

Nonsuicidal Self-injury: Examining the Relationship between Diagnosis and Gender

Amanda C. Healey

Heather C. Trepal

Kelly Emelianchik-Key

Amanda C. Healey is affiliated with Sam Houston State University, Heather C. Trepal with the University of Texas at San Antonio, and Kelly Emelianchik-Key with Old Dominion University. Correspondence concerning this article should be directed to Amanda C. Healey, 200 Fountains Lane 10108, Conroe, TX 77304. E-mail: ach027@shsu.edu.

This study examined the perceptions of counselors in training concerning nonsuicidal self-injurious behaviors (NSSI), diagnosis, and the influence of gender-normative expectations on clinical decision making. Participants were asked to respond to a set of questions after reading a randomly assigned case study. The purpose was to determine the process through which counseling professionals diagnosed adolescents who self-injure and whether the sex of the client influenced the decision. Cases presented were identical except that the sex of the client was altered. It appears that societal expectations associated with biological sex may influence counselor diagnostic decisions at the training level. Implications for diagnosis, counselor training, and future research are presented.

Nonsuicidal self injury (NSSI) has been defined as the "deliberate, socially unacceptable destruction of one's own body tissue without the intent to die" (Simeon, Favazza, & Hollander, 2001, p. 1). The term encompasses a range of behaviors, such as cutting, burning, skin-picking, interfering with wound healing, hitting oneself, and inserting objects under the skin, (Favazza, 1998; Fliege, et al., 2006; Klonsky, 2007b). Prevalence has been estimated at 14–39% of adolescents (Nock & Prinstein, 2005) and 17–35% of undergraduate students (Gratz, Conrad, & Roemer, 2002); lifetime prevalence rates may range from 13–23% with onset of NSSI typically occurring at ages 12–14 (e.g., Jacobson & Gould, 2007). There appears to be considerable variability as self-reported in methods used, location of NSSI on the body, and NSSI frequency (Berman, Bradley, Fanning, & McCloskey, 2009; Klonsky, 2007a; Lloyd-Richardson, 2010). Although NSSI was once thought to be more common among females (McAllister, 2003), recent studies challenge that assumption (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Muehlenkamp & Gutierrez, 2004).

Factors Associated with NSSI

Features typically associated with NSSI can be divided into two broad categories: risk factors and motivations. Risk factors can be defined as those behaviors, symptoms, or diagnoses empirically associated with self-injury with regard to client actions as well as clinical judgment and perceptions. To properly assess and treat self-injurious behaviors, it is important to be aware that clinically significant risk factors may influence the severity and type of NSSI used by clients to cope with emotional distress (Craigien, Healey, Walley, Byrd, & Schuster, 2010). Awareness of risk factors associated with a client's presenting issues may also provide clues to the purpose or motivations of the thoughts, feelings, and behaviors reported.

Risk Factors

In assessing NSSI it is important to be aware of common co-occurring behaviors and diagnoses so as to determine the possible purpose, severity, and treatment of the client's self-injurious behaviors. Many factors, such as childhood abuse (Gratz, 2006; Marx & Sloan, 2002; Weierich & Nock, 2008); chronic physical or mental illness (Barnes, Eisenberg, & Resnick, 2010); and substance abuse have been linked to NSSI (Berman et al., 2009). It is also often associated with such diagnoses as bulimia nervosa, depression, posttraumatic stress, bipolar disorder, and borderline personality disorder (Bierer et al., 2003; Etzel, 2006; Gollust, Eisenberg, & Golberstein, 2008; Hawton, Sutton, Haw, Sinclair, & Harriss, 2005; Sansone & Levitt, 2002; Symons & Danov, 2005). Symptomatology associated with each of these diagnoses will vary as they relate to NSSI; however, common symptoms include somatic problems, emotional inexpressivity, distress resulting from trauma, impulsivity, and other self-destructive behaviors (Gratz, 2004; Hilt, Cha, & Nolen-Hoeksema, 2008; Marx & Sloan, 2002).

Motivations

Self-injury is a purposeful behavior with a variety of motivations linked to a need for emotional regulation and control of present experience. For example, individuals may utilize NSSI to internally regulate emotions by using the behavior to stop, start, or limit feelings (Gratz, 2007). They may also use NSSI to regulate their external environment (avoid something, get attention in order to fulfill needs, elicit a reaction for various purposes). Such behaviors may also serve a variety of functions that may change over time as individuals gain more experience with NSSI and as developmental needs change (Lloyd-Richardson et al., 2007).

Sex Differences and NSSI

There may be sex differences in the presentation of NSSI that it would be clinically important to note when assessing risk factors and motivations to determine treatment. These differences are likely due to societal gender role expectations associated with the biological indications of being male or female. For example, it has been reported that males experience more pain while self-injuring, tend to burn and self-hit more often, engage in less wound care, place less priority on concealing their wounds, and are less concerned about disfigurement (Andover, Primack, Gibb, & Pepper, 2010; Hawton, 2000). Males are also more likely to engage in outwardly aggressive behaviors, which could influence the presentation of self-injury (Berman et al., 2009; Harris, 1995). Conversely, females tend to use cutting and scratching, report more sexual abuse experiences, and report earlier onset of NSSI (Andover et al., 2010). It has also been noted that clinicians are more likely to assess for self-injury when working with females, and they are more likely to consider diagnoses like as posttraumatic stress disorder (PTSD) and borderline personality disorder (BPD) when determining treatment (McAllister, 2003; Nehls, 1998; Sargent, 2003). Although these reported sex differences are intriguing, they deserve further study.

Based on what is known about gender role socialization, it can be hypothesized that the functions of NSSI may differ by biological sex due to the expectations associated with identification as male or female. The behaviors may be engaged in to manage emotions. For example, for men such gendered expressions of emotions as control, physical aggression, competition, and risk-taking are common. Further, NSSI may serve a gendered external social function in males (attention getting and competition) (Claes, Vandereycken, & Vertommen, 2007) as well as an internal one (managing feelings and relieving frustrations when oral demonstrations of emotions are thought not to be acceptable) (Taylor, 2003). Claes and

colleagues found that men who reported NSSI referred to the behavior as a sign of strength more than women did. Although the results of this study were not statistically significant and participants were inpatients, they suggest that gendered motivations for NSSI may be an area meriting further exploration.

Gender Norms and Diagnosis

Socially constructed gender roles often pit males and females as opposites. According to Gilbert and Scher (1999), western society supports the Traditional Opposite Model, where men are encouraged to be independent, aggressive, stoic, goal-oriented leaders and women are encouraged to be relational, supportive, emotionally expressive, emotionally reactive, and social followers or nurturers. These socialized roles can serve both positive and limiting functions, and violations of gender-guiding lines may lead to frustration, devaluation, exclusion, and disappointment (1999).

In a classic study, mental health professionals equated the characteristics of a healthy adult to those of a healthy male (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970). More recent studies have echoed these findings (Danzinger & Welfel, 2000; Vogel, Epting, & Wester, 2003). Current diagnostic prevalence norms overlap with stereotypes of western society. For example, men are more commonly diagnosed with disorders definable as acting out (e.g., oppositional defiant disorder, antisocial disorder, attention deficit disorder) and women with depression and eating disorders, which could be characterized as acting inward (Fliege et al., 2006; Hirshbein, 2009; McKnight-Eily et al., 2009; Sansone & Levitt, 2002). Further, it has been suggested that there is a masculine bias in DSM-IV-TR diagnoses that would account for the greater prevalence of mental illness in women (Eriksen & Kress, 2006). These studies make it reasonable to conclude that clinicians may not be aware of how gender

expectations affect clinical conceptualization and diagnostic impressions. The intersection of client-gendered behavior and clinician-gendered expectations has been found to be an issue with regard to clinical decision making, particularly for categorizing and treating self-injury (Bjorklund, 2006; McAllister, 2003; Sargent, 2003).

Diagnosis and NSSI

The relationship between NSSI and diagnosis is complex. For example, in the current edition of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; APA, 2000, p.710), self-mutilating behaviors are listed as a diagnostic criterion for BPD. They are not mentioned elsewhere, although a distinct diagnosis of NSSI has been proposed for the next edition (APA, 2010). Arguments have been presented for and against a distinct diagnostic category for NSSI (e.g., Muehlenkamp, 2005). However, since diagnosis can be one concrete way of thinking about behaviors, much attention has been paid to researching NSSI in persons diagnosed with BPD.

NSSI and BPD share a central feature of emotional dysregulation. For example, dissociation, alexithymia, and less awareness of emotions are commonly reported by both persons who self-injure and those diagnosed with BPD (Gratz, 2007). Mental health professionals have historically viewed BPD as a complicated condition. Women are diagnosed with it three times as often as men (Bjorklund, 2006). It has been argued that mental health professionals may treat some clients differently, particularly women, when they have been diagnosed with this potentially stigmatizing label (Bjorklund, 2006; Sargent, 2003). Moreover, sex differences that favor a BPD diagnosis for women may make it more difficult for clinicians to diagnose these behaviors in males. That is why clinicians must consider context when forming diagnostic impressions.

There is evidence that mental health counselors considering the possibility of BPD tend to look beyond the BPD diagnosis. For example, Trepal and Wester (2007) found that although many clinicians would diagnose clients who self-injured with BPD (39.5%), other diagnoses were also routine, such as depression, PTSD, anxiety disorders, bipolar disorder, substance abuse, and eating disorders. Counselors in that study also reported positive treatment rates with clients who self-injured with a variety of diagnoses and treatment modalities. That suggests that clinicians may need to look beyond BPD as the standard diagnosis when NSSI has occurred.

This study sought to examine the relationship between NSSI, diagnosis, and gender in treating adolescents. The age selected for the case study was chosen because of the prevalence of NSSI onset during adolescence. A qualitative methodology and case study analysis was used to evaluate whether historical assumptions about the presentation of self injury still prevail and to develop a nuanced understanding of the development of clinical decision making about self-injury and the influence of societal gender expectations.

Method

Sample

Participants were recruited from the counselor preparation programs at three universities in the southeastern United States. After institutional review board approval, participants were recruited over two academic semesters through internship coordinators and supervisors at each program. Given a case study and open-ended questions about NSSI, master's-level internship students were asked to conceptualize the issues presented, provide preliminary diagnostic impressions, highlight concerns, and discuss ideas for treatment. Participants were randomly assigned a case study. Of the case studies completed, 34 participants responded to the male case study and 33 to the female (Appendix A).

The 67 participants who completed the response packet were 83.6% female and 13.8% male. Their self-reported racial identity was 42% Caucasian (42%), 13.4% Hispanic/Latino, 4.5% African-American/Black, and 3% Asian. Average age was 29 (range 23–52). The majority of the respondents reported to be heterosexual (58%) with 8% reporting lesbian, gay, or bisexual; the remainder of participants did not report their sexual orientation. Of their specializations, 66.7% were on the community mental health track, 31.3% in school counseling, and 1.5% in family counseling. Half the participants reported completing 100 hours or less of direct contact with clients, though the average number of direct hours completed was 146.

Asked about their experience with diagnosis, 20.9% had taken a graduate course on it, and 5.9% had practicum and internship experience. Other responses were community agency workshops, working in a health hospital, and other training (e.g., intake diagnosis, employment, internship, assessment class, undergraduate course, observation of charts). As for their experience with NSSI, 22.4% ($n = 15$) reported that they had learned about it in a graduate course, 7.46% in seminars, and 2.98% in conference workshops (2.98%). Other responses were working with a client who self-injured, work-related experience, internship, practicum, school workplace, and reading and literature reviews (Table 1).

[Insert Table 1.]

Data Collection Procedure

This study was conducted using a qualitative design consisting of two case studies that were created to illustrate an adolescent client who had displayed self-injurious behaviors. A grounded-theory approach was used to extract themes from participant responses to a uniform questionnaire (Creswell, 2009). The cases were identical except for the reported sex of the client. The researcher randomly assigned case studies to participants the day they participated. They

were given six questions to answer after reading the case study. These asked them to provide their diagnostic impressions, clinical judgments about treatment, thoughts on motivation or behavioral purpose, clinical concerns, and possible referrals for additional mental health services, and then to offer a diagnosis they would be inclined to consider for the client in the case study. They were also asked to read the case and complete a structured open-ended questionnaire about their impressions and rationale. This inquiry followed coding procedures consistent with a grounded theoretical tradition (Charmaz, Hesse-Biber, & Leavy, 2008; Corbin & Strauss, 2008).

Data Analyses

The resulting data were analyzed using consensus coding and categorical response tracking after themes were agreed upon (Patton, 2002). Demographic variables were entered into SPSS for analysis. Three researchers supervised the collection of data from each site and then assessed participant responses for themes. After individual coding, team members exchanged data and discussed impressions and results in order to reach final consensus on themes. In conjunction with overall thematic coding, each categorical theme was then assessed for sex differences that might be associated with clinician gender-normative beliefs. Data were reviewed to identify categories associated with each theme as they related to the sex of the client as presented. This was done to determine gender differences in diagnostic impressions and labeling, treatment approaches, and concerns for clinical work with the client. The results were consistent with previous studies on diagnosis of clients presenting with self-injurious behaviors (Trepal & Wester, 2007) and indicated the possibility of significant gender differences in clinical decision making.

Results

Treatment Themes

In assessing the case, participants discussed a variety of treatment approaches; some focused on a specific theoretical modality, others on developing client-focused interventions, and some addressed both aspects of treatment. The majority of participants related a need to approach treatment from a cognitive-behavioral (CBT), person-centered (PC), or solution-focused (SF) perspective. Typically participants discussed using a PC approach in order to build a therapeutic alliance and create an atmosphere for collaborative work. For example, one participant who received the female case study stated that she or he would “start with client-centered approaches to develop a therapeutic relationship; it might take a long time for her to trust me and to open up.” However, participants seemed to view the PC approach as necessary only for relationship and trust building: one respondent would “want to move on to a more direct approach as I earn the client’s trust” and another would “take a humanistic approach while building rapport and then use solution-focused or cognitive-behavioral techniques” to help change the self-injurious behaviors.

While participants accepted overlapping theoretical approaches (CBT, PC, and SF), there was more variety mentioned for working with the female client than with the male. For instance, participants discussed the possibility of referring clients for Eye Movement Desensitization and Reprocessing therapy (EMDR) for working through the trauma experiences described in the case study, integrating art or expressive therapeutic approaches, or using other theoretical frameworks like Adlerian or Gestalt when discussing work with the female client more than with the male client. When participants discussed therapeutic work for the male, approaches were more focused on behavioral interventions and developing coping skills for dealing with overwhelming emotions. There was not as many options offered for treatment (Table 2).

[Insert Table 2.]

When behavioral interventions for the male were discussed, the idea seemed to be to help the client create “appropriate” or “nonaggressive” ways to express emotions. One participant said, “He needs to be allowed to get his anger and hurt out; the counselor should teach him appropriate ways to do so.” This CBT approach was related to the creation of no-harm contracts, with one participant stating that “I would work to make the client aware of his feelings about cutting... and work with the client to come up with a list of alternative activities to cutting... additionally I would engage the client in a no-harm contract.” Participants discussed creating a no-harm contract with the client only for the male case study (5 of the 34 responses).

Clinical Conceptualization

Asked to discuss what purpose they thought the self-injurious behavior was serving for the client and explain their reasoning, most participants emphasized emotional release and control, self-punishment, distraction from difficult emotions, and a need for attention. Common themes associated with client conceptualization were that self-injury might be used as a coping mechanism, a way to control or release emotions and divert attention away from feeling emotions. One participant thought that perhaps “the self-injury may come from her feeling in control of her actions and giving herself a strong [physical] pain to outweigh her internal pain or anger.” Another participant thought that perhaps the client felt that “the self injury was the only thing that he had control over.” The theme of emotional control or regulation seemed to dominate how participants conceptualized the purpose of self-injury for both the male and female case studies.

There were, however, differences with regard to perceptions of attention-seeking behavior, self-punishment, and desire to feel physical rather than mental pain. Participants conceptualized the female client as needing to release stress through self-injury but the male as

self-punishing or preferring physical pain to dealing with difficult emotions. One participant stated that the male client may be using self-injury to make “him focus on the physical pain versus his emotional pain” and another that the behavior may be a “way to release pain and take the focus off his internal feelings onto something physical,” implying it may be easier for the male client to deal with physical pain than emotions. This idea may be connected to the idea that physical aggression is more socially acceptable for males in our society (Claes et al., 2007; Harris, 1995; Leadbeater, Boone, Sangster, & Mathieson, 2006). Other participants stated that the male client may “feel some kind of blame for the sexual abuse and punish himself.”

When discussing the female, participants emphasized the possibility that the client may be “using the self-injury as a way to seek help” or maybe “she even likes the attention she gets from it.” In that regard, participants also discussed it as a method for “connecting to her only friend” or getting attention from her family members. This was linked by one participant to the idea of stress relief: “maybe it helps her release stress or deal with her past abuse or she could be trying to get sympathy.” It is interesting to note that the term “anger” was used more often to describe the male client’s behavior and “emotion” was used more often to describe the female’s. Table 3 summarizes diagnostic impressions and conceptualizations participants offered for each case study.

[Insert Table 3.]

Diagnosis

Respondent statements indicate that bipolar, posttraumatic stress, depression, and anxiety-related disorders were of paramount consideration in making a diagnostic decision. It was thought that depression might be a valid diagnosis “because of suicidal ideations and self injury... there should be some emotions that would motivate someone to [self-injure]” and that

depression would be evidenced by isolating behaviors such as “self-injury, dropping grades, suicidal ideation, and demonstrated behavior by cutting and burning self.” Anxiety seemed to be a consideration for working with the female client in relation to the history of sexual abuse. For example, one participant “would be inclined to focus on the anxiety as a result of her sexual abuse”; however, anxiety was only considered in conjunction with a diagnosis of depression.

The diagnosis of depression and recognition of related symptoms was a common result for both the male and female case studies and was typically related to adjustment issues, isolation, suicidal ideation, and the NSSI behavior itself. In all, 32 participants were inclined to diagnose a depressive disorder either alone or in conjunction with another diagnosis, such as BPD or PTSD. Other diagnostic impressions offered began to diverge with regard to reasoning and inclination for assignment of diagnoses as it related to gender status (Figure 1).

[Insert Figure 1.]

There was some overlap in the diagnoses of PTSD for both the male and female client, though a slight majority were associated with the male case study: 10 of the 35 male case reviews and 8 of the 34 female . Decision-making about PTSD typically focused on “the client’s history of sexual abuse and nightmares.” Another 9 participants evaluating the female case study stated that they would want to assign a diagnostic v-code specifically for the past childhood sexual abuse, but only 2 more did so for the male case study. Two participants responding to the female case study also stated a concern related to body image issues emerging in conjunction with PTSD and the need for treating this. This issue did not emerge in any of the responses to the male case study.

Diagnoses that were reported in responses to one case and not another or seemed to significantly diverge with regard to sex included BPD for both male and female cases (8

respondents, male and female cases); adjustment disorder for females (3 respondents); and bipolar disorder (2 respondents), conduct or oppositional defiant disorder (3 respondents) and substance abuse (respondents) for males. Two respondents to the male case study discussed the possibility of a BPD diagnosis but related it either to “self injury, suicidal ideation, and history of substance abuse” or the idea that the client might have borderline features “because he’s okay with being alone, but injures self like borderline.” Six respondents to the female case discussed the possibility of diagnosing BPD or features of it for reasons associated specifically with the self-injurious behaviors and because the behavior could be the result of a need for attention or to “drown out the pain” from past abuse. Six respondents stated that they needed more information before they would be willing to speculate on a diagnosis (Table 3).

[Insert Table 3.]

Clinical Concerns

Of the 67 participants who completed a case-study guided-response packet, 37 were concerned that the client might plan to or accidentally commit suicide while under their care; one stated that the “only concern is the suicidal thoughts but otherwise nothing else would concern me.” This concern occurred in conjunction with apprehension that the client might continue to self-injure during counseling in 14 cases, 10 of them responding to the female case study. Those stating a concern for both suicide and continued self-injury seemed to feel that those who “self injure are more likely to attempt suicide.” Another 10 participants related a concern for continued self-injury without mentioning a concern for possible suicide or suicidal ideation. Three seemed to be concerned about whether or not the female client’s uncle was sexually abusing her and about the relationship between uncle and client. Eight stated that they were concerned about the perception that there might be a lack of a positive male role model and

wanted to address this in counseling. Four were concerned about the client being placed in a home away from the biological mother, thinking the placement away from her may be contributing to symptoms related to depression or “possible feelings of abandonment.”

Other treatment issues mentioned as concerns were building rapport and trust, creating a supportive social network, and engaging the family in the counseling process. Four respondents stated a concern about whether they were competent to work with a client who was self-injuring and whether they “might be too inexperienced... I would want to make sure he was able to receive the very best care available to him.”

When respondents were asked to discuss referrals for care, the most frequent response (n = 28) was based on a perception that the client needed to be on medication, so referral to a psychiatrist was warranted. Several also mentioned the need for medical evaluation of the self-inflicted injuries as well as assessment for possible hospitalization. Eleven participants, two in response to the male case, discussed a referral for specialized services to work with the client’s history of sexual abuse. Other referrals or services recommended to supplement individual counseling were group counseling (n=14), family counseling (n=10), and coordination of care with a school counselor (n=3). One respondent to the male case study suggested exercise and another finding a church-based support group.

Discussion

The purpose of this study was to determine clinician perspectives that may influence decisions about the diagnosis of adolescents who self-injure and used case study analysis to examine the influence of gender on decision making. The results indicate that gender role expectations may play a role in the conceptualization, diagnosis, and treatment of NSSI. However, the study does have limitations. First, the participants were all counselors in training with limited clinical experience; the themes generated from this inquiry might differ if the study

were replicated with more experienced, practicing clinicians. Also because qualitative research is intended to be used to describe and develop themes in context—it focuses on particularity, not generalizability (Creswell, 2009)—the results may not be representative of all counselors-in-training.

Although there were overlapping conceptualizations, diagnoses, and treatments offered for both male and female clients in the case study, there were also several significant differences. Since the sex identified for the client was the only difference in the case studies, it is assumed that it was the cause or a major contributor to respondents diagnosing and treating the case differently. Gender-normative expectations may influence how a clinician assesses the behaviors and diagnosis of the client, which can ultimately affect client outcomes (Vogel et al., 2003). In this study both clinician and client gender norms and socialization may have played a role in the sex-related discrepancies in conceptualization, diagnosis, and treatment. From an early age, society shapes the way we view gender and gendered behaviors. This could account for instinct of the respondents to frequently attribute problematic, gender-normed behaviors to the NSSI. For example, in this study, participants more frequently referred to males as *angry* and females as *emotional*. Clinicians need to recognize the role of sex and gender norms because the client's sex may influence recognition of presenting issues as NSSI. Also, the functions of NSSI may differ by sex (Claes et al., 2007; Taylor, 2003), which could alter diagnosis and treatment.

This study also revealed that student counselors know little about the conceptualization and diagnosis of NSSI. Many did not differentiate between diagnosis and conceptualization; the same responses were reported for both questions. Some repeatedly conceptualized features of male clients as “angry, lack of male role model, and self-punishment,” and of female clients as “body image, emotional expression, and attention seeking.” These conceptualizations reflected

typical gender-normed concerns, although as a whole they did not address concerns about actual NSSI behavior. The student counselors who actually diagnosed the client cases tended to diagnose both males and females with depression and PTSD, males more often with bipolar disorder and substance abuse, and females more often with adjustment disorder and BPD. These diagnoses could be viewed as guided by gender but also show a lack of information about diagnoses that include self-injurious behaviors. In several cases the participants did not give a conceptualization of the client that supported the diagnoses given.

Hays, Prosek, and McLeod (2010) indicated that there is inconsistency in the frequency with which more severe diagnoses are given to clients within marginalized populations or diverse cultural groups (i.e., racial/ethnic minority and gender). Counselors tend to exhibit cultural blindness in clinical decision making, diagnoses, and projected prognosis or outcome. Gender stereotypes have also been reported to affect the clinical decisions of mental health professionals, which have led to more severe diagnoses of marginalized or oppressed cultural groups (Ford & Widerer, 1989). Culture and gender clearly influence clinical decision making. Because clinical decisions determine the trajectory of a client's treatment, culture and gender need to be considered in a therapeutic relationship. Counselors, whether experienced or in training, need to be aware of the role of culture in their own clinical decisions, with regard to similarities as well as dissimilarities. When diagnosing a client presenting with NSSI behavior, a counselor needs to determine if the diagnosis would be the same if the client's gender or culture were different.

Recommendations for Mental Health Counselors and Research Implications

The results of this study indicate that there is a need to address both gender bias and the diagnosis of NSSI, particularly in counselor preparation programs. There was a general lack of

certainty and knowledge of the conceptualization, diagnosis, and treatment of NSSI. Aspiring counselors need additional training in diagnostic considerations relative to clients who present with self-injurious behaviors. Training is also needed in how gendered perceptions and biases may translate to later clinical decisions and treatment. It has been recommended that counselor preparation programs include literature and training on the topic of gender and diagnosis (Eriksen & Kress, 2008). Counselors and counselors in training are encouraged to examine their own gender socialization and the role of early messages for themselves and their clients.

Finally, more research is clearly needed in the area of NSSI and gender, particularly with regard to gender-based expressions and expectations of these behaviors (Andover et al., 2010; Claes et al., 2007; Taylor, 2003). Diagnoses and treatments need to account for gender when NSSI is evaluated; further research examining the role of gender through societal expectations and gender norms that might influence the presentation of these behaviors is necessary. More research is also needed on clinician efficacy in the diagnosis and treatment of clients who self-injure (Trepal & Wester, 2007). It has recently been reported that there is a proposal that the new edition of the DSM V set out a distinct diagnostic category for NSSI (American Psychiatric Association, 2010). If this new diagnosis is indeed adopted, researchers and clinicians will have an opportunity to expand their thinking about these behaviors.

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Appendix A

Case Study

You are a licensed counselor working at an outpatient mental health facility. Recently, you were referred a new client. The client is a 15-year-old Caucasian female who has been having difficulties at home and at school. She has been living with her aunt and uncle since age 8 after being removed from her mother's home. She was placed with her aunt after reports of sexual abuse perpetrated by her 13-year-old biological brother and 16-year-old step-brother. Aunt reports that the client has been very irritable and isolating herself from the family for the past two years. Prior to that time, it was reported that the client had nightmares and was relatively shy but did not have any overt disruptive behavioral problems. The client was recently hospitalized for cutting herself on the forearm with a razor in her high school bathroom. Her aunt stated that she had previously noticed burn marks on the client's arms. In addition, the client has refused to do work in school or follow the instructions given by her teachers. She frequently goes to the school nurse during the day for headaches, and her grades have been steadily dropping since the beginning of the school year. Since the start of the school year, the client has also been in two physical fights with other students. At home the client spends most of her time in her room listening to music and refuses to eat dinner with her family. She becomes argumentative when asked to do chores or contribute to household duties. The client's aunt states that when she noticed the burn marks on her niece's arms, she began talking with the client nightly, but states most of the conversation revolved around the client's desire to leave school and her annoyance at completing household chores. The client was hospitalized a year ago for suicidal ideation.

Upon initially meeting with the client, you ask her about the recent hospitalization. The client tells you that she burned herself with ice and salt while in treatment and was upset when the staff wouldn't let her use implements that would result in self-injury. The client refused to talk about her family and instead focused the discussion around self-injury. She stated that it made her feel better, but could not articulate how she felt when she would self-injure or why it made her feel better. The client states that she has one close friend and informs the counselor that they often hang out together and listen to music while smoking and burn themselves with their cigarettes. The client's aunt is interested in being involved in treatment but states that her husband is very involved with his job and is rarely able to participate in the client's treatment.

Table 1**Participant Demographics**

Age	
Mean	29
Range	25–52
Sex (n = 65)	
Male	9 (13.8%)
Female	56 (83.6%)
Ethnicity (n = 43)	
Caucasian	28 (42%)
Hispanic/Latino	9 (13.4%)
African-American/Black	3 (4.5%)
Asian	2 (3%)
Native American	1 (1.5%)
Track (n = 66)	
Community	44 (66.7%)
School	21 (31.3%)
Family	1 (1.5%)
Sexual Orientation (n = 44)	
Heterosexual	39 (58%)
LGB	5 (8%)
Direct Clinical Hours	
Completed	146
Mean	5–800
Range	

Table 2**Treatment Approaches Considered**

Theory/Technique	Male Case	Female Case
Person-Centered/Existential/Humanistic	16	12
Cognitive-Behavioral/REBT	19	17
Solution-Focused	3	2
Reality	0	5
EMDR	3	1
Process/Discuss past abuse	0	3
Examine/Verbalize emotions	0	5
Group	2	0
Unsure	0	2
Art/Music therapy	2	1
Strengths-Based	1	0
Gestalt/Adlerian/Other	0	3

Table 3**Diagnostic Impressions Influencing Provided Diagnosis**

Conceptual Themes	Male Case	Female Case
Borderline personality disorder (features)	0 (3)	4 (1)
Depression/major depression	12	18
Sexual abuse	0	7
Depression and anxiety	3	2
Post-traumatic stress disorder	15	8

Substance abuse	3	0
Social isolation/Poor support/School factors	14	9
Anger/Aggression, conduct, or oppositional defiance	12	7
Lack of male role models	2	0
Attention-seeking	2	4
Somatic symptoms	12	1
Risk of suicide	10	4
Antisocial/Emotional suppression	9	0
Adjustment disorder	0	4
Sexual confusion	0	3
Unsure how to conceptualize	2	1

Figure 1

Diagnosis Results

