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Measurement and Evaluation in Counseling and Development 2010; 43; 3
DOI: 10.1177/0748175610362237

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Measurement and Evaluation in
Counseling and Development
43(1) 3–15
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DOI: 10.1177/0748175610362237
<http://mec.sagepub.com>



Laurie M. Craigen¹, Amanda C. Healey²,
Cynthia T. Walley³, Rebekah Byrd¹,
and Jennifer Schuster¹

Abstract

This article provides readers with an understanding of self-injury assessment. The article begins with a critical review of a number of self-injury assessments. The latter section of the article introduces a comprehensive two-tiered approach to accurately assessing self-injury. Implications for counselors related to the assessment of self-injury are also provided.

Keywords

self-injury, assessment, self-injurious behavior

Self-injurious behavior is an increasing issue among adolescents and young adults. According to current research, self-injurious behavior occurs in 4% to 39% of adolescents in the general population and the numbers are predicted to rise, due to various reasons, ranging from levels and quality of social interactions with peers to the availability and assimilation of coping behaviors through access to the Internet (Briere & Gil, 1998; Favazza, 1996; Gratz, 2001; Gratz, Conrad, & Roemer, 2002; Muehlenkamp & Guitierrez, 2004; Nock & Prinstein, 2005; Ross & Heath, 2002). Statistics on the incidence of self-injury can be unreliable, underestimating the true incidence of self-injury. The reality is that many incidents will be dealt with by the individual, in private, and will never reach the attention of medical services or mental health professionals (McAllister, 2003). Recently, there has been a surge in the literature related to defining and explaining the behavior (Gratz, 2006). Conversely, very little is known about the assessment of self-injury, and therefore, a gap exists between understanding the behavior and implementing focused counseling interventions and treatment (White Kress, 2003). The

purpose of this article is to provide readers with knowledge about the difficulties related to accurately evaluating self-injury and the history of self-injury assessments, while also introducing a comprehensive two-tiered approach to assessing self-injury, emphasizing a holistic perspective.

Review of Self-Injury Assessments

The development of inventories to evaluate self-injury began in the early 1990s and continues today. As the conceptualizations and definitions of self-injury have evolved, so too has the focus of the assessments tailored for its evaluation. Although the newer scales appear to assess the behaviors and attitudes associated

¹Old Dominion University, Norfolk, Virginia, USA

²East Tennessee State University, Johnson City, Tennessee, USA

³Hunter College, New York City, New York, USA

Corresponding Author:

Laurie M. Craigen, PhD, LPC, Old Dominion University,
110 Education Building, Norfolk, VA 23529 USA
Email: lcraigen@odu.edu

with self-injury, many have not been through the rigorous testing necessary to fully evaluate their efficacy, reliability, and validity. Thus, when selecting and administering assessments, it is necessary for counselors to understand the evolving nature and continuing development of the instrument they select for evaluating self-injury. In the following section, a brief overview of the inventories available for assessing self-injurious behaviors is provided (see Table 1).

Self-Injury Trauma Scale (SITS)

One of the first inventories to be developed for the assessment of self-injurious behaviors is the SITS created by Iwata, Pace, and Kissel (1990). It was created to evaluate the extent of tissue damage caused by self-injury. This inventory examines categories including location, type, number, and severity of the tissue damage as well as a summary evaluation of severity and current risk for continued self-injury. SITS defines its typical use in terms of quantifying tissue damage directly. It also permits differentiation of self-injury according to topography, location of the injury on the body, type of injury, number of injuries, and estimates of severity through evaluation of the injuries themselves. Test-retest reliability was reported at $r = .68$ (Iwata et al., 1990). This assessment was later used to evaluate self-injury in conjunction with physical pain as based on the proposition that the experience and expression of pain is somehow different among those individuals who self-injure, therefore leading to the acceptability and tolerability of self-injury as a behavior (Symons & Danov, 2005).

The SITS was later used in a study to determine the effects of a psychopharmacological treatment on those with intellectual disabilities who engaged in self-injury. In this study, the SITS inventory was found to be reliable when used in conjunction with the Non-Communication Children's Pain Checklist-Revised (NCCPC-R) in recognizing and tracking self-injury from the perspective of an outside observer—in this case, the parent (McDonough, Hillery, & Kennedy, 2000). No specific data were reported related to concurrent

validity beyond the statement that “the mean NCCPC-R score was 20.1 for time intervals scored with self-injurious behavior (SIB) and 2.5 for time intervals scored without SIB” (p. 474) as indicated by the SITS. The initial evaluation of the inventor's efficacy and subsequent usage found the scale to be a reliable method for collecting data on surface tissue damage caused by self-injury. However, the use of this scale might not be practical for counselors but could be useful for professionals who intervene with the physical consequences of self-injury, such as school nursing staff or medical professionals.

Self-Harm Inventory (SHI)

The SHI was developed by Sansone, Wiederman, and Sansone (1998) in the context of screening for Borderline Personality Disorder (BPD). It was the belief of the instrument developers that BPD exists on a continuum in which self-injury is the most severe manifestation of self-sabotaging behaviors. With regard to the uses of the 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. The SHI assesses frequency, severity, duration, and type of self-injurious behavior. The SHI was found to be highly related to the Diagnostic Interview for Borderlines (DIB) at a correlation of $r = .76$ and the Personality Diagnostic Questionnaire-Revised at $r = .71$ with regard to non-psychotic adults (Sansone et al., 1998).

The developers of this inventory also showed that the SHI was able to predict the diagnosis of BPD as based on its convergent validity. This inventory is made up of 22 items that were selected due to their correlation with the DIB, and each question begins with the phrase, “Have you ever on purpose, or intentionally . . . ,” and respondents were asked to give a “yes” or “no” answer (Sansone, Songer, Douglas, & Sellbom, 2006, p. 976). The final score is a simple summation of the items endorsed by the client. In developing and testing the measure, it showed acceptable levels of clinical accuracy as a measure for the diagnosis of BPD by assessing a pattern of self-destructive

Table 1. Strengths and Weaknesses of Current Scale

Inventories	Author(s)	Created	Reliability	Validity	Use/Factors	Predictive Ability	Suicidality
SITS	Iwata, Pace, & Kissel	1990	Test-retest		Assessing tissue damage as result of self-injury	Able to predict current risk	Not evaluated
SHI	Sansone, Wiederman, & Sansone	1998		Predictive convergent	Identifying self-injury in conjunction with BPD	Predict presence of borderline personality features	Can differentiate between high and low lethality
SIQ	Alexander	1999	Internal consistency; test-retest	Face and convergent divergent	Use with those who have suffered trauma	Measures intent to self-harm	Measures for major suicide concepts
DSHI	Gratz	2001	Test-retest	Internal consistency construct convergent and discriminate	Behaviorally based; clinical populations	Able to predict the features of self-injurious behaviors	Suicidal intent assessed
SI-IAT	Nock & Banjai	2007		Predictive	Assessing beliefs and identification with self-injury	Predict suicidal ideation and behaviors	Evaluated and differentiated
SASII	Linehan, Comtois, Brown, Heard, & Wagner	2007	Interrater	Predictive content	Provide descriptive info on suicidal and self-injurious behaviors	Evaluates past behavior; based on PHI	Suicidal intent and lethality of self-injurious behaviors
SITBI	Nock, Holmberg, Photos, & Michel	2007	Inter-rater test-retest	Construct	To assess a wide range of self-injury-related constructs	None stated	Assessed gestures, plan, ideations, and attempts

SITS = Self-Injury Trauma Scale; SHI = Self-Harm Inventory; SIQ = Self-Injury Questionnaire; DSHI = Deliberate Self-Harm Inventory; SI-IAT = Self-Injury Implicit Association Test;

SASII = Suicide Attempt Self-Injury Interview; SITBI = Self-Injurious Thoughts and Behaviors Interview; BPD = Borderline Personality Disorder; PHI = Parasuicide History Interview

behaviors (Sansone, Whitecare, Meier, & Murry, 2001). Additionally, the SHI has been shown to have an acceptable level of internal consistency with Cronbach's $\alpha = .80$ (Sansone et al., 2006). The developers have stated that the inventory could help clinicians identify and distinguish high-lethality and low-lethality self-injury.

Self-Injury Questionnaire (SIQ)

The SIQ was developed by Alexander (1999) and later evaluated by Santa Mina, Gallop, and Links (2006). This inventory was created to evaluate and differentiate the intentions behind self-injurious behaviors as based on a history of childhood physical and/or sexual abuse. The questionnaire was developed using a guiding definition of *self-injury* as simply self-destructive behaviors without the intent to die. Preliminary findings of the initial research study that used the SIQ showed good face validity and adequate test-retest reliability in nonclinical populations. Test-retest reliability over a 2-week period of the behavioral items ranged from $r = .29$ to $r = 1.0$, with a total correlation of test-retest of $r = .91$ (Alexander, 1999). A separate study also revealed similar results for the SIQ in acute populations, with the addition of statistical analysis resulting in findings of high internal consistency of the total scale ($\alpha = .83$; 95% Confidence Interval [CI]) and an adequate Cronbach's alpha for each subscale ($\alpha = .72$ to $.77$) (Santa Mina et al., 2006).

Convergent validity analyses were also conducted by Santa Mina et al. (2006) between the SIQ and the Suicide Intent Scale (SIS), the Beck Depression Inventory II (BDI II), and the Self-Inflicted Injury Severity Form (SIISF). The convergent validity between the SIQ and the scales was reported to be $r = -.37$ with regard to the factor of stimulation and the SIS, $r = .23$ with regard to the affect regulation factor of the SIQ as compared to the BDI II, and $r = -.25$ with regard to the dissociation factor of the SIQ and the SIISF. The SIQ is a 30-item self-report instrument conceptualized from developments in trauma research. This questionnaire measures the intent of self-injury through evaluation methods across various

subscales, including body alterations, indirect self-injury, failure to care for oneself, and overt self-injury. The SIQ measures the functions, types, and frequency of self-injuring behaviors in association with a trauma history. Questions on the SIQ related to agreement to engagement in behaviors such as tattooing and the frequency and number of self-injurious acts related to these behaviors. Following each behavioral item, if agreement was stated, participants were then asked to circle further items related to the reason contributing to the behavior. At the time of this publication, this inventory was yet to be tested in a clinical setting; therefore, its efficacy with regard to counseling is unclear and needs to be tested further.

Deliberate Self-Harm Inventory (DSHI)

The DSHI was developed using an integrated definition of self-injury in order to help provide a clear foundation for the instrument, given that previous assessments lacked consensus in definition (Gratz, 2001). It is based on the notion that self-harm is the deliberate, direct destruction of body tissue without conscious suicidal intent but results in injury severe enough for tissue damage to occur (Fliege et al., 2006). This measure evaluates various features of self-injury, including frequency, severity, duration, and types of self-injurious behaviors. The inventory consists of 17 items that are behaviorally based and reliant on self-report. The DSHI has been found to be reliable and valid for assessing self-injury and past suicidal behaviors (Gratz, 2006; Gratz & Chapman, 2007; Gratz et al., 2002; Lundh, Karim, & Quilisch, 2007), with adequate internal reliability at $\alpha = .62$ (Fliege et al., 2006) and adequate test-retest reliability during a 2- to 4-week period of $\phi = .68$ ($p = .001$) (Gratz, 2001). In the study by Gratz (2001), adequate construct, convergent, and discriminant reliability was also found. This assessment is in wide use, and its brief length lends itself to application in clinical and outpatient settings. This assessment could be useful in mental health as well as school settings to determine the need,

immediacy, and level of intervention needed with regard to a client or student presenting self-injurious behaviors.

Suicide Attempt Self-Injury Interview (SASII)

The SASII was designed to evaluate factors involved in what the authors referred to as “nonfatal suicide attempts and intentional self-injury” (Linehan, Comtois, Brown, Heard, & Wagner, 2006, p. 304). This measure, once referred to as the Parasuicide History Inventory, was developed to better understand the methods involved in self-injury—the motivations, consequences, ritual, and impulsivity of the act itself. Its validity and reliability measures were taken using an inpatient population. In defining *suicidal behavior*, this instrument includes all general definitions pertaining to parasuicide, fatal and nonfatal suicide, and self-injury without the intent to die. Therefore, it does provide descriptive details about self-injurious and suicidal behaviors but does not differentiate between the two beyond lethality.

This instrument has been used in several recent studies that confirm its usability and importance in assessing the multiple aspects of suicidal and self-injurious behaviors (Brown, Comtois, & Linehan, 2002; Koons et al., 2001). Six scales were developed based on factor analysis with factors loading at .4 or above. These six scales evaluated lethality of the method, suicidal and nonsuicidal intent associated with an episode, communication of suicide intent prior to the episode, impulsivity, physical condition, and level of medical treatment. The assessment showed high inter-rater reliability at $r = .918$ for classification of suicidality components and $r = .843$ for episodes classified as a single event versus a cluster of self-injurious events (Linehan et al., 2006). The SASII instrument is useful in that it provides a rating concerning the lethality of the act in question in terms of several components including medical and other consequences. This instrument can also be used to evaluate treatment outcomes through pre- and postassessment.

Self-Injury Implicit Association Test (SI-IAT)

The SI-IAT was developed by Nock and Banjai (2007) to assess self-injury in terms of the identity with and beliefs surrounding the act itself. This test was based on the Implicit Association Test (IAT), developed by Greenwald, McGhee, and Schwartz (1998). To understand the SI-IAT, it is important to know a little bit about the test from which it was developed. The IAT is primarily used for evaluating associations to nonclinical constructs and beliefs. The IAT itself has been shown to have strong reliability, construct validity, and the capacity to distinguish clinical changes caused by treatment and attempts to mask feelings. The SI-IAT was created in order to integrate the advantages of the IAT in an attempt to assess self-injury without relying on explicit self-report. The test measures the implicit associations individuals have concerning self-injury in terms of identification with the behavior as well as attitudes about it.

The research studies conducted by Nock and Banjai (2007) using the SI-IAT showed that the assessment was able to strongly predict recent suicidal ideation and suicide attempts, with good incremental predictive validity ranging from .74 to .77 with the participating adolescent population. The assessment could also distinguish between groups of nonsuicidal adolescents who had negative beliefs about self-injury, adolescents with suicidal ideations who showed some positive identification, and adolescents who had attempted suicide while having strong identification with self-injurious behaviors. Because of the interpretive nature of this assessment, it would be important for counselors to use this in conjunction with multiple informal assessment techniques to evaluate the client's perceptions with regard to his or her statements. This would help avoid counselor bias in determining the client's level of identification with the behaviors. This assessment is also helpful in evaluating how useful the client views his or her self-injurious behaviors in managing symptomatology. The level at which a client integrates self-injury into his or

her identity and views self-injury as assistive to his or her functioning could drastically affect the approach and interventions the counselor ultimately decides to use in the process of treatment. For example, if the client views self-injury as an effective coping strategy to reduce stress, the counselor and client could explore alternative stress-reduction strategies in counseling sessions.

Self-Injurious Thoughts and Behaviors Interview (SITBI)

The SITBI was developed by Nock, Holmberg, Photos, and Michel (2007) as a 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. The SITBI assumes that, by definition, self-injury does not include the intent to die and thus differentiates self-injury from suicidal intent and action. In assessing the strengths of the interview as an assessment tool, the authors found it to have strong inter-rater reliability (Nock et al., 2007), good test-retest reliability (average $\kappa = .70$) after 6 months, good construct validity in relation to suicide measures and suicide attempts ($\kappa = .65$), and concurrent validity with measures of suicidal ideations and gestures. However, it did have weak reliability in assessing suicide gestures and plans. Predictive validity for suicidal ideation or future self-injury was not addressed in the study conducted by Nock et al. (2007). It is the belief of the authors that the interview could be used easily in a variety of clinical settings to get an overview of current and recent self-injurious behaviors; however, because of the length of the assessment, there are time constraints to consider with regard to the practicality of its use.

The self-injury assessment tools that have been developed over recent years have clear strengths and weaknesses. For counselors, it is important to consider the population you are using before selecting a particular self-injury assessment tool as well as the setting in which you will be implementing it. Also, it is critical

to realize that the aforementioned formal assessments are only one piece of the assessment process. Counselors should never use these measures in isolation for determining the course of treatment, outcomes, or need for intervention. The following section outlines a recommended approach for assessing self-injury and using formal assessments in conjunction with additional evaluation methods.

Comprehensive Assessment Approach

The need for a comprehensive and multilevel approach to the assessment and evaluation of self-injury is clear because of the multifaceted nature of self-injury. The following section outlines a two-tiered process of assessing self-injury. This process includes the use of both formal and informal assessment procedures (see Figure 1).

Formal Assessment

The first step in this integrated approach involves the formal assessment of self-injury (as introduced above) as well as other possibly related concerns, such as depression, traumatic history, or anxiety. These mental health concerns necessitate mentioning because of independent empirical indications of association with self-injurious behaviors (Conaghan & Davidson, 2002; Herpertz, Sass, & Favazza, 1997; Klonsky & Olino, 2008; Sansone, Chu, & Wiederman, 2007; Sansone & Levitt, 2002). Overall, formal assessment measures allow for more accurate diagnoses and appropriate evaluation and enhance the formulation of an informed treatment plan.

Self-injury assessment measures. Many self-injury assessment tools are available for consideration during the implementation of a formal assessment process as previously presented (see Table 1). Selecting an appropriate tool based on population, validity, and reliability is necessary in treating self-injurious behavior.

Additional formal assessments. Self-injury rarely occurs in isolation. As stated previously, many mental health disorders coexist with

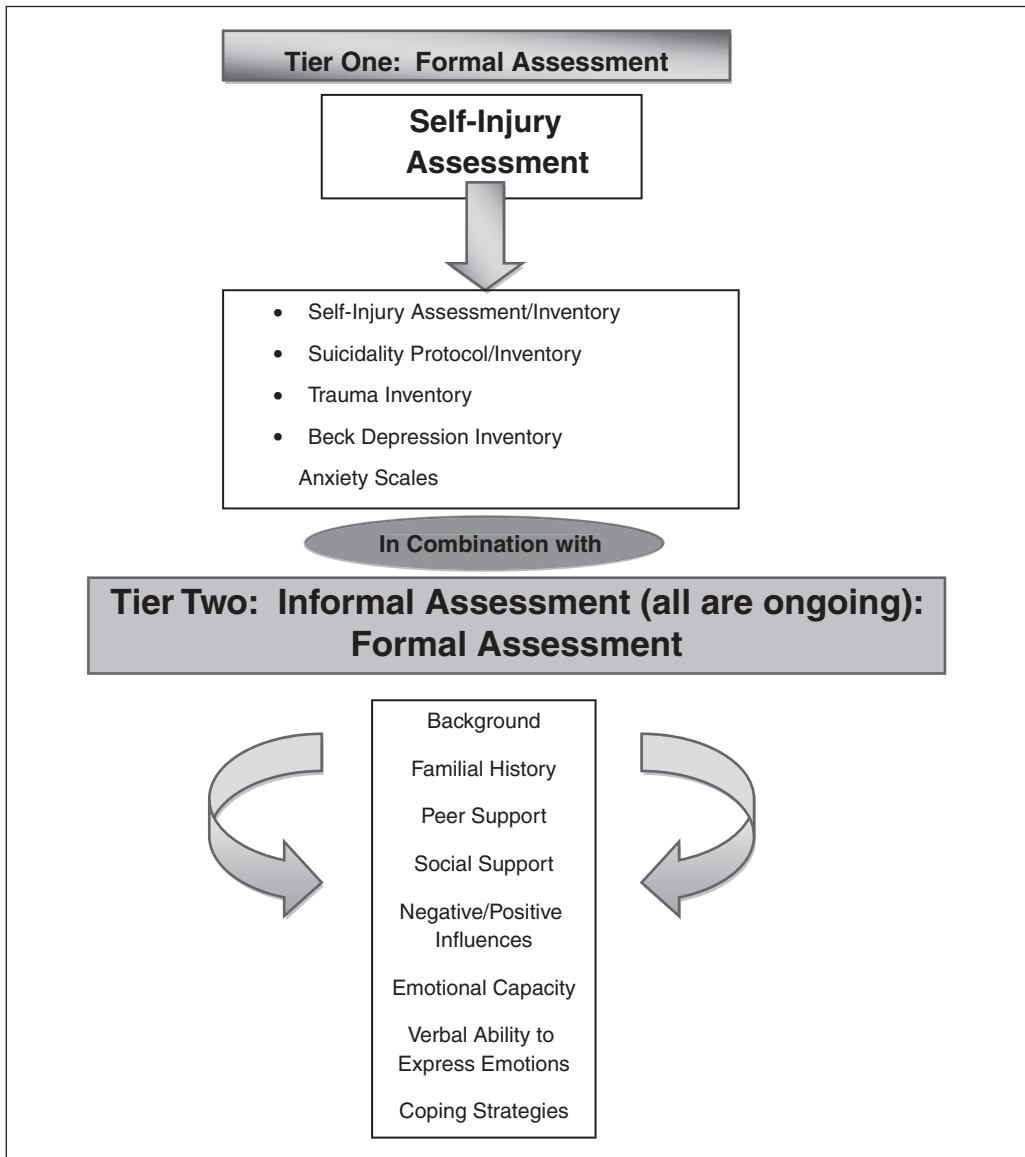


Figure 1. Two-tier model of assessment

self-injury. Thus, a combination of formal assessments is fundamental, as it is imperative to examine the intent behind each act of self-injury to carefully evaluate which elements of concern or distress are present for each unique individual. Because of the complex nature of self-injury, the more accurate the evaluation, the better suited and successful the treatment will be (White Kress, 2003). Thus, it would

behoove counselors to also use standardized assessments that evaluate areas such as (but not limited to) suicide, trauma, depression, anxiety, and eating disorders. The following are examples of assessments that could address these indicators. Although this list is not comprehensive, other assessments may be selected and should be matched to the unique needs of the client:

- **Suicidality Protocol/Inventories:** that is, Inventory of Suicide Orientation-30, Beck Suicide Inventory, Reasons for Living Inventory, Hopelessness Scale, Scale for Suicide Ideation, Suicide Probability Scale, Suicide Ideation Questionnaire, and Suicide Probability Scale
- **Trauma Inventories:** that is, Early Trauma Inventory, Trauma Coping Inventory, Trauma Symptom Inventory, Trauma Assessment Inventories
- **Depression Inventories:** that is, Inventory of Depressive Symptomatology, BDI, Children's Depression Inventory, Major Depression Inventory, Inventory of Depression and Anxiety Symptoms, Zung Self-Rating Depression Scale
- **Anxiety Inventories:** that is, Beck Anxiety Inventory, Spielberger State-Trait Anxiety Scales, Anxiety Status Inventory
- **Eating Disorder Inventories:** that is, Eating Disorders Inventories, Eating Attitudes Test, Eating Disorder Examination, and additional measures suited for the particular client

The aforementioned formal assessments vary according to reliability and validity. Thus, prior to selecting a measure, it is important to examine its strengths as well as the population being served.

Informal Assessment

The second step in this approach involves using informal assessment measures. Informal assessment techniques are subjective and provide counselors with additional tools for understanding clients (Neukrug & Fawcett, 2005). The majority of informal assessments are used in a formative evaluative manner, rather than through a pretreatment or posttreatment (summative) evaluation. Informal assessment techniques combined with formal assessments allow the clinician to gain a comprehensive, holistic, and in-depth understanding of the

client and his or her presenting concerns. For example, gaining an understanding of past and current familial and relational connections as well as relational conflicts could lead to greater insight into the client's reasoning for his or her self-injurious behaviors and the structure of his or her current support network. With all informal assessment techniques, it is necessary to consistently be aware of cultural context and how this could be a factor for each client. Although many techniques can be used to conduct informal assessments, only those most pertinent to the treatment of self-injurious behaviors are addressed in this section.

Intakes. Many informal assessment measures exist and should be used during intake and also throughout the treatment process for each individual. At intake, it is important to add a section or line dedicated to self-injury. This is an area that is often left off of intakes and is important in the initial assessment. For example, "Have you ever intentionally hurt yourself for any reason?"

Interviews. Parent and teacher interviews are a great tool to access valuable information about your client and his or her experiences with self-injury. Although many individuals go to great lengths to hide their self-injury from parents and teachers, valuable information can be garnered from speaking with these individuals, as they may play an important role in the client's self-injury and might also serve as an ally for the client as he or she explores issues related to his or her behaviors in counseling. Some questions that might garner useful treatment information include the following: "Is the client's behavior consistent at home and school?" "Does the client engage in isolative behaviors?" "How does the client normally express his or her feelings or needs?" "What type of internalizing or externalizing behaviors are the parents or teachers aware of in your client?"

Observations. Observations are an important assessment tool, providing counselors with an additional mechanism for understanding the client (Neukrug & Fawcett, 2005). Although not all clients who self-injure present in the same way, there may be consistent behaviors,

appearances, or nuances that could provide counselors with helpful information to supplement their understanding of the client. For example, a client who self-injures may often-times wear clothes that hide his or her injuries or have many unexplained cuts, scars, or burns (White Kress, Gibson, & Reynolds, 2004). Additionally, clients may avoid conversations about self-injury or deny their personal experiences with self-injury.

Background information. Acquiring background information is a vital aspect of self-injury assessment and can potentially provide the counselor with valuable information about the contributing factors related to the client's self-injurious behavior. When obtaining background information, it is necessary to focus on all aspects of the individual and not limit the assessment to the behavior itself. This knowledge provides counselors with valuable information about what lies beneath the surface of the wounds, a focus of treatment that has been ignored in the past (Craigien & Foster, 2009; Walsh, 2006).

Familial history is one aspect of background information that is often overlooked. Gathering information about an individual's family history avoids pathologizing the behavior and views the presenting behaviors through more of a systemic lens. Seeking to understand all contributing factors such as a client's perspectives and experiences regarding his or her family might not have been considered in the past; however, it is necessary (McAllister, 2003; Selekman, 2002). For example, the counselor may ask, "Who do you talk to in your family about your feelings?" "How does your family typically deal with their emotions?" "What feelings do you have for different members of your family?" or "What events in your past family history have affected you negatively?"

In addition to familial information, it is also important to discuss with the client his or her peer and social supports (Walsh, 2006). This is particularly relevant in the adolescent population because at this developmental milestone, peer supports are highly valued. For example, counselors may say, "Tell me about your friends." Or they may ask, "When you are

upset, do you typically talk with your friends?" "Do your friends know about your self-injurious behavior?" Other factors that affect the individual and need to be assessed are negative or positive influences that could facilitate self-injury. These could include Internet sites dedicated to perpetuating self-injurious behavior, friends who self-injure, and/or media role-models who self-injure or have self-injured.

Emotional capacity. Evaluating the emotional capacity of the individual using informal assessment techniques is an essential process in developing effective treatment interventions and conceptualizing the issues related to the self-injurious behaviors. Examining an individual's ability to outwardly express and understand his or her feelings involves an ongoing process of assessment, evaluation, and treatment with clients who self-injure. One's ability to express emotions is a concern for many but particularly those who self-injure. Since this is the case, it may be important to ask clients, "If your wounds could speak, what would they say about you?" (Levenkron, 1998). Additionally, basic questions that assess one's feelings vocabulary can also be beneficial in the informal assessment process.

Coping strategies. In addition to assessing the emotional capacity of clients who self-injure, coping strategies can also be assessed by using informal assessment techniques and can be incorporated in any treatment approach for those who self-injure. For example, it may be important to ask clients, "What do you do when you feel angry, anxious, or upset?" or "What function does self-injury serve for you?" These two questions allow the counselor to examine how and to what extent that self-injury serves as a maladaptive coping strategy for clients presenting with self-injurious behaviors.

Typically, the use of self-injury is seen as an effective method for dealing with overwhelming emotions associated with traumatic memories or other issues occurring in the client's life (Gratz, 2007). Therefore, it is necessary to determine how invested the client is in the counseling process and how interested he or she is in working toward a change with regard to this pattern of behavior. Clients may be

fearful that any attempt to alter their current way of coping could result in an increased level of instability that would result in hospitalization or worse. Evaluating the fear and anxiety clients may be associating with change could be critical in determining an effective treatment approach. Determining a client's concerns, commitment, and understanding with regard to the counseling process is an integral component of any assessment process and is particularly crucial with regard to the issue of self-injury.

Synthesis of Approaches

This article serves to illuminate the benefits of both a formal and informal approach to assessing self-injury. Although each approach is important, the integration of both approaches is vital (see Figure 1). In the comprehensive two-tiered model of assessment, the formal assessments serve as the first step in evaluating self-injury; formal assessments provide counselors with a standardized and quantifiable way of determining the seriousness of the problem and can also reflect progress or regression in treatment. The informal assessments, as described above, serve to support, enhance, and depict a comprehensive view of self-injury. In addition to using the perspectives of others, the informal assessment also widens the lens in which self-injury has been examined in the past. Although the formal assessments focus on the behavior of self-injury, the informal assessments examine context, background, and emotional capacities. Thus, although both approaches are important, counselors will benefit from using them in tandem when assessing self-injury to focus treatment and hopefully improve short- and long-term outcomes.

Counselor Implications

Counselors will inevitably encounter individuals who self-injure, creating instances whereby they may have a responsibility to properly assess and evaluate self-injury in their clients. Although the assessment of self-injury is clearly in the early stages, further research on

new and established assessment tools is needed. Conceptualization of self-injurious behaviors is multidimensional; therefore, assessment of these behaviors needs to be complementary. For mental health professionals, to accurately assess focusing on frequency, severity (tissue damage and intention), duration, type, thoughts and attitudes, and age of onset is essential in treatment. Professionals must also be aware of culture when assessing those who self-injure. Cultural considerations would include, but not be limited to, family experiences, religion, ethnicity, and gender.

Additionally, qualitative research methods that examine counselors' and client's perceptions about self-injury assessment tools as well as their perceived usefulness could be helpful. In addition, cultural considerations need to be included in current research. Cultural dimensions may contribute to the variability of accurately assessing those who self-injure, which would eventually affect treatment. In addition to research, counselors must begin to expand their knowledge base on the topic of assessment and self-injury. Because the definition of self-injury continues to be debated, which affects the consistency of assessment, further research is needed in this area.

Trainings that increase awareness about self-injury assessment scales are imperative. Because suicide is often discussed in counselor education programs, incorporating self-injurious behavior into the curriculum could be a way to dialogue about this topic. By encompassing self-injurious behavior into counseling programs, students will be exposed to characteristics and features of this behavior that are vital to assessment and intervention. In addition, training may also be in the form of community-wide or in-service trainings that focus on assessment. Training and practice must comprise numerous difficulties in assessment of self-injury, such as various nomenclature, conflicting theoretical definitions, and inconsistencies with other disorders. In addition, training must include the comprehensive assessment approach, which includes formal and informal assessment measures. On a broader level, the topic of self-injury and assessment

should be presented at local, regional, and national counseling conferences.

Given the review of the current self-injury assessments, there are notable limitations and weaknesses within these scales. For example, all of the reviewed inventories were either developed in conjunction with a diagnosis of BPD or they assessed a component of suicidal ideation. Furthermore, the assessments reviewed failed to consider cultural context and were normed on homogeneous samples, ignoring diverse populations. Thus, to accurately assess self-injury, it is imperative for counselors and researchers to develop a scale that (a) is normed on a heterogeneous sample, (b) is independent from the criteria of BPD, and (c) evaluates self-injury without the inclusion of suicidal ideations. The development of a scale like this would benefit clinicians and clients and would contribute greatly to the accurate assessment of self-injury.

Summary

The topic of assessment and self-injury is quickly beginning to gain attention among mental health professionals and researchers. Although there are several assessment tools available to counselors, many have methodological flaws (e.g., low reliability and validity and lack of factor analytic procedures) and are used solely for a distinct population of individuals who self-injure. Prior to selecting a formal self-injury assessment, it is important to examine the strength of the assessments as well as the population being served. Additionally, it is important never to use one instrument in isolation. Combining additional formal assessments and using many informal assessment methods throughout the counseling relationship is imperative. Future research and training on the topic of self-injury is clearly needed.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interests with respect to the authorship and/or publication of this article.

Financial Disclosure/Funding

The authors disclosed receipt of the following financial support for the research and/or authorship of this article: Institute for the Study of Disadvantage and Disability awarded a student research honorarium to the second author.

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- mental health concerns in women, particularly with self-injurious behavior. Additionally, she has presented at local, regional, and national conferences on the topic of self-injury and is an Assistant Editor of *Human Service Education*.
- Amanda C. Healey**, PhD, LPC-MHSP, NCC, is currently a temporary fulltime counseling program faculty member at East Tennessee State University. She is involved in research pertaining to issues of self injurious behaviors, professional identity development in counseling, and burnout in mental health and has published on these topics. Amanda works from an Adlerian-Feminist perspective and this is reflected in her professional and scholarly activities.
- Cynthia T. Walley**, PhD, NCC, is an Assistant Professor in the Educational Foundations and Counseling Department at Hunter College in New York, NY. Dr. Walley's research interest include, school counseling preparation, adolescent mental health, and assessment and diagnosis.
- Rebekah Byrd**, MEd, LPC, NCC, is a doctoral candidate at Old Dominion University in Norfolk, Virginia. She currently works as the Director of CARE NOW, a middle school based Character Education Program and also serves as President for the ODU chapter of Chi Sigma Iota. Rebekah supervises master's counseling students and teaches undergraduate and master's classes. Over the last year she has published two book chapters and two articles; presented at the national, regional, and state level and won a competitive research grant.

Bios

Laurie M. Craigien, PhD, LPC, is an assistant professor in the Department of Counseling and Human Services at Old Dominion University in Norfolk, Virginia. She also works as a Licensed Professional Counselor at Southside Counseling Center in Suffolk, VA. Laurie is actively involved in research on

Jennifer Schuster, MEd, is a 2009 graduate of Master's Program in School Counseling at Old Dominion University. Jennifer is currently working as a school counselor in Newport News, Virginia and continues to engage in research projects at Old Dominion University.