ASSESSMENT, CONCEPTUALIZATION AND TREATMENT OF SELF INJURY

A Protocol for Adolescents

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Self Harm is an umbrella term –

- Includes Self Injury and Self Mutilation
- Self Injury: A kind of self harm that leads to visible and direct bodily injury including cutting and burning (McAllister, 2003)
- Research shows there is no association between suicidal intent and the act of self injury
  - Attempt at self soothing/coping
  - Harm done in the belief they will survive
Self Injurious Behaviors are those behaviors that involve the “deliberate destruction or alteration of body tissue without conscious suicidal intent” (Stone and Sais, 2003)

Can co-exist with suicidality, but the act does not involve the intent to die and is believed to be a preventive action by the injurer.
• 97% of “cutters” are female (according to current research; BPD)
• Middle/Upper class
• Intelligent
• History of physical and/or sexual abuse
• Observed Family Violence
• Eating Disorders
• Alcoholic Homes
• Have friends or family members who self-harm
• High levels of depression/anxiety
• Experienced a traumatic event/loss
• CDC Statistics all for expanded research
• Depression
  – Observable “inexpressivity” as well as low reactivity to situations that would typically induce emotional response (Gratz, 2001).
  – May also experience somatic symptoms (Croyle An Waltz, 2007)
  – Hopelessness with relation to their life (Nock and Prinstein, 2005)
Eating Disorder/Purging Behaviors

- Self injury has been shown to be more commonly associated with the bulimia nervosa type (Ruuska, Riitakerttu, Rantanent and Kovisto, 2005)
- Related to the need to self soothe and relieve emotional tension
- Self injury in this population is also related with substance abuse
• Trauma History/PTSD
  – Those individuals with PTSD who self injure display the typical symptoms associated with PTSD, however, they use self injury to deal with their stress
  – Most prominent symptoms:
    • Reoccurring nightmares associated with the abuse
    • Feelings of being out-of-control
    • Experiencing a constant state of fear for reasons they may not be able to identify.
• **Self-Injury Trauma Scale (SITS)**
  
  – created to evaluate the extent of tissue damage caused by self-injurious behavior
  
  • quantify tissue damage directly
  
  • permits differentiation of self-injury:
    – Topography
    – location of the injury on the body
    – type of injury
    – number of injuries
    – estimates of severity
  
  – initial evaluation of the inventories efficacy and subsequent usage found the scale to be a reliable method for collecting data on surface tissue damage caused by SIB (Iwata, Pace and Kissle, 1990)
**Self-Harm Inventory (SHI)**

- Self-harm is defined as the deliberate, direct destruction of body tissue without conscious suicidal intent but results in injury severe enough for tissue damage to occur
- Made up of 22 items that were selected due to their correlation with the Diagnostic Interview for Borderlines (DIB)
- *Developed in context of screening for BPD*
  - Borderline Personality Disorder exists on a continuum in which self-injury is the most severe manifestation of self-sabotaging behaviors
  (Sansone, Wiederman, and Sansone, 1998)
• **Self-Injury Questionnaire (SIQ)**
  – Developed to evaluate differentiation in self-injury intentions based on a history of childhood physical and/or sexual abuse
  – Defines self-injury as self destructive behaviors without the intent to die
  – 30-item self-report instrument conceptualized from developments in trauma research measuring the intent for self-injury through methods across subscales of body alterations, indirect self-injury, failure to care for oneself, and overt self-injury (Alexander, 1999)
• Deliberate Self-Harm Inventory (DSHI)
  – Developed using an integrated definition of self-injury in order to help provide a clear foundation for the instrument, given that previous assessments had lacked consensus in definition (Gratz, 2001)
  – 17-items that are behaviorally based and reliant on self-report
**Suicide Attempt Self-Injury Interview (SASII)**

- designed to evaluate factors involved in what the authors referred to as “nonfatal suicide attempts and intentional self-injury” (Linehan, et al., 2006)

- Once called the Parasuicide History Inventory
  - developed in order to better understand the methods involved in self-injury, the motivations, consequences, ritual, and impulsivity of the act itself

- In defining suicidal behavior, this instrument includes all general definitions pertaining to para-suicide, fatal and nonfatal suicide, and self-injury without intent to die

- Six scales are evaluated which include lethality of the method, suicidal and non-suicidal intent associated with an episode, communication of suicide intent prior to the episode, impulsivity, physical condition, and level of medical treatment
• **Self-Injury Implicit Association Test (SI-IAT)**
  – Developed and examined in two forms by Nock and Banaji (2007) as based on The Implicit Association Test (IAT) as developed by Greenwald, McGhee and Schwart (1998)
    • IAT is primarily used for evaluating associations to non-clinical constructs and beliefs
  – Measures the implicit associations individuals have concerning self-injury in terms of identification with the behavior as well as attitudes about it
Self-Injurious Thoughts and Behaviors Interview (SITBI)

- Developed by Nock, Holmberg, Photos and Michel (2007)
- 169-item structured interview that assesses the presence, frequency, severity, age-of-onset, and general characteristics associated with the thoughts and behaviors of suicidal ideations and suicide attempts
- Assumes that by definition, self-injury does not include the intent to die and thus differentiates self-injury from suicidal intent and action
For mental health counselors, it is important to consider the population you are using before selecting a particular self-injury assessment tool. Critical to realize that formal assessments are only one piece of the assessment process and mental health counselors should never utilize measures in isolation.
### Table 1. Strengths and Weaknesses of Current Scales

<table>
<thead>
<tr>
<th>Inventories</th>
<th>Author(s)</th>
<th>Created</th>
<th>Reliability</th>
<th>Validity</th>
<th>Use/Factors</th>
<th>Predictive Ability</th>
<th>Suicidality</th>
</tr>
</thead>
<tbody>
<tr>
<td>SITS</td>
<td>Iwata, Brian A.; Pace, Gary M.; Kissel, Robert C.</td>
<td>1990</td>
<td>2</td>
<td></td>
<td>Assessing tissue damage as result of self injury</td>
<td>Able to predict current risk</td>
<td>Not evaluated</td>
</tr>
<tr>
<td>SHI</td>
<td>Sansone, Randy A.; Wiederman, Michael W.; Sansone, Lori A.</td>
<td>1998</td>
<td>2</td>
<td>Predictive</td>
<td>Identifying self injury in conjunction with BPD</td>
<td>Predict presence of borderline personality features</td>
<td>Can differentiate between high and low lethality</td>
</tr>
<tr>
<td>SIQ</td>
<td>Alexander, L.</td>
<td>1999</td>
<td>2</td>
<td>Face and Convergent</td>
<td>Use with those who have suffered trauma</td>
<td>Measures intent to self harm</td>
<td>Measures for major suicide concepts</td>
</tr>
<tr>
<td>DSHI</td>
<td>Kim L. Gratz</td>
<td>2001</td>
<td>4 Test-Retest</td>
<td>Internal Consistency Construct Convergent and Discriminate</td>
<td>Behaviorally based; Clinical populations</td>
<td>Able to predict the features of self injurious behaviors</td>
<td>Suicidal Intent assessed</td>
</tr>
<tr>
<td>SI-IAT</td>
<td>Matthew K. Nock &amp; Mahzarin R. Banaji</td>
<td>2007</td>
<td>3</td>
<td>Predictive</td>
<td>Assessing beliefs &amp; identification with self injury</td>
<td>Predict suicidal ideation and behaviors</td>
<td>Evaluated and differentiated</td>
</tr>
<tr>
<td>SASII</td>
<td>Marsha M. Linehan, Katherine Anne Comtois, Milton Z. Brown, Heidi L. Heard, and Amy Wagner</td>
<td>2007</td>
<td>3 Inter-rater</td>
<td>Predictive Content</td>
<td>Provide descriptive info on suicidal and self injurious behaviors</td>
<td>Evaluates past behavior; Based on PHI</td>
<td>Suicidal intent and lethality of self injurious behaviors</td>
</tr>
<tr>
<td>SITBI</td>
<td>Matthew K. Nock, Elizabeth B. Holmberg, Valerie I. Photos, and Bethany D. Michel</td>
<td>2007</td>
<td>4 Inter-rater Test-Retest</td>
<td>Construct</td>
<td>To assess a wide range of self injury related constructs</td>
<td>None Stated</td>
<td>Assessed gestures, plan, ideations, and attempts</td>
</tr>
</tbody>
</table>

**Notes:** 1= No reliability indicated in literature, 2 = Good reliability for disordered population developed, 3= Good general reliability for use with those who self injure, 4 = Excellent reliability for self injury, well tested
<table>
<thead>
<tr>
<th>Inventory</th>
<th>Internal Reliability</th>
<th>Test-Retest Reliability</th>
<th>Predictive Validity</th>
<th>Construct Validity</th>
<th>Convergent Validity</th>
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<tbody>
<tr>
<td>SITS</td>
<td>.80</td>
<td>.68</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>SHI</td>
<td></td>
<td>.84&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>SIQ</td>
<td>.83</td>
<td>.34&lt;sup&gt;2&lt;/sup&gt;</td>
<td>.89&lt;sup&gt;3&lt;/sup&gt;</td>
<td>.64&lt;sup&gt;3&lt;/sup&gt;</td>
<td>.45</td>
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<tr>
<td>DSHI</td>
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<td>.68</td>
<td>.34</td>
<td></td>
<td>.49&lt;sup&gt;4&lt;/sup&gt;</td>
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<tr>
<td>SASII</td>
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<td>SI-IAT</td>
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<td>.74-.77</td>
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<tr>
<td>SITBI</td>
<td>.70</td>
<td>.54</td>
<td></td>
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</tbody>
</table>

1. The average predictive ability in classifying individuals with Borderline Personality Disorder at a score of 5 on the SHI scale;  
2. The correlation with the Suicide Intent Scale (SIS) total;  
3. Correlation with affect regulation, coping, disassociation with SIQ affective subscale;  
4. A correlation representing similar convergent and discriminate validity to Mental Health History of self-harm item;  
5. Agreement of assessment over treatment intervals during a one-year period.
Tier One: Formal Assessment

Self Injury Assessment

- Self Injury Assessment Inventory
- Suicidality Protocol Inventory
- Trauma Inventory

In Combination with

Tier Two: Informal Assessment (all are ongoing)

- Background
- Familial History
- Peer Support
- Social Support
- Negative Positive Influences
- Emotional Capacity
- Verbal ability to express emotions
- Coping Strategies
Core Assumptions

- Grounded in Multiculturalism and Diversity
- Personal is Political
  - Cultures strongly impact who people are and how they experience life
  - Person’s style of living either contributes to or challenges the culture that influenced them

- The ways in which individuals choose to respond to the dominant culture causes individual difficulty or fulfillment.
- Each person’s unique response is a political stand in the face of the restrictions of the culture.
  - Recognizing this in therapy and helping clients understand and express themselves allows for a greater contribution of diverse voices within the community
Egalitarian Relationships

- Dreikurs (1971) recognized that each person was unique and different and in this sense true equality in relationships cannot be based on *sameness*.
- Necessary to pay attention to how our differences are perceived by others.
- Social equality is a proclamation that every person still has an *equal right to be valued and respected*.
• Gathering background information in order to better understand the perspective of the client
  – Contributing Factors
• Focus on how Self-Harm is serving a purpose in the client’s life
  – Coping Mechanism
  – Connection to Trauma and/or need for control
  – Impulsivity, ritual behaviors, episodic
• Focusing on empathy, resiliency, encouragement, understanding, and connection rather than conflict
  • Focusing on problem-solving and contribution
• Four Phases of Adlerian Therapy

I. Forming a Relationship
   I. Addressing Power Differentials in Therapy
   II. Building an egalitarian relationship

II. Psychological Investigation
   I. Naming and conceptualizing cooperation and social equality within intimate and familial relationships
   II. Gender Guiding Lines
   III. Consciousness-raising
   IV. Valuing Perspective
• Four Phases of Adlerian Therapy

  III. Psychological Disclosure/Interpretation
    I. Tentative Suggestions: Purposefulness of behaviors and feelings
    II. Acknowledgment of present experience
        – Noting the perspectives of the client and the experiences and contexts for experience in which these perspectives were developed
        – Exploring alternative interpretations, convictions, ideas, stories, and beliefs as new possibilities

  IV. Re-orientation and Re-education
    I. Reframing old experiences, patterns, and messages
    II. Creating new experiences
BASIC INTERVENTIONS

• Take the client seriously!
• Assess seriousness of the wound with permission.
• Check for suicidal intent.
• Consult colleagues if questions about ethical and legal obligations.
  – School/Agency Policy v. Ethical Codes
• Utilize a chain of helpers (i.e. keep communication lines open between school and community counselor)
BASIC INTERVENTIONS

• Make statements that demonstrate your understanding of the self-harmer’s feelings.
• Make a list of people she/he can use as a support.
• Attempt to understand why the client is utilizing these behaviors (be aware of the family system/history).
BASIC INTERVENTION

• Help the client to find words to express her/his pain:
  – "If your wounds could speak, what would they say about you?"

• At each meeting, briefly ask the client whether or not there are any new injuries.

• With each new cut, ask her/him to verbalize her/his feelings before, during, and after the act.

• **DO NOT** treat as suicide attempt.
• Discuss power imbalance and role differences in the therapeutic relationship
  • Help clients understand process of counseling
  • Dialogue on ways to reduce power differentials
  • Therapy is a collaboration where clients are viewed as active participants in redefining themselves
– Suited for practitioners to invite clients to discuss the role, value, process, and goal of therapy.
  • Valuing the voice of those individuals who have otherwise been marginalized or diminished in society begin to find significance, contribute more effectively, and are able to be pro-active in taking a stand on their own behalf.
• Assessment of Power Differentials in Life
  – Self-Injury a way to control feelings, etc.
  – Assessment of Private Logic
    • Where and how did personal beliefs develop
  – Develop realistic view
    • When they feel they are being controlled
    • What they can do in discouraging situations
    • How situations of power differential affect their lives and what can be done to address that
**Externalization**: Counselors formulate questions that would encourage the client to begin to see their self-injury as external to themselves.

- By focusing on function, role, and the feelings associated with self-injury, the client may begin to see the behavior exists independent of her. For clients, the process of verbalizing this aloud can be an empowering exercise.
  - What function does self-injury have in your life?
  - How does the self-injury take over you, what is your role in letting it take over?
  - What feelings are often associated with self-injury?
Adhering to White’s model for narrative therapy, externalizing questions are to be followed by questions that search for unique outcomes (Gondim, 2006).

Searching for unique outcomes allows the client to imagine what their future may look like, once they no longer need or want to harm themselves.
  – Was there ever a time when you wanted to harm yourself and didn’t?
    • How did this feel? What did you do to prevent yourself from cutting?
  – If you could imagine resisting the temptation to cutting, what would it look like?
Encourage the client to “create an audience” or to imagine how someone in their lives would view the accomplishments they have had thus far.

This approach allows the counselor to assess support systems, but also serves to validate and empower the client.
• Eye Movement Desensitization and Reprocessing
  – Shown to be empirically successful in working with issues related to trauma
• Address the issue of trauma without reviewing the details verbally
  – Prevent triggering Self-Injurious Behavior
• Replacement Behaviors
  – Must address physical, psychological, and emotional needs that are being met by the self-injurious behavior
    • Ex. “I start to calm down when I see the blood…”
  – Use of ice, rubber band snapping, red markers
  – Approach has a hyper-focus on the outward symptoms of self-injury, ignoring the underlying issues
  – Meant for temporary assistance complimenting holistic treatment approach


