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Understanding Nonsuicidal Self-Injury

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Introduction

The paper will address self-injury in its historical and cultural concept. The nature, prevalence and demographics of the behavior will be discussed, followed by common etiological models of nonsuicidal self-injury. Special consideration will be given to nonclinical populations that self-injure such as adolescents and young adults.

Next, assessment questions and considerations will be explored. Finally, treatment options and clinical recommendations for working with nonsuicidal self-injury in its various presentations will be discussed.

Learning Objectives

- 1) Understand the history and nature of self-injury, and its differentiation to suicide.
- 2) Learn the most common etiological models of self-injury, its prevalence and demographics.
- 3) Learn the most common treatment models and treatment considerations for clinical practice.

History, Culture and Self-Injurious Behaviors

Self-injury is not a new phenomenon. Throughout history humans have inflicted pain, suffering and physical discomfort

upon themselves for aesthetic purposes, as well as for religious reasons in order to feel part of some cosmic order (Hewitt, 1997).

Favazza (1996) states that self-injury "is not alien to the human condition; rather it is culturally and psychologically embedded in the profound, elemental experiences of healing religion and social amity" (p.191). Favazza argues that the body has been central in many religions. The most obvious examples are that of Christ who, according to Christian beliefs, allowed his body to be altered through crucifixion, and Siva, the Indian god, who according to Hindu beliefs castrated himself.

Another very vivid example is that of Hamadsha, a healing Muslim brotherhood group in Morocco. Their rituals include drinking boiling water and slashing their heads with razors and knives during ecstatic rites. The blood produced from such rituals gets smeared on patients to drink and be healed (Crapanzano, 1973).

Blood customs have also been very common throughout history with various sociocultural meanings. With reference to North American native mysticism, Favazza (1996) cites the gazing of the sun ceremony where incisions were made on people's backs and pieces of wood inserted under the cut muscles. The warriors who could tolerate the pain until it ended were thought to have a vision that gave meaning to their lives. Another example is that of male nose bleeding that purportedly protects against illness. The function of such practices such as penis cutting, foot-binding, and scarification has historically been to prevent social disorder by clearly defining status as well as proper comportment between the sexes and between generations. For some

cultures, self-mutilative and cannibalistic mortuary practices foster group solidarity and ensure the passing on of desirable traits and ritual powers (Favazza, 1996)

The practice of body alteration often indicates spiritual status and "simultaneously exposes inner qualities and mystical truths" (Hewitt, 1997, p.11). Alterations of the body and pain have also been ritualized to mark important features of different societies such as passage into adulthood. Circumcision is a means of introducing infant males to Jewish culture and society. Morris (1991) writes, "[A]lmost every culture includes rites and ordeals of initiation that work the passage into adulthood; and pain constitutes one of the most important features of these varied rites" (p.180).

Finally, self-injury has been observed in different civilizations in various other forms such as theatre, art and major manuscripts. The theme of body alteration has appeared in major literary works such as the Bible. "If your hand is your undoing, cut it off; it is better for you to enter into life maimed than to keep both hands and go to hell into unquenchable fire" (Mark 9:43 New American Standard). Favazza (1996) refers to Sophocles' tragedy Oedipus Rex, where Oedipus blinds himself to show his guilt and remorse over marrying his mother.

Definition, Methods, and Demographics of Nonsuicidal Self-Injury

Definition

Inconsistent terminology and lack of publications until the 1980's have made it very

difficult to classify and understand nonsuicidal self-injury or to contrast it to suicidal acts. The impact of this inconsistency and how it has shaped treatment models has resulted in self-injury often being treated as a suicide attempt (Shaw, 2002). However, consensus among researchers, academics and clinicians allowed nonsuicidal self-injury to be recognized as a distinct phenomenon (Muehlenkamp, 2005). A widely-accepted definition is that nonsuicidal self-injury refers to purposeful, non-life threatening injuries that are self-inflicted and aim to alleviate emotional distress but have no suicidal intent (Alderman, 1997; Jacobson, & Gould, 2007; Kokaliari, & Berzoff, 2008 in press; Muehlenkamp, 2005; Walsh, 2006; Whitlock, Eckenrode & Silverman, 2006).

Classification and Methods of Nonsuicidal Self-injurious Behaviors

Favazza (1996) has offered a widely-accepted classification of self-injurious behaviors. He distinguishes three categories based on the degree that the tissue has been damaged, and the rate and pattern of the behavior. The first category, major, refers to rare but severe incidents of self-injury often known as self mutilation such as eye enucleation and genital mutilation, directly related to psychotic disorders. The second category, stereotypic, refers to acts such as head banging, self-hitting, and self-biting, commonly observed in developmental disorders. These behaviors tend to be repetitive and rhythmic. Favazza's third category is superficial/moderate. It refers to acts such as skin cutting, burning, scratching, and trichotillomania. This final category of self-injurious behaviors is thought to be the most common form and it the focus of this paper.

The most common types of self-injurious behaviors engaged in are: cutting, burning, scratching, interfering with healing of wounds, biting, self-hitting, and breaking one's bones (Alderman, 1997; Andover, Pepper, & Gibb, 2007; Muehlenkamp, 2005; Walsh, 2006). Among these behaviors, cutting might be the most common way that people injure their own bodies. Most often, it is accomplished with the use of razors, blades, or pieces of glass. Burning is the second most common type of self-inju-

ry. Methods to inflict a burn vary, including such things as cigarettes, lighters, or heated objects (Alderman, 1997). A former female patient once said "[U]sually I hold a hanger against the light until it is heated and then I press it against my arms or legs. There is no way you can stop me. I can find so many ways to do it."

Cutting may be the most commonly recognized form of self-injury because of its intense nature. Most individuals cut themselves on arms, wrists, and legs, but others cut on the face, neck, breast and genitals (Alderman, 1997; Sutton, 1999; Walsh, 2006). Feldman (1988) commented that people tend to use their arms since they are more accessible and because arms can either be hidden easily or exposed. However scratching to the point of bleeding and interfering with healing of wounds may be even more common but not recognized as self-injury (Jacobson & Gould, 2007; Kokaliari, 2005). In addition, most individuals use more than one method to self-injure (Walsh, 2006), which may speak to the level of psychological distress that they experience.

Tattooing, extensive piercing and cosmetic surgery have also been discussed as forms of passive or indirect ways to self-injure (Connors, 2000; Farber, 2000). It is unclear which forms are performed as socially accepted ways of inflicting pain to the body. For example, a patient in the process of trying to give up cutting presented in therapy with a new small tattoo on her ankle. She reported that the week had been particularly difficult. "I really wanted to feel some pain, but I did not want more scars, so I went and had a tattoo. It is really hard not to self-injure." Although the relationship is unclear literature indicates that individuals who get tattooed could also be classified as more adventurous and more likely to take risks (Drews, Allison & Probst, 2000).

Prevalence

Much of the literature discusses self-injury in relation to severe psychiatric conditions (Deiter, Nicholls, & Pearlman, 2000). Faulconer and House (2001) argue that rates of self-injury for adult psychiatric inpatient units vary from 4.3% to 20% while rates double among adolescent inpatient populations (Hurry, 2000). Self-injury has also been described as an institu-

tional phenomenon that has been observed in settings like prisons (Favazza, 1992; Feldman, 1988). It has been argued that 50% of prisoners exhibit self-injurious behavior while only 10% pose a suicidal risk (Holley & Arbededaflorez, 1988 in Haines, Williams, Brain & Wilson, 1995). Self-injury has also been highly linked to eating disorders, and especially to bulimic disorders (Casper, Eckert, Halmi, Goldberg, & Davis, 1980; Favarro & Santonastaso, 1998) with rates that can be as high as 50% (Muehlenkamp, 2005).

Self-injury, however, has become a common problem, having burst onto the cultural scene in very much the same way that eating disorders emerged three decades ago (Farber, 2000). These behaviors have also been on the rise among adolescents and young adults in the general population (Conterio & Lader, 1998).

Estimates of self-injury in the general population vary between 750-1,600 per 100,000 (Favazza, 1996; Favazza & Conterio 1988). Strong (1998) argues that approximately eight million Americans may currently be self-injuring.

More specifically non suicidal self-injury has become a common phenomenon in schools and colleges, with rates identified between 16%-38% (Alexander, 1999; Conterio & Lader, 1998; Gratz, Conrad & Roemer, 2002; Gratz, 2006; Hawton & Rodham, 2006; Kokaliari, 2005; Ross & Heath, 2002; Shaw, 2002; Turp, 1999; Walsh, 2006; Whitlock, Powers, & Eckenrode, 2006). For example, Gratz, et al. (2002) reported that 38% of the students in a random sample had self-injured at least once, while 18% had self injured multiple times. Whitlock et al. (2006a) reported that 17% of the sample from elite academic institutions had a history of self-injury.

Age, Gender, Race, and Ethnicity

The onset of non suicidal self-injury is generally found to be early -adolescence (age 12-14), (Muehlenkamp & Gutierrez, 2004, 2007; Ross & Heath, 2002) often reaching its peak in early adulthood (age 24), predominantly among white single or separated women (Kokaliari, 2005; Muehlenkamp & Gutierrez, 2007; Ross & Heath, 2003; Skegg, 2005; Shaw, 2002; Whitlock, et al.2006a). However, some lit-

erature suggests that gender may not be a factor (Gratz, et al. 2002; Muehlenkamp, & Gutierrez, 2004; Walsh, 2006; Zoroglou, Tuzun & Sar, et.al.2003), and other studies suggest that race has not proven to be a significant factor (Kokaliari, 2005; Whitlock et al. 2006a)

Race and ethnicity have not been widely addressed in the literature (Jacobson, & Gould, 2007). Increasing rates of self injury have started emerging in isolated international studies, characterized by variations across different cultural backgrounds. For example, self-injury seems to be a major issue among South Asian women in the United Kingdom (Ahmed, Mohn, & Bhuda, 2007). In two studies that took place in Turkey – one among female trauma survivors (Baral, Kora, Yüksel, & Sezgin, 1998) and one among high school students (Zoroglou, et al. 2003) – head banging was the most common way to self-injure. Baral et al., hypothesized that this may be a more socially and culturally acceptable way to self-injure.

Differentiation of Nonsuicidal Self-Injury and Suicide

Few publications existed prior to the 1930's in regards to self-injury. In the literature between the 1930's through the 1960's self-injury is dropped as a topic of investigation and is submerged within the suicide literature (Shaw, 2002). This lack of knowledge led to major misconceptions that often created fear, and prevented professionals from fully understanding and exploring self-injury and differentiating it from suicidal behaviors (Kokaliari, & Lanzano, 2005). Deiter, et al., (2000) cited a study by Borgan, Peterson, Golann and Hardiman (1990) in which 80% of the patients who were treated as chronic suicidals at an emergency psychiatric facility actually seem to have been engaging in nonsuicidal self-injury.

Self-injury and suicidal behavior are separate phenomena though the relationship between the two is complex and still only partially understood. Suicide is “the human act of self-inflicted, self-intentioned cessation” (Shneidman, 1985, p.4). Suicide is the ultimate wish to terminate life. In the suicidal mind, the only way to escape unbearable levels of hopelessness and an-

guish is by killing the self, or part of the self. Shneidman (2004) names these intolerable feelings of hopelessness, despair, and anguish “psychache” (p.7), the experience of not being able to tolerate one's own skin that ultimately leads the person to constricted thinking where suicide is the only solution.

Intent is a major point of differentiation between suicide and self-injury. The intent of the suicidal person is to kill the self, while the intent of the person who self-injures is to alleviate distress. As Walsh (2006) states, one engages in self-injury “not to terminate consciousness but to modify it” (p.7). Researchers have recognized that individuals who reach the point to act on suicidal wishes do not tend at the same time to also practice nonsuicidal self-injury (Gratz, 2003). Narratives from young adults have also indicated that they stopped self-injuring when they heard from friends, relatives, and professionals that it may give them an infection that could be life threatening, which speaks to their wish to preserve the self (Kokaliari, 2005). It seems that popular media images of suicide by cutting of the wrists may have exaggerated this connection between self-injury and suicide. In fact, suicide attempts are most often carried out by firearms, followed by suffocation, self-poison, and jumping from high buildings. Only 1.4% of suicide attempts occur by cutting of an artery and not as described above (Walsh, 2007).

While the intent of self-injury and suicide are distinctly different (Favazza, 1996) people who self-injure may also be at increased risk for suicide ideation and/or suicide attempts. Recent research on the overlap of self-injurious behaviors and suicide reveals that 40% of individuals who report nonsuicidal self-injury may also report suicidal ideation. In addition, research has identified self-injury as a strong predictor of suicidal ideation (Whitlock & Knox, 2007). However, this is not a clear relationship, as there are other variables that impact the relationship between self injury and suicide, such as alcohol, drug abuse, and depression.

People who self-injure and who have more negative attitudes towards life, are more self-punitive, more confused and engage in other risky behaviors, have less positive connections to family and do not fear death are more likely to attempt suicide

(Muehlenkamp & Gutierrez, 2004, 2007; Walsh, 2006). For example chronic self-injury can lead the person to feel defeated and desperate as life proceeds and self injury continues to be the main coping mechanism. Also, self-injury tends to take place in isolation, often accompanied by shame that can exaggerate feelings of distress and depression that can lead to suicidal ideation (Kokaliari, 2005). Another explanation is that through self-injury, people habituate to risk, pain, decreased fear and even ideas of death (Joiner, 2006).

Etiological Models of Nonsuicidal Self-Injury

People who self-injure do so to feel better and to regulate intense affect (Conterio & Lader, 1998; Gratz, 2003; Walsh, 2006, 2007). Walsh (2006) summarizes that when people self-injure, they tend to want release from feelings of “anger, shame, anxiety, tension, or panic, sadness, frustration, contempt” (p.7). To indicate how self-injury helps them, patients often report statements such as

When I start feeling overwhelmed I just can't bear it. It is like being trapped in my head, and it feels as if it will never end. I cannot think. All I know is that it will finish only if I cut.

Often the intent of the nonsuicidal self-injury is to stop dissociation. A former client of mine who was cutting to deal with her dissociative states said:

Before cutting, I was feeling the indescribable nothing. After cutting, I felt back to my “space.” This is me in my body. Before, I felt nothing, and I did not feel that I was in myself. I am there but not there, and then, when there is blood, even a tiny bit; this is a part of me...I can touch it. I am still here. This is part of my life force.

Apart from major psychiatric disorders such as schizophrenia, trauma (Connors, 2000; Herman, 1992; van der Kolk, Perry & Herman, 1991), borderline psychopathology (Brodsky, Clotrie & Dulit, 1995; Linehan, 1993), and major attachment disruptions (Dubo, Zanarini, Lewis & Williams, 1997; Farber, 2000; van der Kolk et al., 1991) have been cited as under-

lying reasons for self-injurious behaviors. However, not all people who self-injure fit the diagnosis of borderline personality disorder (Sutton, 1999; Turp, 1999), nor do they necessarily have a major trauma history (Kokaliari, 2005; Walsh, 2006; Whitlock, et al., 2006a). Similarly to borderline personality disorder and trauma, the relationship between self-injury and attachment disruptions should not be assumed to be direct (Gratz, 2003). So far, there is no consensus about why people employ self-injury as a coping mechanism (Muehlenkamp, 2005)

Personality Disorders and Non suicidal Self-injury

Personality disorders, especially borderline personality disorder, have been associated with non suicidal self-injury (Brodsky et al., 1995; Linehan, 1993; Zanarini, Frankenburg, Hennen, et al. 2005). Self-injury is identified as one of the diagnostic criteria for borderline personality disorder: “(5) recurrent suicidal behavior, gestures or threats, or self-mutilating behavior” (DSM-IV, 1995, p.654). Many individuals with borderline personality disorders (69- 80%) are characterized by self-destructive behaviors (Gurdermson, 2001; Linehan, 1995). A large percentage of individuals with borderline personality disorder (70%-85%) have a history of at least one incident of self-injurious behavior (Bohus & Schmahl, 2007). Most individuals with borderline personality disorder who self-injure experience relief from dysphoria, feelings of emptiness, and rage. Affect dysregulation is a predominant characteristic of borderline disorders, and self-injurious behaviors are utilized as external and effective emotion-regulation mechanisms (Linehan, 1993, 1995).

However, increasing evidence in the literature indicates that not all individuals who have been diagnosed with borderline personality disorder self-injure, and not all individuals who self-injure should be assumed to have a personality disorder (Herpertz, 1995; Klonsky, Oltmanns & Turkheimer, 2003). In support of this perspective, Sutton (1999) argued that, apart from the diagnosis of post-traumatic stress disorder, other diagnoses such as borderline personality are unhelpful in understanding and treating non suicidal self-injury. Turp (1999) noted

a new sub-clinical population that self-injures and disputes that they fit the description of the borderline disordered client.

Trauma and Nonsuicidal Self-Injury

Various traumatic experiences have been associated with self-injury (Burstow, 1992; Herman, 1992; Miller, 1994; van der Kolk, 1996; Walsh, 2006). Most studies have linked self-injury to childhood trauma (Low, Jones, MacLeod, Power, & Duggan, 2000; Romans, Martins, Anderson, Herbison, & Mullen, 1995; Strong, 1998; van der Kolk et al., 1991), with early childhood trauma (of physical and sexual abuse) the main risk factor identified with self-injury (Gratz, 2003).

Favazza and Conterio (1988) reported that 45% of their study's participants who self-injured had experienced childhood physical abuse and 29% had experienced childhood sexual abuse. Van der Kolk et al. (1991) reported that 79% of their subjects who self-injured experienced significant childhood trauma. Incest survivors, in particular, have been reported to employ self-injury extensively with rates that vary from 17% to 58% (Turell & Armsworth, 2000).

Trauma survivors often experience disconnection from the body, the self, and from social life. They present with a sense of disrupted boundaries, poor tolerance for stimuli, an inability to express or process feelings and sensations, and dissociation (Connors, 1996; Farber, 2000; Herman, 1992). In addition, trauma survivors often tend to re-enact the trauma in several different ways, including engaging in abusive relationships and substance abuse and/or addictions (Allen, 2001; Miller, 1994). Self-injury may function to reenact and control the pain of the original trauma, to master what was lost while traumatized, or to deal with overwhelming stimuli related to the trauma (Connors, 1996, 2000; Farber, 2000; van der Kolk et al., 1991; Walsh, 2006). In addition, many trauma survivors use self-injury as a way of recovering from dissociative episodes (Connors, 1996, 2000; Pattison & Kahan, 1983; van der Kolk et al., 1991). There are various degrees of dissociation related to self-injury. Some survivors describe dissociating from the pain of the original trauma and having a

sense of control over the self-injury. Some experience that a dissociated part of the self engages in the act of self-injury, while others believe that they inflict the injury, rather than the dissociated part of the self (Connors, 1996). Herman (1992) has stated, “self-injury is perhaps the most spectacular of the pathological soothing mechanisms” that trauma survivors might employ (p. 109).

Referring to incest survivors, Turell and Armsworth (2000) contend, “although many self-mutilators have incest histories, not all incest survivors self-mutilate” (p.238).

Although there is a high correlation between self-injury and trauma, not all people who have trauma histories self-injure (Kokaliari, 2005; Walsh, 2006). A direct relationship of cause and effect between abuse and self-injury cannot be assumed, as it might simply serve “to elicit symptoms in an individual already at risk” (Winchel & Stanley, 1991, p. 324). It seems that sexual and physical abuse may not necessarily be the main cause of non suicidal self-injury, as there may be other adverse factors that are implicated in its development. Contemporary writers, such as Potter (2003), have argued that simply looking for childhood traumatic events in therapy to understand the cause of self-injury is insufficient. Instead, she argued, “rather than looking for meanings that go back to childhood experiences, clinicians might explore ways that the culture produces such expressions” (p.8).

Attachment Disruptions and Nonsuicidal Self-Injury

Attachment theory has also provided a way to understand how intense experiences such as trauma, neglect, and attachment disruptions may endanger fragile individuals and lead to the use of behaviors such as self-injury. Authors have linked less secure patterns of attachment to psychopathology (Beebe, Lachman & Jaffe, 1997; Beeghly & Cicchetti, 1994; Heinzer, 1995; Wekerie & Wolfe, 1998). For example, Fonagy (2001) found that disorganized attachment is linked to childhood aggression, dissociation, and violence.

An emerging body of literature has suggested that there is a relationship between

physical or emotional abandonment and self-harming behaviors (Chu, 1992; Dubo, et al., 1997; Farber, 2000; van der Kolk et al., 1991). Dubo et al. (1997) identified that sexual abuse and neglect by the caretaker as critical factors in the development of self-harm. Other studies have focused on difficulties of emotion regulation as related to early attachment disruptions and neglect, which contribute to the development of self-harming behaviors (Crittendon, 1992; Kogan & Carter, 1996). Children who have had attachment disruptions or have experienced neglect may develop over-sensitivity to stimuli and deal poorly with anxiety (van der Kolk, 1996). Attachment disruptions may create problems in a person's capacity to regulate affect, as well as problems with social and cognitive skills (Fonagy, 2001).

Early attachments influence the ability of a child to develop and care for the self emotionally, and to feel that he/she deserves good care (Farber, 2000). According to Farber, if a child grows up feeling unworthy he/she may start neglecting his/herself and become attached to self-harm. Conversely, secure attachment becomes the fundamental basis for affect regulation and self-care (Farber). Attachment styles have become fundamental in understanding interpersonal adaptation, as well as in understanding how people cope with distressing feelings of anger and the regulation of affect (Fonagy, 2001).

There is not a clear relationship between self-injury and neglect; however Gratz (2003) has argued that both factors could be related to some third variable, such as genetic predisposition or impulsivity. For example, impulsive parents might be more prone to emotional neglect of their children, and impulsive children may be more prone to self-injury. The relationship between attachment styles and self-harm warrants further investigation. Some authors have already identified a shift in the profile of the person who self-injures and argue that more psychologically vigorous individuals may self-injure (Shaw, 2002; Strong, 1998; Turp, 1999).

Neurophysiology and Nonsuicidal Self-Injury

Given a natural predisposition towards self-

preservation, self-injury presents a challenge to biology (Harper, 2006). Biological explanations for self-injury are not clear as to the mechanism behind the behavior. Bridging biology and psychology, animal experimentation indicates that while self-protection of animals is automatic, for higher mammals it is contingent upon a positive caretaking environment (Harper)

Research on neurophysiology has offered some very interesting insights about self-injury. Decreased levels of serotonin in humans have been related to impulsivity and aggression, suggesting that serotonin levels might be affected in the central nervous system (van der Kolk, 1994). There is also a strong possibility that self-injury gets repeated as it affects the endogenous opiate system (Harper, 2006; van der Kolk, 1989). Endogenous opiates that reduce pain and panic have been observed to be at higher levels after prolonged exposure to stress (van der Kolk, 1989). Many people who self-injure experience little or no pain and instead often report feelings of euphoria. Thus, the behavior becomes addictive and is repeated in order to re-experience the resulting feeling of euphoria. (Alderman, 1997; Connors, 1996; Winchel & Stanley 1991).

Beyond Traditional Etiological Models

Gratz (2003) has argued that none of the factors above provide an adequate explanation for self-injury, and points out the need for more complex etiological models:

None of the risk factors for self-harm examined thus far has been specific to self-harm. More complex models of the development of self-harm are likely needed to understand more fully the etiology of this behavior, as well as to determine whether there are experiences (or combinations of experiences) that increase the risk for self-harm specifically, as opposed to psychopathology in general. (p. 201)

Some authors have argued that in studying self-injurious behaviors, we are confronted with a new and different population. Turp (1999) has referred to this new population

as "sub-clinical," suggesting that these individuals maintain productive lives in their communities. Suyemoto and MacDonald (1995) agree and claim that many women self-injure to temporarily alleviate stress and difficulties. Fennig, Carlson & Fennig (1995) have reported the same findings in their study of an outbreak of self-injury at a high school. They have stated that, in contrast to previous literature, individuals who self-injured did not show any overt psychopathology, were fully integrated in their peer circle, and excelled academically.

Conterio and Lader (1998) have recognized a different group of people who self-injure: people who remain hidden in society and rarely come to the attention of medical or mental health professionals. Their symptoms are different, less lethal, and self-injury does not take over their lives. It is these individuals that "make up the bulk of the silent 'epidemic' of self injury" (Conterio & Lader, p. 19).

In 2002, Shaw interviewed more psychologically healthy women who had a history of non suicidal self-injury, and reported being inspired by the resilience that these women demonstrated. Kokaliari & Berzoff (2008 in press) interviewed a non clinical sample of college women who did not meet the criteria for borderline diagnosis, did not have trauma histories and self-reported being securely attached, but nevertheless had a history of non suicidal self-injury. There was considerable consensus among interviewees that nonsuicidal self-injury is also a social phenomenon of modern western societies. These societies focus on productivity, accumulation of power, and capital at the expense of the individual experience. Self-injury can be seen as an internalized punishment system or a quick fix that minimizes psychological distress and helps the body reorganize and rapidly regain its capacity to produce. Likewise, Walsh (2006) notes:

It can be stated that the new population of self-injurers appears to be of diverse age, less psychologically challenged and less functionally impaired in the areas of social relationships and school and/or work. Also important is that many of these self-injuring persons may have experienced far less in the way of trauma. (p.34)

This new non clinical population, who experienced lower- or no overt psychopathology, is distinct and requires further examination. Also, this distinct population compels clinicians to be mindful in their treatment approaches and interpretations of self-injurious behaviors. Given the broad spectrum of individuals found to engage in self-injury (including healthier populations) a complete assessment of the meaning behind and experience of self-injury for the individual client provides significant information.

Treatment

Conterio and Lader (1998) comment that mankind's natural and instinctive aversion to physical pain is powerful, and the innate human instinct towards preservation makes self-injury "seems inexplicable and even terrifying" (p.209). Nonsuicidal self-injury is a complex treatment issue that requires consistency, patience, commitment and deep understanding of its paradoxical nature. Treatment can be very challenging not only due to the disturbing nature of the behavior but also because at times it "may not be possible to protect the individual from danger" (Deiter, et al., 2000, p.1174).

The reality is that people rarely come to therapy to address nonsuicidal self injury. Adolescents and young adults in particular tend to come to therapy for other reasons such as academics, family and peer relationships, identity issues, trauma history, rape, depression, bipolar disorder, or anxiety. There is significant stigma and shame around this behavior, which can make people feel that they do not deserve treatment. In addition, there have been many reports of people being mistreated by mental health and medical professionals, at times receiving stitches without local anesthesia, being hospitalized without their consent, or being asked to leave school or work (Kokaliari & Lanzano, 2005; Shaw, 2002; Walsh, 2007). Moreover, nonsuicidal self-injury works so effectively for people as an addictive coping mechanism that it is hard to relinquish. Patients will generally address nonsuicidal self-injury when it has escalated or when the soothing effect ceases, such as when he/she needs to cut more to achieve the same effect.

Assessment of Nonsuicidal Self-injury

While it is standard practice to ask about suicide in an initial assessment, specific questions about cutting, burning or other forms of self-injury are often neglected. Since people do not tend to bring the behavior to treatment, it needs to be part of the standardized assessment. By standardizing such inquiries, the clinician automatically communicates familiarity with the topic that will help the patient accept and further explore self-injury.

Self-injury triggers anxiety and intense responses among clinicians, either because of its nature, or for its resemblance to suicide. Thus, to begin, it is wise to differentiate between self-injury and suicide.

What was the person trying to do by self-injuring?

The major issue as discussed earlier that differentiates self-injury and suicide is intent. Was the person seeking relief or wanting to end her/his life? Although the two were presented differently, they can also coexist sometimes with less articulate clients or confused adolescents. Also, repetitive self-injury can be misunderstood as suicide attempts and lead to unnecessary hospitalizations (Walsh, 2006). If the person exhibits both self-injury and suicidality, the clinician should also perform a detailed assessment of both behaviors.

The method used, tools, rituals, and timeline

How does the person self-injure? Do they use one method or more to self-injure? Does it help them? The more methods a person is using, the more distressed he/she is. In non-clinical samples, individuals mostly report one method of self-injury. In contrast, patients with psychiatric disorders, such as dissociative and personality disorders, report multiple methods (Farber, 2000; Jacobson & Gould, 2007; Walsh 2006). Despite how people self-injure, clinicians should be alert when patients report that self injury no longer provides affect regulation. This may be an indicator that the person's psychological distress is escalating (Walsh, 2006). Also, the more they habituate to fear and risk, a major crisis precipitates a suicidal act (Joiner, 2006).

Patients use a wide range of tools to injure the body, including razors, knives, pins, heated hangers, metals, pieces of glass, and broken sharp items. In addition to methods used, rituals around when self-injury occurs are also important clinical information. Patients may even have a cutting kit that they keep in a drawer. They use it to cut, sterilize it, and store it again. Patients can feel very connected to their tools; for some of them the tools have been "faithful" friends for a very long time. It is both respectful and wise to inquire about cutting tools' importance to the patient. More impulsive patients may use anything available to them. Use of rusty and unclean cutting implements is alarming in terms of safety and escalation of the self injury symptom. The more impulsive a person's behavior, the more he/she is at risk to cut deeper and/or to use infected tools. A patient told me, "I use a razor. Sometimes I clean it, and sometimes not. If I do not have one, I will use anything available."

Farber (2000) argues that it is crucial to know whether individuals are impulsive, compulsive, both or neither when they self-injure. Impulsive individuals tend to experience an irresistible urge to cut, while compulsive individuals feel that if they do not injure, something bad is bound to happen. Questions that should be asked include; do they use sterile instruments or do they share with others. The condition of the instruments should also be explored; were they rusty, sharp and how deep the cuts were.

Sometimes patients do not use tools at all. In such cases, they bite or punch themselves, throw themselves against the wall, or scratch the skin to the point of bleeding. Walsh (2006) indicates that these patients tend to function on a more primitive level and have less ability to organize and perform an act of cutting.

Patients may have specific times that they self-injure, such as every evening before going to bed or every two hours while they study for finals. A recent study pointed out those individuals may also self-injure as a response to participating in internet chat rooms (Whitlock, et al., 2006b) another area that clinicians should consider when assessing self-injury.

Another issue to be investigated is the level of consciousness associated with self-

injury. The person injures in a state of hyperarousal, dissociation, derealization, or depersonalization or they may experience total amnesia of the self-harming act (Farber, 2000). If patients do not recall the incidence of self-injury this is alarming as they may injure more severely than they intended.

As the assessment evolves, the clinician should inquire about the history of the self-injurious behavior. How long has the person been cutting? How did it start? What were the original triggers; and, do they continue to function as triggers? As elaborated earlier patients may self-injure for a variety of reasons that significantly vary for each individual. At other times, patients do not recall how it started or why. Due to its addictive nature, the symptom may eventually take on a life of its own. Patients may report that they self-injure because it just feels good.

The severity of the act and length of episode

The clinician can obtain information from the client based on observations and a possible medical examination. Superficial scratches are less severe than cuts. Cuts that need stitches are more severe than others; burns with heated pins are possibly less severe than burns with cigarettes or heated hangers. Injury that takes place on a daily basis is more severe than injury that happens once a month (Farber, 2000).

When the injuries are on visible areas such as the arm or lower legs, the clinician should discretely ask to view them. Very often there is a gap between verbal descriptions and reality. People are often embarrassed and therefore minimize the acts in their descriptions. Others have very superficial cuts but might describe them as very painful, deep, and extensive. Others carve designs or names on their bodies that often carry important meanings related to their histories or their core beliefs. Every cut and every scar has a story and contains important assessment information. The level of physical damage can also indicate that the person is more in need of structured intensive psychiatric care.

In combination with severity of tissue damage, it is essential to assess the length of episode (Walsh, 2006, 2007). Most people feel better after inflicting some cuts or

burns, but if the person needs to perform self-injury for a lengthy period of time the clinician should be concerned that the behavior may be escalating or is not working. Another piece of information embedded in this question is that a patient who consistently inflicts a few injuries in some paradoxical way may be protecting and caring for themselves.

It is important for the clinician to be respectful when asking to see the wounds and not to ask in every session. The clinician should be very clear about the inquiry and its purpose. Self-injury can trigger curiosity and anxiety in the clinician's responses that are often palpable to the patient. Such reactions can be experienced as intrusive, or as an interrogation and may have the opposite results. Therapists should be mindful in the communication inherent in self-injury, and work with clients to replace self-injury with verbal avenues of communication.

Significance of body part chosen to self-injure

The significance of the area chosen is noteworthy to the assessment of self-injury as well as to the understanding of its meaning. Injury to specific parts of the body may be indications of other conditions. For example, self-injury on the face might indicate that the person has lost interest in societal responses and might be dealing with psychotic experiences. Self-injury on the genital area and the breasts might indicate earlier experiences of sexual abuse (Walsh, 2003, 2006).

Where did they perform the act?

Most people choose to self-injure in private such as in their rooms, while some choose public places such as parks, restrooms, and classrooms (Kokaliari, 2005). Others might do it in the presence and with the encouragement of peers, which can elevate the risk as the patient may have been sharing instruments. If this is the case, the clinician should also inquire if they have allowed another person to cut them or burn them. This can have several meanings, for example it could be reenactment of abuse, and an indication of passivity.

Other issues to raise are if there was alcohol and substance abuse involved. A former patient reported, "I learned how to cut from my boyfriend. He used to cut, do

drugs, anything you can imagine. One day he asked me to cut him. It did not take long until we were cutting each other."

Similarly, people may easily use the Internet to locate others with similar self-injury practices. More than 500 self-injury message boards have been identified and the number continues to grow. In addition to message boards, people have access to vivid images and videos through web pages such as youtube.com (Whitlock, et al., 2006; Whitlock, Lader, & Conterio, 2006).

Other self-destructive behaviors

Additional indicators of lethality that the clinician should assess are other accompanying self-destructive behaviors, such as reckless driving, promiscuity, alcohol or substance abuse, and exposing oneself to risk. Walsh (2006) noted that it is very common for self-destructiveness to spread to several aspects of one's life; and people can get poly-destructive. When trying to stop self-injuring or when their self injury is disclosed, many patients may switch to other forms of self-destructive acts such as eating disorders which should be alerting to therapists (Kokaliari, 2005). Working with high achieving college students, I have often come across patients who even in therapy have high expectation for themselves and their self-harm behaviors. One patient commented on a similar idea: "I would never take pills to kill myself. If I did it I would make sure I jumped off the highest building. I would not want to do a lousy job." On the other end of the spectrum, when they decide to stop self-injuring, they seem to do it instantly, compelled by a sense of perfectionism.

Strengths

While assessing for self-injury, we unavoidably carry out a discussion with the latent message of how the patient fails to care for the self. It is important to keep a balance, and to identify the client's strengths and abilities. One piece of this exploration is to inquire about strategies that have prevented them from self-injuring in the past. The therapist should ask the patient about previous times that the patient was able to resist self-injuring even for a short period of time. Such questions can also provide information to the clinician as to how distressed the patient is and if he/she is ready to stop self-injuring.

Therapeutic Relationship

A positive therapeutic relationship is a major predictor for positive treatment outcome, and therefore, establishing a positive initial therapeutic alliance is critical. The therapeutic setting and relationship can function as transitional factors that offer the patient the experience of not being abandoned or alone in the struggle with self-destructive behaviors and can function as a holding environment (Winnicott, 1971). Clear boundaries and consistency allow people to feel safer and more contained, and facilitate the examination of the context in which the patient's symptoms emerge and get perpetuated (Feldman, 1988).

People are very likely to experience shame, fear, concern, and uncertainty when coming to therapy. Patients often look to the therapist for indicators of comfort and openness to hearing about self-injurious behaviors (Farber, 2000). Patients can be reassured by a therapist's ability to communicate understanding of self-injury and its ego-syntonic role in a particular context.

As discussed earlier, it is likely that people who self-injure might have had attachment disruptions caused by a range of experiences such as sexual and/or physical abuse, parental emotional unavailability and lack of opportunities for relatedness. Thus, attachment and the relational dynamics in therapy are of great importance not only in establishing a trustworthy relationship but in the recovery process. As Farber (2000) argues, patients are likely to resist and get caught up in: destructive repetition reenactments of early experience and negative therapeutic reactions, regressing in response to therapeutic progress, especially when they consciously regard therapist as a good-object. All these factors threaten to destroy the treatment and impede or destroy the attachment to the therapist (p.383).

The therapist must be prepared to address such reenactments as this might help the client to see how this behavior might also manifest in relationships outside therapy (Farber, 2000). The clinician needs to be attentive to issues that might trigger feelings of separation, neglect, or loss, as these are common interpersonal stressors that can function as precipitant factors to an episode of self-injury (Allen, 2001; Gratz, 2003; Walsh, 2001, 2006).

Clinical Recommendations

Reflection-affect regulation

Secure attachment in therapy "is a platform for reflection, reflection is a platform for self-regulation" (Allen, 2001, p.313). As previously discussed, people who self-injure most often have difficulty regulating affect. They often have difficulty describing what they feel before an incident of self-injury and they seldom name their feelings. The capacity to identify and verbalize the emotion is missing, and the act of self-injury comes and fills this gap. The goal for the patient in therapy is to start reflecting and sitting with feelings. Otherwise, he/she may easier engage in self-destructive acts. Thus, security in therapy is healing, as it will allow the client to identify emotions, experience them, and be informed by them. This active acknowledgement of affective experiences can empower patients and direct them towards the care of the self as opposed to self-injury (Allen).

Self-injury is a coping mechanism

A core issue that needs special attention in therapy with people who self-injure is that despite its destructive nature, self-injury is an effective coping mechanism. Therefore, a clinician's effort to cease a patient's self-injury needs to be carefully considered. Premature attempts may arouse anxiety and negative affective experiences, disrupting the therapeutic relationship. Any attempts to remove self-injury should be accompanied by encouraging strong social support and by replacing primitive defenses with other more mature defense mechanisms (Vaillant, 1992). Patients should be encouraged to explore alternative ways to manage and reduce distress such as breathing exercises.

Impulse Log

In addition to exploring the core issues behind self-injury, it is recommended that patients keep an impulse log. These logs are a means for patients to report on the frequency of acts, physical damage incurred, method of self-injury, tools used, location, triggers, consciousness of acts and other information that may be pertinent to the individual patient's experience. Adolescent patients have been found to have the most difficulty being consistent with academic logs (Walsh, 2006), thus they should be encouraged to make it as

personal as possible and be creative.

Do not use suicidal language

Patients often report that they have felt offended, minimized, and devalued when a therapist uses suicidal language referring to their self-injurious behaviors. Such language includes "suicide gesture" "parasuicide" or even "suicide attempt". Walsh (2006) comments on the use of such language and argues that for example, "suicide gesture" implies that the act is insignificant, while parasuicide means something similar to suicide. All such interpretations may discourage the patient from engaging in treatment. On a similar note, gestures that simulate self-injurious behaviors such as cutting on the wrists are also experienced as offensive by patients.

Transference and Countertransference

Self-injury can trigger intense transference and counter transference. Starting from the very act itself, open wounds, blood, scars, disfigured skin, new scars on top of old scars and the idea of injuring one's own body can be very difficult to comprehend.

Transference is often intense and appears to reflect a repetition of the client's internal world. Given the relationship between trauma and borderline pathology in patients who self-injure, splitting can occur in therapy; the therapist may be idealized or totally devalued. The therapist may be put in a position of being "responsible" for the perpetuation of the symptom. Furthermore patients who have experienced physical or sexual trauma may use self-injury to accomplish the reenactment. Therapy may also become a space to reenact trauma. Thus the therapist and client may each participate in the roles of victim, victimizer, or the bystander (Basham, & Miehl, 2004)

Due to its addictive components, self-injury can also elicit a powerful dependency upon the therapist that is usually destructive in nature. Attachment issues can also be evoked on the transference level. For example, dismissive clients will dismiss the therapist outside of their experience while the therapist will be left feeling similar to what the patient once experienced as a child – angry, unappreciated, and incompetent (Slade, 1999). Preoccupied clients will be difficult to collaborate with and might make the therapist feel again as they may have felt as a child – angry,

overwhelmed, unsupported and puzzled (Slade).

Failing to process such intense transference reactions risks that the patient will succeed in driving the clinician away. Such an outcome creates a self-fulfilling prophecy: rejection and abandonment giving further unconscious justification to self-injury – the most consistent faithful relationship in the patient's world.

Similarly, nonsuicidal self-injury can provoke intense countertransference reactions within the therapist that vary from unproductive to dangerous ones (Feldman, 1988). Clinicians ought to be aware that patients who use their bodies as a vehicle of communication are also attuned to nonverbal communications such as body language. As Farber (2000) argues, these patients have “very sensitive radar systems for detecting and exploiting clinician's hidden and not so hidden vulnerabilities and for bringing out the worst features” (p.433).

When asked in trainings about reactions to self-injury, clinicians often report feelings of sadness and worry as countertransference feelings. They often express a desire to reach out and “rescue” the patient. More dangerous and unconscious in the countertransference is clinicians' fear of the symptom, hesitation to explore it, or devaluation of the symptom and assignment of blame to the patient for self-injury (Feldman, 1988). Some clinicians may experience it as a narcissistic injury, while others may feel angry and disgusted by the behavior (Walsh, 2006). Some see self-injury as a manipulative behavior that the patient is employing to extend the therapeutic session or receive more attention from the therapist. Such countertransference feelings can be more complex and difficult to bring to awareness as they may make the clinician feel guilty and uncomfortable. As a response, therapists may act out by hospitalizing patients in anticipation of an act of self-injury. Another common mistake is based in the therapist's feelings of anger. This can move to a sadistic rejection and rush to an inconsiderate interpretation of such feelings (Slade, 1999).

Another common pitfall is that such intense countertransference can create preoccupation with the therapist's internal experience, which may lead to the abandonment

of the client. Therapists must be attuned to their countertransference in such extreme moments and use it effectively so that they can function as a container of the client's projections (Farber, 2000).

Plakun (1994) discusses principles in the psychotherapy with self-destructive patients and states that often therapists withdraw emotionally from the patient as it requires extensive energy to deal with ongoing self-destructive crises. He describes self-destructive behavior as including both suicidality and self-injury and proposes seven principles to consider in practice. The first is to incorporate discussion of self-destructive behaviors from the onset of treatment as it indicates commitment from both members to the therapeutic process. Next, he strongly encourages therapists to metabolize their countertransference and even avoid contact with clients when it is not processed. His third and fourth points include the importance of a meaningful therapy relationship and the avoidance of punitive interpretations. In his fifth principle, he encourages incidents of self-destructive behavior be considered aggressive attacks on the therapeutic relationship and possible interruptions to treatment, for example with a hospitalization. Sixth, once self-harm has been discussed and conceptualized as the patient's possible wish to terminate or interrupt therapy, the preservation of the therapy stays possible but the patient is held responsible by assigning ownership of treatment to the patient. After an incident of self-injury instead of the therapist resigning due to unresolved countertransference reactions, he encourages them to explore the patient's experience of the therapy. Both therapist and client join in an exploration as to why it happened. Lastly he proposes reparation as a process that reestablishes collaboration between therapist and patient and not as an apology.

Therapeutic Goals

Connor (2000) argues that the focus of the treatment should never exclusively be on self-injury. Self-injury is an indicator that the person is struggling with a lot of other issues that needs further investigation.

A very important and common issue that emerges in therapy is the difficulty in verbalizing emotions, as people who self-injure function on a preverbal level (Farber,

2000; Zila & Kiselica, 2001). Therefore, in treatment the individual learns to express affect, and reduces the pattern where they move from being overwhelmed to self-injury without been able to identify any in between feelings and expressions or being able to self-soothe (Deiter, et al., 2000).

The approach needs to be flexible and the therapist should meet the patient where he/she is at while also continuing to assess the self-injury. The first goal should be to encourage the patient to communicate about self-injury in the context of the patient's life (Connors, 2000). This gives space to the individual to address self-injury, see its relevance to her/his life and then proceed to the second goal to enhance quality life in relation to self-injury. In this phase the individual is helped to reduce shame and isolation and seek medical attention as needed. Later, the person is able to move to the third goal to help the patient reduce self-injury as a coping mechanism and replace it with other less self-destructive behavior (Connors, 2000).

Treatment should aim to integrate ‘good’ and ‘bad’ parts of the internal world of the person and should function to create secure attachments in treatment and other relationships” (Allen, 2001). One of the ways to establish this bridge is to see attachment as a skill. The client who will form a secure attachment in therapy will feel more comfortable to explore the internal world and to secure other attachments outside therapy (Allen).

Adolescents and Self-injury

In most cases, the onset of repetitive, intentional, self-injurious behaviors tends to start in adolescence or early adulthood. Thus, special attention needs to be paid to the idiosyncratic characteristics of this age group. The focus of the treatment must stay or return again and again to readdress self-destructiveness. While other issues of concern may present in therapy, the clinician must be alert as to how and where else self-destructiveness might manifest (e.g., forgetting repeatedly to take important exams, or eating issues). Clinicians should remember that with adolescents and young adults there is a part of them that is accusing, punitive and motivated to be self-destructive (Noshpitz, 1994). Another detrimental concern with adolescents is their fear of suc-

cess. The person often wants to feel better but often also is convinced that they should fail or do not deserve to get better. The desire to get better unconsciously then becomes a barrier. This is very important and should be part of the work with adolescents (Noshpitz, 1994).

Trauma and Nonsuicidal Self-injury in Therapy

As mentioned earlier, many people who self-injure have experienced trauma. Thus, long term psychotherapy can then become trauma-resolution therapy (Walsh, 2001). The recurrence of self-injury can be seen as repetition compulsion. Walsh sees three facets in this repetition compulsion. Initially the patient becomes preoccupied and repeats self-injury to express the original trauma, usually sexual abuse. Next, self-injury becomes a way of conveying the need to blame and punish the self for their belief that their body is responsible for the abuse. Lastly, self-injury is a way to communicate and find solution to the distress coming from the trauma (Walsh 2001).

With such patients, recovery is about relatedness and empowerment of the survivor. Recovery, therefore, can take place only within the context of relationships. Herman sees the healing relationship as the first step to recovery, to the empowerment of the survivor, and to the establishment of safety. The core task of the next phase is remembrance and mourning. Following mourning, the third stage is reconnection with ordinary life. Herman discusses self-injury as one maladaptive coping mechanism that permits the child to survive and regulate the overwhelming experience of the trauma. As trauma work progresses and the survivor increases his/her tolerance for conflict, maladaptive coping mechanisms reduce (Herman, 1992). However the second phase, remembrance, should not always be assumed as necessary. Often clinicians are tempted to listen to the trauma in detail in order to help the client 'get rid of it' and feel better. Retrieval of the trauma is not always advisable, especially with patients who are unable to tolerate affect, as they may actually deteriorate and employ self-destructive behaviors in this process (Allen, 2001, p.292). Allen argues that the therapeutic work should focus on facilitating clients' ability to nurture the self as

well as relationships; processing of traumatic memories should be utilized only as it augments these abilities (Allen, 2001). Patients should be encouraged to reflect on their trauma rather than going over extensive, detailed narratives.

Trauma survivors use self-injury as a defense mechanism to cope with their trauma. The therapist should recognize the adaptive elements of the symptom and explore together with the client how it was developed, what it symbolizes and the possible challenges it presents to coping with a traumatic history.

Individual Psychodynamic Psychotherapy

Individual psychodynamic psychotherapy has been neglected in the literature in favor of cognitive based treatments that have quicker results and have the benefit of extensive empirical support. However, psychodynamic therapy has a lot to offer in terms of understanding the dynamics (meanings and roots) of non suicidal self-injury central to its treatment (Gardner & Cowdry, 1985; Levy, Yeomans, & Diamond, 2007).

Psychodynamic psychotherapy can illuminate how conflicted individuals can use self-injury either on the neurotic, characterological or psychotic level to achieve equilibrium. This method seeks to understand and help integrate representations of the self and other, and it aims to help the patient employ mature defenses to establish a coherent identity. All such factors lead to improvement in the overall functioning of the person, including the area of affect regulation.

Long term psychodynamic therapy, combined with cognitive and behavioral exercises that alter distorted beliefs and offer replacement skills, is a powerful way to help patients who self injure.

Cognitive-behavioral treatment

Cognitive treatment has been very effective with patients who engage in self-inflicted behaviors as it illuminates the relationship between distorted cognitions and self-harming acts (Zila & Kiselica, 2001). Intense affective experiences can distort cognitions, which initiates a vicious cycle. The main assumption that underlies cognitive behavioral treatment is that emo-

tional disturbances are caused by negative thoughts and that changing negative, unrealistic thoughts will reduce or prevent emotional disturbance (Sutton, 1999).

Initially, the treatment seeks to identify emotions, behaviors, and experiences along with thoughts and core beliefs identified with self-injurious behaviors (Walsh, 2006). Next, the treatment aims to reduce these cognitions and then tries to change the behavioral or environmental reinforcements of the self-injurious behavior. Patients are encouraged gradually to learn to self-observe functions of self-injury and monitor their own thinking. At the same time, through general questions, clients are encouraged to recognize positive personal attributes. This can be the beginning of providing space for self-esteem to grow, as some have never taken the time to identify positive attributes in themselves. Many challenges may arise when patients experience intense feelings that in the past have led to self injury. Thus, learning to recognize affect is important and at times a difficult process. Clients should be encouraged to recognize feelings and allow themselves to experience them and gradually try to regulate them through non self-destructive means.

Another critical component of cognitive therapy is how patients think about self-injury in terms of communication and relationships. In therapy, patients learn that communication can occur just with words and not necessarily with actions. This is a very difficult part to change, as this might make relationships less intense and may be stable. Patients might be ambivalent, since this excitement in relationships is addictive (Walsh & Rosen, 1988). Alderman (1997) has written a very comprehensive list of emotions and possible responses to manage affect (e.g. afraid-boxing). She encourages people to use the list to help name feelings. In addition, Alderman encourages people to keep a journal that pairs emotions with actions that they have identified from the past that help when they are overwhelmed and before they consider self-injury (Alderman)

Cognitive behavioral treatments have been characterized as very useful and especially empowering for women. This is because cognitive-behavioral treatments address the difficulties these women have to address

their feelings when they choose to adopt a false self (Zila & Kiselica, 2001). One of the main disadvantages that has been identified is that cognitive behavioral treatment does not tend to resolve core issues of self-injury, which might reoccur if the issue gets reactivated (Alderman, 1997).

Dialectical Behavioral Treatment

Dialectical behavioral treatment (DBT) was introduced in 1991 by Dr. M. Linehan. Dialectical behavioral treatment was developed to treat people with borderline personality disorders with a major priority on reducing self-injurious and life threatening behaviors. DBT is a problem – oriented approach that is complimented with supportive techniques such as the development of empathy and acceptance. For the most part, it contains traditional cognitive and behavior therapy components but also has some distinctive characteristics (Linehan, 1993). DBT has incorporated feminist theory and Buddhist philosophy and has become an empowering therapeutic model particularly for women.

The dialectic perspective has three characteristics. The first is interrelatedness and wholeness. This perspective is congruent with feminist thinking. This argument came to support the fact that mostly women get diagnosed with borderline personality disorders, often based on their relatedness. This principle is oppositional to the basic western value that recognizes mostly individualistic values. The second is the principle of polarity, that supports that reality is not static but in constant movement and is comprised of opposing forces ('thesis' and 'antitheses'), and that from the integration of these a new set of opposing forces can evolve. This dialectical perspective aims to create the necessary conditions for change; for example, it explores dysfunction as containing function and sees construction within destruction. Finally, the principle of continuous change, which follows wholeness achieved through the previous principles, leads to synthesis. The last principle indicates how synthesis is a composition of opposing forces that implies ongoing change and progress (Linehan, 1993).

In DBT therapy, the therapist recognizes suicide and self-injury as problem solving functions. These behaviors are always addressed in therapy while an important aspect of every intervention is to help patients

replace destructive problem solving techniques with more adaptive ones (Linehan, 1995). DBT actively teaches emotion regulation and tolerance, interpersonal effectiveness, core mindfulness and self-management skills (Linehan, 1993; Robins, & Chapman, 2004). DBT encourages patients to develop strong attachments to their therapists, and call their therapists any time, though the later is true only if they have managed to resist self-injury. Telephone consultations are an important part of DBT, especially with patients who self-harm, as they might need more support than one psychotherapeutic session per week. In DBT, active intervention is taken to prevent suicide but not to avert self-injury, unless potential medical harm is involved (Muehlenkamp, 2006).

Skills-training is also an important part of DBT. This takes place twice per week in open groups, and part of the individual therapy is to integrate those skills into everyday life situations. Supportive process group therapy is also offered after completing skills training (Linehan, 1993).

DBT, like other therapies, is applied in different sequences in different settings and has proven effective for adults as well as adolescents (Rathus & Miller, 2002). DBT is the primary cognitive therapy that addresses cessation of self-injurious behavior with empirical evidence of its effectiveness (Bohus, Haaf, Stiglmayr, Pohl, Böhme, & Linehan, 2000; Muehlenkamp, 2006).

Group Treatment

Group treatment should be carefully approached as nonsuicidal self-injury can be a contagious phenomenon (Walsh, 2006). In addition, adolescents may self-injure in the context of a group and have experienced group dynamics as reinforcing of the behavior:

The daughter disclosed that she and her friends were cutting their arms as part of a game they called 'chicken'. The rules of the game required that the cuts be superficial and not draw too much blood or else they would be disqualified. The winner was the player who continued the longest and did not 'chicken out'. (Lena & Bijoor, 1990, p.131)

Perspectives on group treatment vary widely. For some, group treatment has been

considered ineffective along with physical restraint, hypnosis, chemotherapy, relaxation therapy, electroconvulsive therapy, and family therapy (Favazza & Conterio, 1988). Walsh (2006) argues that groups should be avoided for discussion of self-injury. He suggests that patients should be in individual treatment and use group treatment to learn replacement skills. In contrast Farber (2000) argues that in the same way that a group can have a negative impact on people, it can also be healing as it makes symptoms less shameful and mysterious. Group work may allow people to even appreciate self injury's adaptive parts and support clients to adopt different coping mechanisms. Group cohesion can promote active problem solving techniques.

Kokaliari & Lanzano, (2005) argue that groups run collaboratively by a consumer and a therapist may be a valuable tool in the treatment of self-injury. This structure may help leaders plan and facilitate a group more effectively, since it creates a partnership where patients are valued as equal members of the group. There have been examples of groups run for 8-10 weeks that were meeting for one and a half hours per week. The groups were designed to address topics identified in the previous week's discussion. Patients agreed to discuss and reflect on emotions, functions of self-injury, shame with self injury and ways to care for themselves. Establishing trust was complicated, but once members started trusting each other, they started utilizing the support the group provided and were able to develop and adopt different skills. Once members learn new skills they are encouraged to practice them outside the group. (Kokaliari & Lanzano).

One of the most well known group therapeutic interventions is the S.A.F.E. alternative programs. The major emphasis in the S.A.F.E. program is to place responsibility on the individual, focusing attention on non-self-destructive behaviors, avoiding descriptions of methods of self-injury, and using careful language. People form a non-harm contract upon admission, but they are not restricted. The contract is very important as it keeps contagion and competition to a minimum. People stay in the program for two-four weeks (Conterio & Lader, 1998).

Individuals who get admitted to the program are screened for strong motivation to

change and find alternative healthier mechanisms. The staff is available to help round the clock. Staff members teach about self-injury, ways to manage moods, other coping mechanisms and relaxation strategies. The establishment of a safe environment where continuation of relationships is congruent to lack of injury is the dominant culture of S.A.F.E. Patients are encouraged to keep an impulse control log where they write about when impulses to cut occurred, what triggered them and how they responded to them. They also encourage the person to have five alternatives to self-injury in place. Patients are encouraged to utilize these alternatives when they try to resist urges. Also they are encouraged to write assignments that help organize their thoughts and feelings in a safe and constructive way. Gradually, these assignments become more challenging and more analytic. Later, patients are encouraged to experience feelings, learn how to listen and communicate feelings and also challenge deeply held assumptions and thinking patterns. The last component of the program is to help participants to plan a life with no self-injury. Self-injury has lost its power and is no longer the center of attention. People are invited to say good-bye to self-injury, make a

list of goals that they can accomplish in the near future, and identify trusted others who will be available to help them (Conterio, & Lader, 1998)

Biological Treatment

Pharmacological treatment for self-injury has been met with varying results. Research supports the effectiveness of serotonin reuptake inhibitors (SSRIs) such as Prozac or Zoloft in treating acts of cutting as they reduce serotonin in the brain (Harper, 2006; Markovitz, Calabrese, Schulz, & Meltzer, 1991). This therapy has been useful in reducing impulsivity and compulsivity, which are strong elements of the behavior (Harper, 2006; Strong, 1998).

Self-injury often evokes feelings of euphoria (Alderman, 1997). The use of Naltrexone, an SSRI, blocks a release of opiates that bring feelings of euphoria following self-injury and reduces the psychological gain of this behavior (Strong, 1998). Winchel & Stanley (1991) completed a very detailed review on the biology of self-injury, suggesting that dopamine antagonists might be beneficial in treating self-injury. A range of pharmacologi-

cal agents have been proven helpful to self-injury in different combinations, including antidepressants, antipsychotics, anxiolytics, and opiate antagonists (Harper, 2006). However, other theorists also point out that medication can have the opposite effects with self-injury, as it can increase feelings of being out of control, isolated and trigger self-injurious behaviors (Connors, 2006).

Conclusion

Given its expanding demographic picture, understanding assessment and treatment of self-injurious behaviors needs to be part of every clinician's knowledge base.

Self-injury is a complex phenomenon with myriad meanings and roots. Therapeutic interventions should include a detailed assessment with attention to possible diagnosis and implications. An eclectic approach based on psychodynamic theory with elements of cognitive approaches may represent the most beneficial course of treatment as it addresses both the underlying causes as well as the current risk factors associated with self-injury. ❖

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September 2008 FOCUS Homestudy Course
Understanding Nonsuicidal Self-Injury
POST-TEST

Circle all correct answers.

1. Non suicidal self-injury has always been considered a distinct phenomenon from suicide.
 - a) True
 - b) False
2. Non suicidal self-injury refers to:
 - a) Accidental, non-life threatening injuries that are self-inflicted and aim to alleviate emotional distress but have no suicidal intent
 - b) Purposeful, non-life threatening injuries that are self-inflicted and aim to alleviate emotional distress but have no suicidal intent
 - c) Predominantly life threatening injuries that are self-inflicted and aim to alleviate emotional distress but have no suicidal intent
3. Suicide by wrist cutting is the:
 - a) Second most common method of suicide
 - b) Third most common method of suicide
 - c) Least common method of suicide
 - d) Can be accomplished by cutting any vein
4. Eye enucleation and genital mutilation are related to:
 - a) Psychotic disorders
 - b) OCD
 - c) Personality disorders
 - d) Mood disorders
 - e) Mental retardation
5. Most common method of nonsuicidal self-injury is:
 - a) Cutting and scratching to the point of bleeding
 - b) Burning and self-hitting
 - d) Cutting and eating disorders
6. Race is a significant predictor of nonsuicidal self-injury.
 - a) Yes
 - b) No
 - c) Evidence is inconclusive
7. Intolerable feelings of hopelessness, despair, and anguish are mostly experienced by individuals who are self-injuring.
 - a) True
 - b) False
8. Common reasons reported for nonsuicidal self-injury are:
 - a) Affect regulation
 - b) Recovery from dissociative states
 - c) Reenactment of previous trauma
 - d) Resulting feelings of euphoria
 - e) a & c
 - f) b & d
 - g) All the above
9. Some authors have argued that in studying self-injurious behaviors, we are confronted with a new and different population. This population is characterized by:
 - a) Individuals who do not have major trauma histories
 - b) Individuals with no overt psychopathology
 - c) Individuals who are otherwise high functioning and in leadership positions
 - d) All of the above
10. Individuals who self-injure rarely present in therapy to address self-injury:
 - a) because self-injury works
 - b) because of the stigma and shame associated
 - c) because of limited access to health care
 - d) a & b
11. A positive therapeutic relationship is
 - a) A key element to successful therapy
 - b) Not as important as a clear contract
 - c) Equally important type of treatment used
 - d) None of the above
12. Many people who self-injure experience little or no pain and instead often report a feeling of euphoria.
 - a) True
 - b) False
13. Self-injury is a pathological coping mechanism. Clinician's should:
 - a) Require the patient to cease the behavior before they commencement of treatment
 - b) Should not require the patient to cease the behavior as premature attempts may arouse anxiety and disrupt the therapeutic relationship
 - c) Not comment on the issue.
 - d) Should not require the patient to cease the behavior as the patient will become suicidal
14. Trauma is a strong predictor for nonsuicidal self-injury.
 - a) True
 - b) False
15. Self-injury can trigger very intense countertransference reactions:
 - a) The clinician should avoid such reactions as they may compromise treatment
 - b) The clinician should be prepared to process such reactions and avoid punitive interpretations and acting out
 - c) The clinician should refer the patient to another practitioner

Congratulations!

You have just completed the Post-Test for this CE Course! Please fill out the Evaluation form and send both pages along with your payment to NASW, 14 Beacon Street #409, Boston, MA 02108.

Continued on page 17

Please indicate whether the following learning objectives were achieved:

1. To understand the history and nature of self-injury and how it differs from suicide

Achieved in full 5 4 3 2 1 *Not Achieved*

2. To learn the most common etiological models of self-injury, its prevalence and demographics

Achieved in full 5 4 3 2 1 *Not Achieved*

3. To learn the most common treatment models and treatment considerations for clinical practice

Achieved in full 5 4 3 2 1 *Not Achieved*

4. Please provide comments on current course and suggestions for future courses.

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