posts
  - The addictive quality of self-injury accounted for 8.9% of posts.
  - Discussion of formal help seeking occurred in 7.1% of all posts and attitudes towards and experiences with treatment were largely positive.
  - Sharing details about self-injury techniques accounted for 6.2% of all posts and were very graphic.

Whitlock, Powers,& Eckenrode (2006)

Ethics & Social Media

- Number of Instagram Posts Associated with SI (December, 2016)
  - #selfharmmm = 1,666,253
  - #selfinjury = 563, 987
  - #cutter = 196, 098
  - #cutterslife = 4,241

Trigger Warning:
Several of the following slides contain graphic images of self-injury.

AT&T LTE 5:31 PM 58%

TOP POSTS
#SELFHARMMM

juxt_let_me_die_ 1d

318 likes

juxt_let_me_die_ Old.. I fucking miss this amount of blood 😩 I was feeling pretty good today, but now I'm low as fuck.. And I did like 2 hours of homework -.- I'm so tired..

#blood #ventaccount #triggerwarning #depression #depressed #death #sadness #suicide #suicidal #selfharmmm

AT&T LTE 5:35 PM 57%

MOST RECENT
#SELFINJURY

ethereal_fragile_angel 5h

amaliazaimis, moddexpupeh23, brokengirl007, mateus321.mc, wewep50, elconde73, alive_guide, iina.xx, lifesuckswithoutfood

ethereal_fragile_angel Looks like my legs right now. #depressed #depression #suicide #suicidal #selfharm #selfinjury #selfhate #selfloathing #anxiety #anxious #panicdisorder #panicdisorders #ptsd #icantdothisanymore #icantdothis #igiveup #fuckedup #pathetic #useless #worthless #scarred

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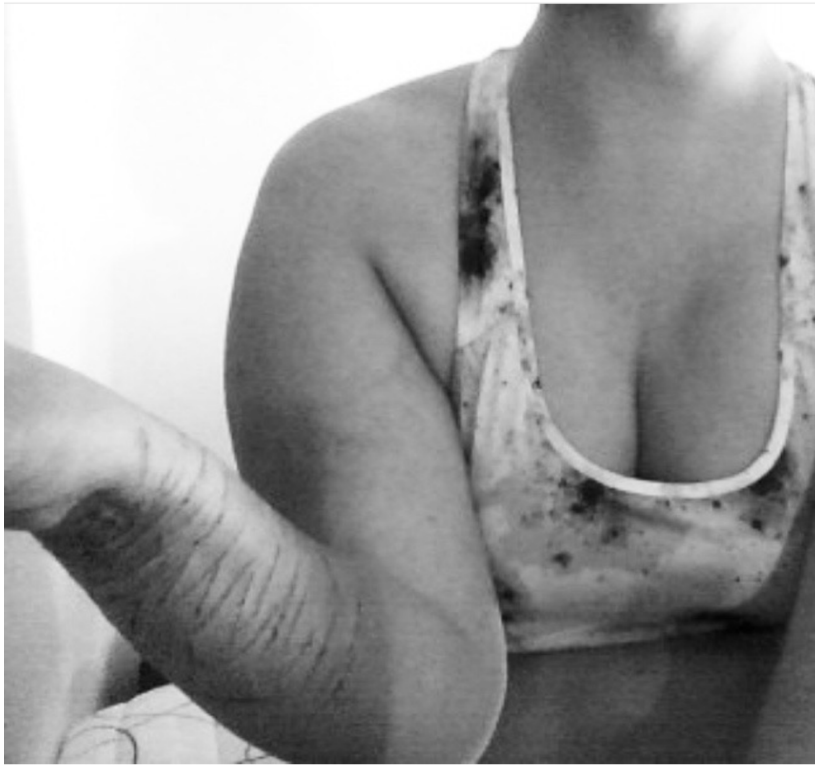
MOST RECENT
#SELFINJURY

deathscutepoison 6h



thebadshit, siegegroup, emxpty, kittiesncake, wonderrr_land_, iina.xx, suicdalboy, xitzjacob, mystiibear

deathscutepoison #scars #cuttter #cutting #depressed #depression #blithe #anxiety #selfharming #selfhate #selfinjury #weak #pain #numb #pills

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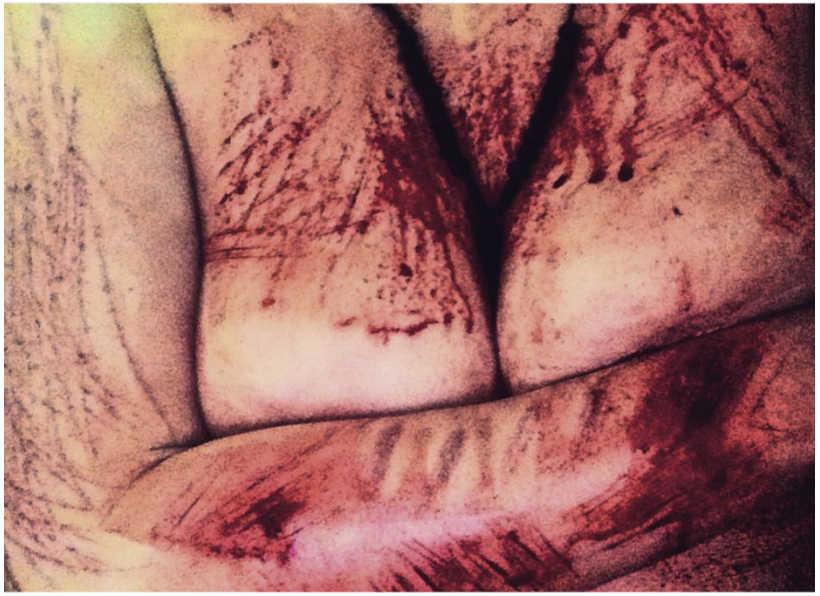
MOST RECENT
#SELFINJURY

peaceofmindinevergot 10h



79 likes

peaceofmindinevergot Old. Well, yesterday's old anyway. Still pulling fucking shards of ceramic out. #selfharm #selfinjury

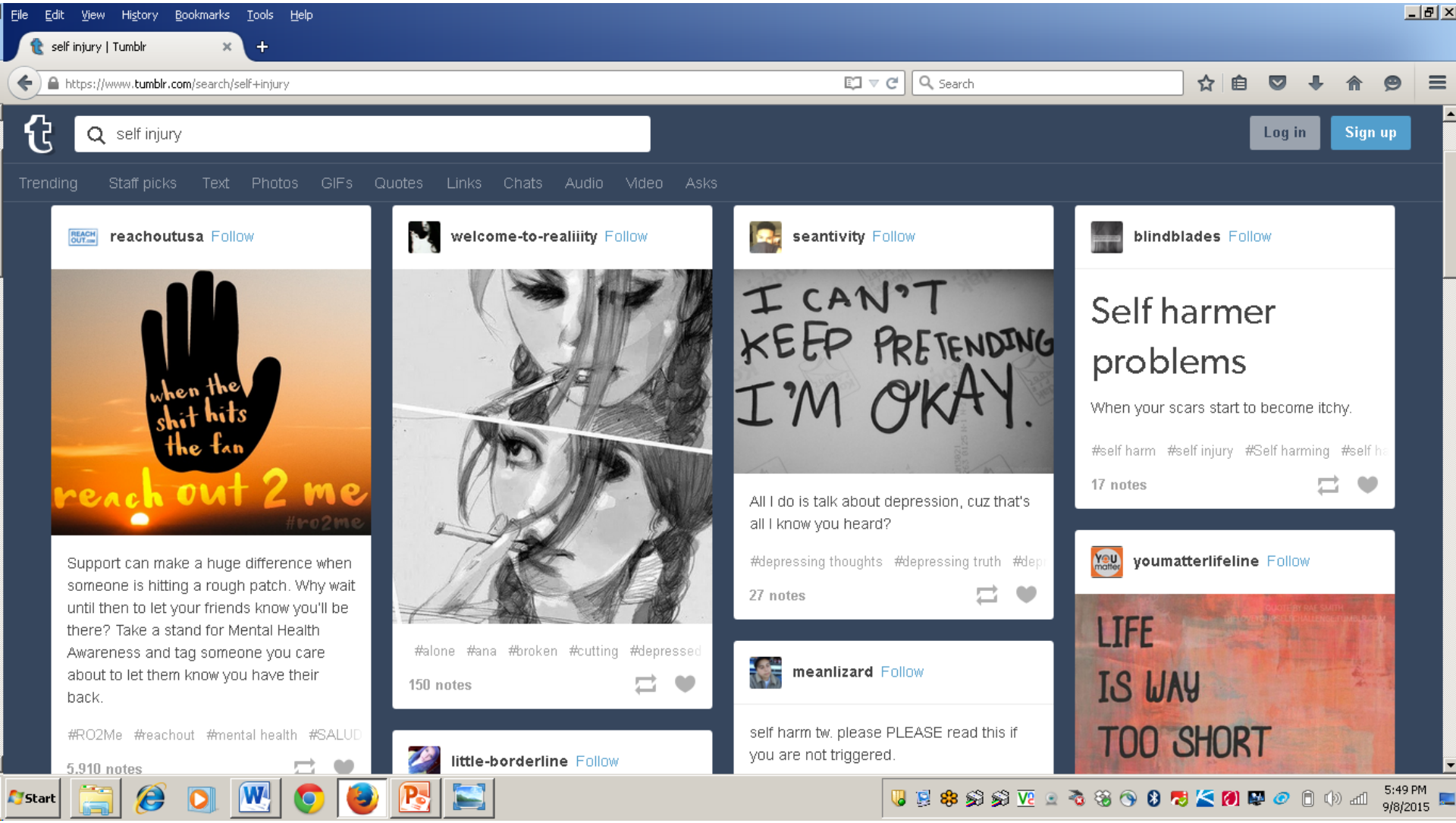
View all 13 comments

weebgasm what the fuck are you doing

live.love.eatcandyy What the fuck is this??

autistic__memes Lol this is hilarious

Self-Injury on Tumblr



Poll Question #6

- True/False: It's okay to Google clients

Ethics & Social Media

ACA (2014) *Code of Ethics* Section H: Distance Counseling, Technology, and Social Media

H.6.c. Client Virtual Presence:

- Counselors respect the privacy of their clients' presence on social media unless given consent to view such information.
- DO NOT GOOGLE YOUR CLIENTS without advanced permission
  - Violation of privacy and could cause harm to the client

Summary & Recommendations

- Clients who present for counseling may not want to cease SIB, and due to variety of factors including wavering readiness & motivations, most clients who take action to modify such behaviors don't successfully maintain gains on their first attempts
- Approaching clients with element of curiosity and recognizing they may not be ready to or want to stop injuring may prove helpful in facilitating open conversation related to SIB, and may be more effective and ethical
- To prematurely assume client is ready to stop self-injuring may result in client's hasty termination of counseling or resistance to proposed treatment plan as evidenced by not following through
- A lack of understanding regarding SI has hindered appropriate treatment of SI
- 75% of those who self-injure feel they are a burden to others (Favazza & Conterio, 1989), pointing to the value of a empowering approach (MI & TTM)

Questions?

Contact Dr. O'Neill
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on Facebook: @mentalhealthconsult

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