The Role of Assessment in the Identification and Intervention of Self-Injury

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Participants will be able to identify core features of self-injury.

Participants will be able to discuss methods of screening for and assessing self-injury.

Participants will be able to identify ways to use assessment data to inform treatment practice with clients who self-injure.

FOUNDATIONS AND BASIC INFO ABOUT SI

DEFINING SI

Self-Injury (SI)—"Non-suicidal self-injury is the deliberate, self-directed damage of body tissue without suicidal intent and for purposes not socially or culturally sanctioned. There are several key elements to our definition" (ISSS, n.d.)

Not necessarily equivalent to *suicide related behaviors* (SRBs) or *parasuicidal behaviors* (check the definitions for any study/author using these terms)

Previously referred to as *self-harm* or *self-mutilation*

(Whisenhunt, 2022)

Self-Injury Statistics

18% approximate lifetime prevalence rate (Muehlenkamp, Claes, Havertape, & Plener, 2012)

12.2% prevalence in Chinese adolescents (Tang et al., 2018)

27% of Swiss adolescents report self-injuring at least once (Steinhoff et al., 2021

17.7%-30.8% prevalence in adolescent girls in the U.S. (Monto, McRee, & Deryck, 2018)

life-time prevalence of 27.6 % during 2020-2021 (Zetterqvist et al., 2021)

3.1% lifetime prevalence for German population (Plener et al., 2016)

6.4%-14.8% prevalence in adolescent boys in the U.S. (Monto, McRee, & Deryck, 2018)

21% prevalence among Dutch Belgian adolescents (Gandhi et al., 2018)

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Suicide and SI Stats

Approximately 60% of people who self-injure may experience suicidal thoughts and behaviors (Whitlock et al., 2013).

Those who self-injure may seriously consider suicide at a rate of 8 times greater than the general public and may have a risk of attempting suicide that is 25 times greater (Glenn & Klonsky, 2009)

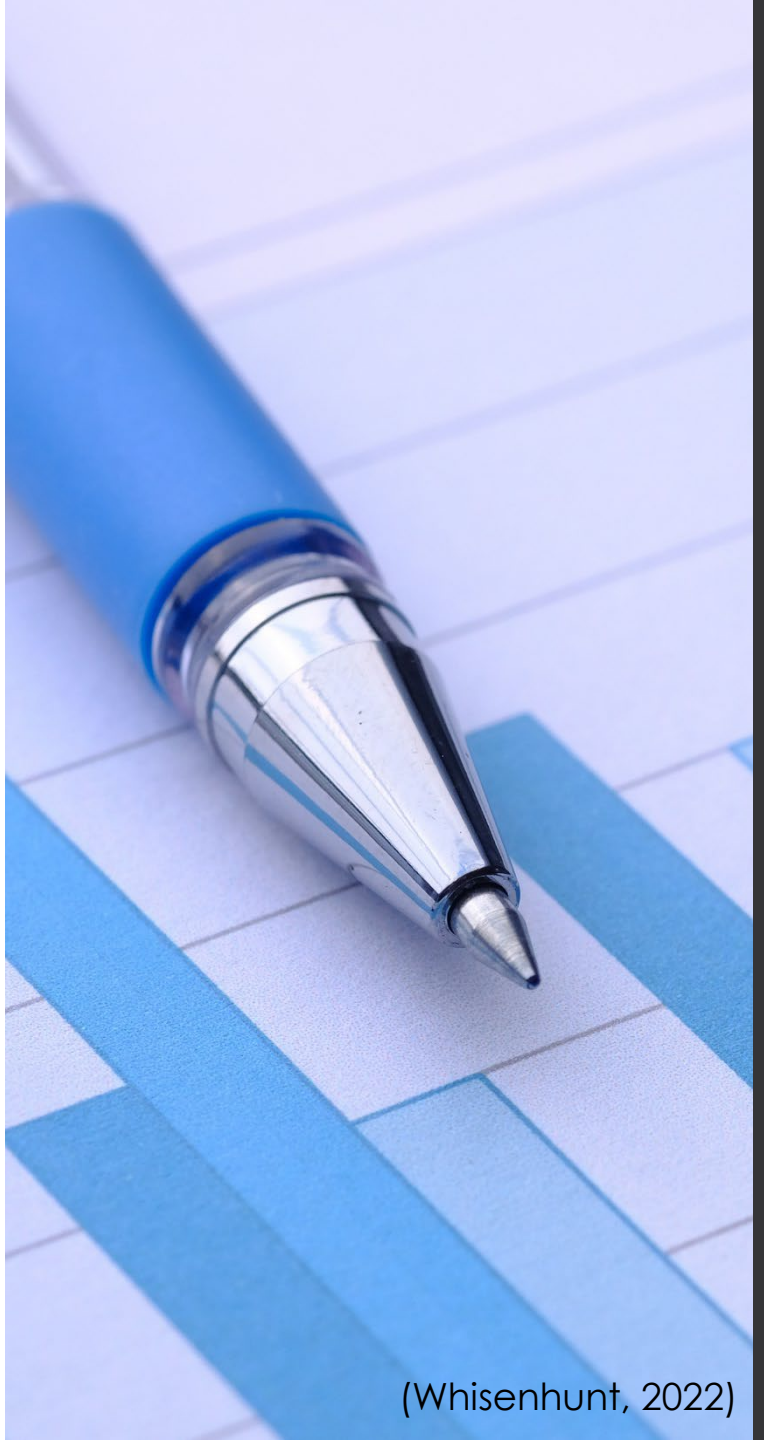
Earlier onset and longer duration of SI is related to higher suicide risk (Brager-Larsen et al, 2022)

People who self-injure multiple times tend to have higher rates of suicidal ideation, trauma, and drug and alcohol misuse (Kakhnovets et al., 2010).

People who self-injure more often and utilize more methods may be at higher risk for suicide (Wester, Ivers, Villalba, Trepal, & Henson, 2016).

In a Brazilian sample, the risk of suicide behavior was 10 times greater for undergraduate students who self-injure (daSilva Bandeira et al, 2022).

Unintentional severe may occur in as much as 31% of people who self-injure (Buser, Buser, & Rutt, 2017).



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Common Functions of SI

#1 Emotion regulation (Klonsky & Muehlenkamp, 2007; Turner, Chapman, & Layden, 2012)

#2 Self-punishment (Klonsky & Muehlenkamp, 2007; Turner et al., 2012)

#3 Anti-Suicide (see Klonsky, 2014)

#4 Feeling generation/ antidissociation (Turner et al., 2012)

#5 Interpersonal influence and communication (Turner et al., 2012)

#6 Sensation seeking (see Klonsky, 2014)

(Klonsky, 2014)

(Whisenhunt, 2022)

ASSESSMENT AT INTAKE

Screening for SI

Items on intake forms

- Define SI, rather than simply asking if they self-injure
- Use non-gender-typing language

Deliberate Self-Harm Inventory (DSHI; Gratz, 2001)

- 17-item self-report measure that screens for the presence of self-injury, age of onset, duration, frequency, and severity
- High internal consistency (i.e., Cronbach's alpha) ($\alpha = .82$)
- Adequate test-retest reliability ($m = 3.3$ weeks) ($\phi = .68$; $p < .001$); high correlation of items endorsed on both first and second administrations ($r = .92$; $p < .001$).

Remain attentive to the possible indicators of SI (next slide)

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Possible Indicators of SI

- Cuts, burns, or other unexplained injuries to the skin (Sweet & Whitlock, n.d.)
- Discovery of cutting instruments and rubber bands (Sweet & Whitlock, n.d.)
- Spending long times alone, particularly in bedroom and bathroom (Sweet & Whitlock, n.d.)
- Wearing clothing that is inappropriate for the weather (Sweet & Whitlock, n.d.)
- Refusal to participate in events or activities where others could observe their skin
- Frequent use of bandages and/or accessories that can hide wounds (Ernhout & Whitlock, n.d.)
- Consistent use of wrist bands or other accessories that could hide injuries (Ernhout & Whitlock, n.d.)
- Talking about friends who self-injure (Ernhout & Whitlock, n.d.)

Screening for Related Issues

Treatment Issues

1. Depression
2. Suicide
3. Anxiety
4. Trauma
5. Substance misuse
6. Cognitive functioning
7. Impulsivity

Sample Assessments

1. Beck Depression Inventory, II
2. Columbia Suicide Severity Rating Scale
3. Beck Anxiety Inventory
4. Trauma Symptom Inventory, II; Trauma Symptom Checklist; The Child and Adolescent Needs and Strengths Trauma Comprehensive (Kisiel et al., 2011)
5. Alcohol Use Disorders Identification Test; Adult Substance Abuse Subtle Screening Inventory
6. Various intelligence tests, typically administered by Psychologist
7. Barratt Impulsiveness Scale

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ASSESSMENT FOLLOWING IDENTIFICATION OF SI

Talking about SI

- Prepare yourself and check your biases at the door
- Make eye contact
- Remain calm, in both body language and voice
- Be specific about your concerns and the reasons you have them (What have you noticed?)
- Exercise warm neutrality
- Be nonjudgmental; do not shame, guilt-trip, or stigmatize SI
- Validate and normalize their distress
- Honor their courage in talking about SI
- Do not focus on trying to make them stop self-injuring; focus on understanding what SI means to them and how it functions for them
- (Ernhout & Whitlock, n.d.)

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List of SI assessments on Cornell University website

SI Assessment

Functional Assessment of SI: Formal

Inventory of Statements about Self-Injury (ISAS; Klonsky & Glenn, 2009)

- 46 items and includes 13 function scales
- Two factor structure: interpersonal and intrapersonal scales
- High internal consistency, for interpersonal and intrapersonal scales ($\alpha = .88$; $\alpha = .80$)

Non-Suicidal Self-Injury–Assessment Tool (NSSI-AT; Whitlock, Exner-Cortens, & Purington, 2014)

- Online administration; consists of 12 modules, which cover various factors related to motivations and functions, recency and frequency, onset, wounds, patterns or rituals, severity, habituation, treatment history, disclosures, and reflections and advice
- High test-retest reliability at 4 weeks for any NSSI behavior (ICC[1,1] = .74, p = .01)

Self-Injury Questionnaire -Treatment Related (SIQ-TR)

- Measures functions, frequency, pain perception, and feelings before and after SI
- Focuses on scratching, bruising, cutting, burning, and biting oneself (with option for "other SI")
- Each scale consists of 45 items
- Cronbach's alpha for the scales range from .51 to .896

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Functional Assessment of SI: Informal

Functional assessment is a means of "identifying factors that motivate and reinforce" SI (Klonksy et al. (2011, p. 41)

Talk with clients about the following: feelings, thoughts, and events that precede, accompany, and follow their self-injurious episodes.

Try to help clients discern what coping functions SI serves for them.

SI can serve multiple functions for any given client. So, talk about different self-injurious episodes.

Remember that some clients who self-injure experience alexithymia.

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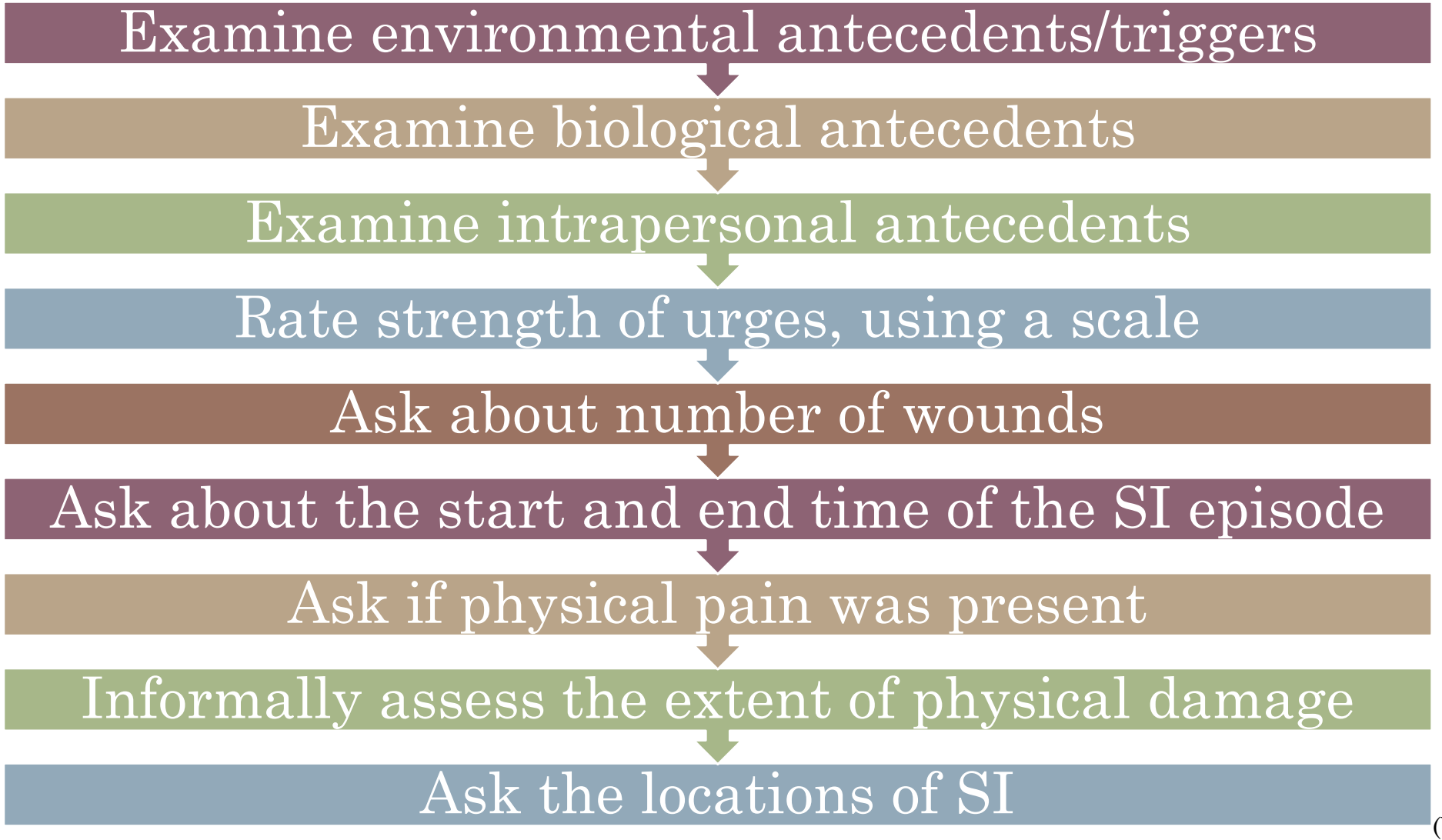
Informal Assessment of SI

Walsh (2014) recommends the following:



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Suicide Risk Assessment with SI

- Given the elevated risk of suicide in people who self-injure (Toprak, Cetin, Guven, Can, & Demircan , 2011; Whitlock et al., 2013), utilize suicide risk assessment procedures
- **Brief Severity Index for Nonsuicidal Self-Injury** (BSI-NSSI; Buser, Peterson, & Hill, 2016)
  - *Still in validation process; assesses severity of SI*
  - *Present version is 32 items on a 3-point Likert scale*
- **Self-Injurious Thoughts and Behaviors Interview** (SITBI; Nock, Holmberg, Photos, & Michel, 2007)
  - *169 item structured interview (also available in a 72-item short-form) that measures suicidal ideation, suicide plans, suicide gestures, suicide attempts, and SI. It also asks participants to identify their means of SI*
  - *Strong interrater reliability (average $\kappa = .99$, $r = 1.0$) and test–retest reliability over 6-month period (average $\kappa = .70$, intraclass correlation coefficient = .44)*

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Suicide Risk Assessment with SI

- **Suicide Attempt Self-Injury Interview** (SASII; Linehan, Comtois, Brown, Heard, & Wagner, 2006, p. 304)
  - Developed to provide a comprehensive assessment of multiple factors related to self-injury, and differentiate between suicidal and non suicidal behaviors
  - *37-item structured interview that includes 6 scales: Suicide Intent, Interpersonal Influence, Emotion Relief, Suicide Communication, Lethality, and Rescue Likelihood*
  - *Internal consistency: suicide intent .93, lethality .85, rescue likelihood: .72, suicide communication: .63*
  - *High inter-rater reliability: .871-.978*
  - *Construct validity: high interrater reliability when comparing medical and nonmedical personnel (.85 for lethality, .93 for physical condition post episode)*

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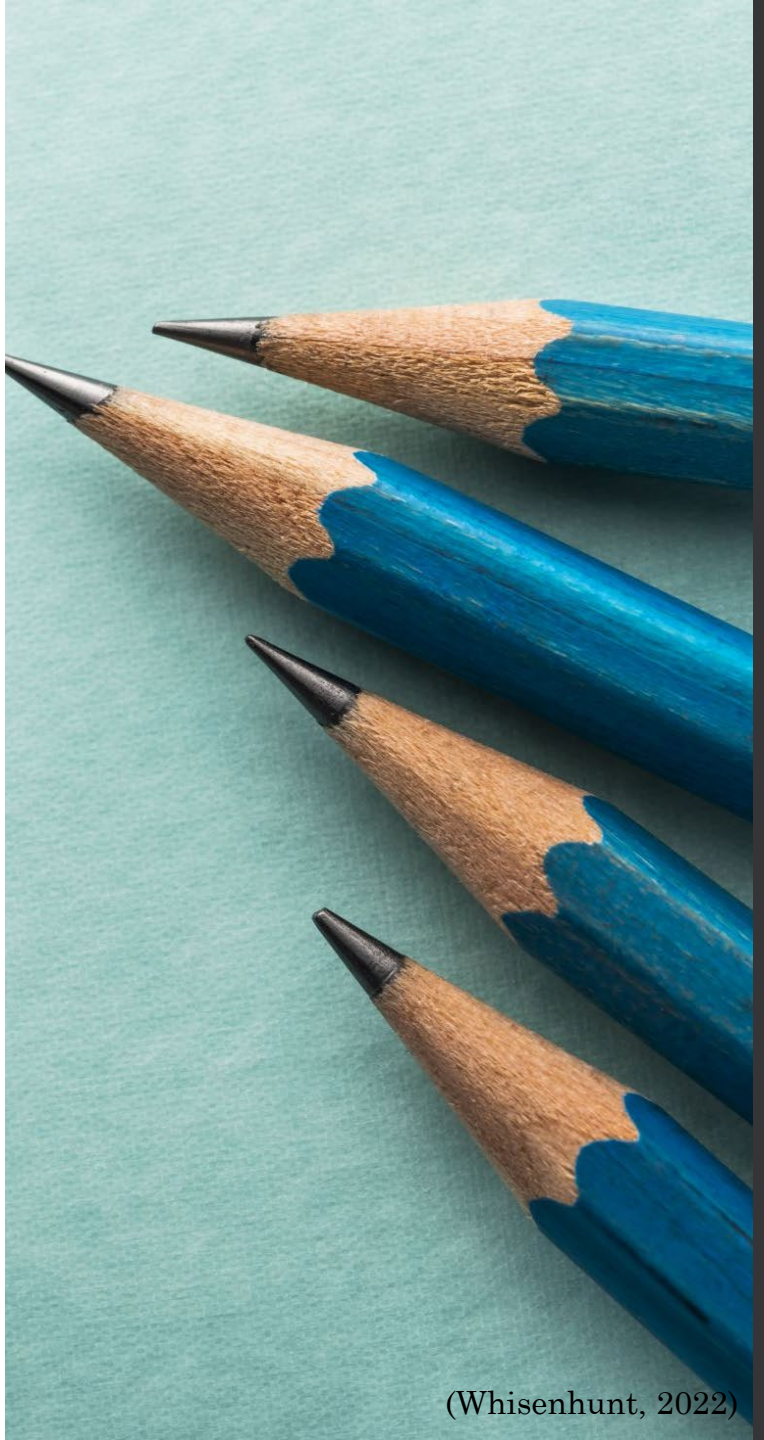
Suicide Risk Assessment with SI

- **Columbia Suicide Severity Rating Scale** (C-SSRS; Posner et al., 2011)
  - Structured clinical interview designed to gather information regarding past/current suicide ideation and behavior, differentiate between suicidal and non-suicidal behavior, be user friendly (available in electronic version)
  - Four constructs: *severity, intensity, behavior, lethality*
  - *Multiple research studies support reliability and validity*
  - *Evidence of divergent validity comparing psychiatric and non psychiatric patients*
  - *Convergent validity with the scale for Suicide Ideation Assessment*
  - *Good internal consistency (range from .73-.946)*



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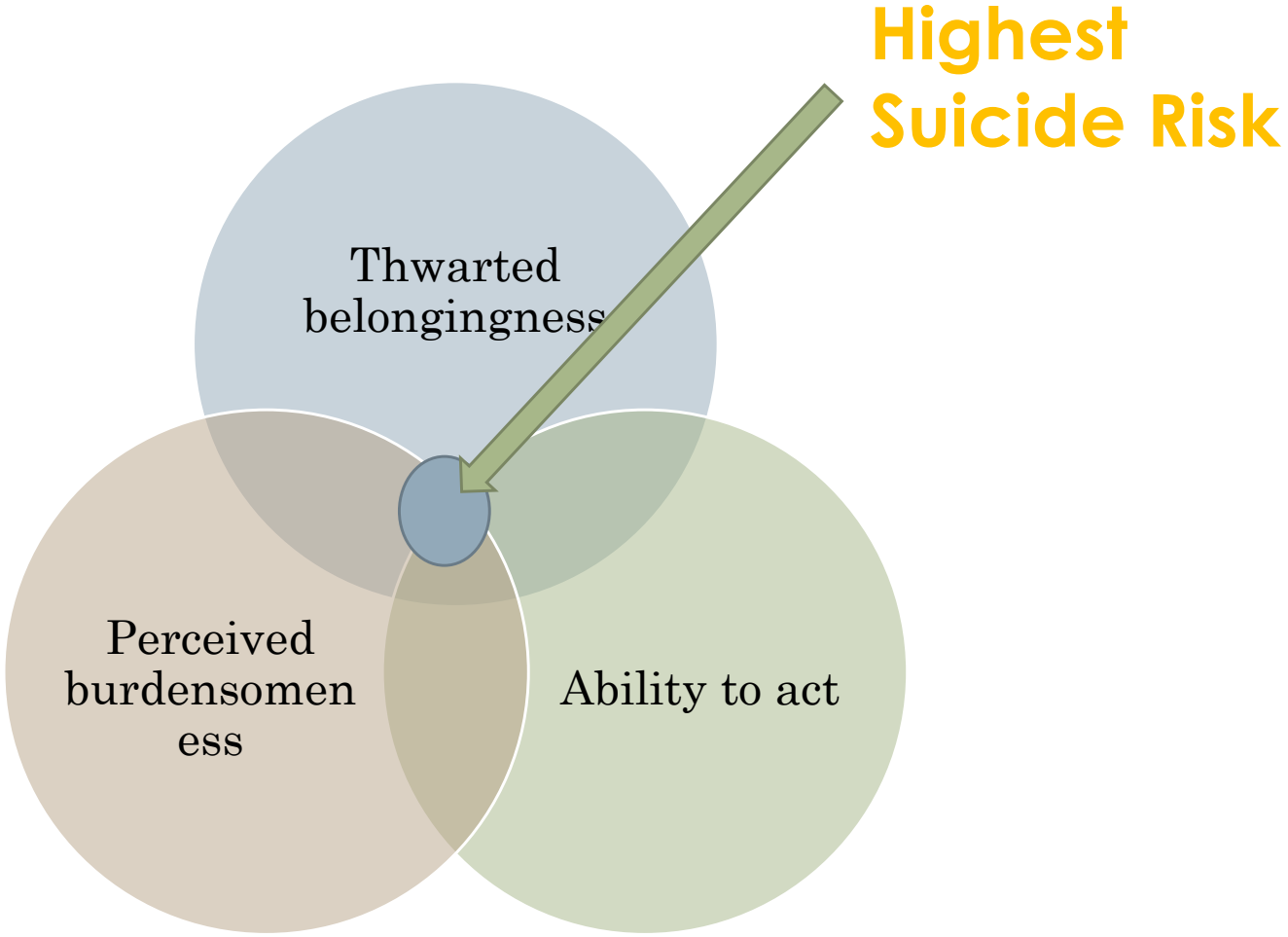
Recursive Assessment of SI

Suicide	Functions	Severity
At intake At specified intervals As indicated	At discovery When new SI methods emerge As indicated	At discovery When new SI methods emerge As indicated

Joiner's Interpersonal-Psychological Theory of Suicidal Behavior



(Ribeiro & Joiner, 2011)

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What Not To Do in SI Assessment

- Do not communicate judgment, either verbally or nonverbally.
- Do not assume clients are engaging in SI for attention
- Do not get impatient with clients who self-injure.
  - *They may struggle to talk about SI because of alexithymia, embarrassment, shame, or fear.*
- Do not assume that all people who self-injure are suicidal.
- Do not forget the high correlation between SI and suicide.

What Not To Do in SI Assessment

- Do not take a mechanical approach to SI or suicide assessment.
  - *Be willing to adapt your approach to meet the client's needs and communicate your interest in understanding the client's unique experience of SI.*
  - *Do not try to force clients into a box if their SI does not make sense to you.*
- Do not assess functions and severity only once, without reassessing at intervals.
  - *Functions and severity can change over time.*
- Do not forget the importance of supervision and/or consultation, especially with high-risk clients…even if you are a very experienced practitioner.

ASSESSMENT-INFORMED TREATMENT

SI Assessment to Guide Treatment

- Non-suicidal Self-injury Decisional Balance (NSSI-DB), Processes of Change, (NSSI-POC) and Self-Efficacy (NSSI-SE) Scales
  - *Based on the Transtheoretical Model of Change*

Treatment of SI

- Cognitive Behavioral Therapy (Ougrin et al., 2015), including Problem Solving Therapy (Muehlenkamp, 2006), and DBT (Choate, 2012; Feigenbaum, 2010; Ougrin et al., 2015)
- Cognitive therapy (Moorey, 2010)
- Mentalization-Based Therapy (MBT) (Najian et al., 2022; Ougrin et al., 2015)
- Behavioral Management Strategies (Barboza & Wilson, 2011)
- Functional Assessment/Functional Analysis of the self-injury (Klonksy et al., 2011; Newman, 2009; Walsh, 2006)
- Means restriction and delay of self-injury (Klonsky & Glenn, 2008)
- Family Therapy (Klonsky et al., 2011)
- Motivational Interviewing (Kress & Hoffman, 2008; see Turner, 2014)

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Treatment of SI with Adolescents

ERITA
- Emotion Regulation Individual Therapy for Adolescents (ERITA; Bjureberg et al., 2018); online version with related parent program in Swedish sample; reduction in SI and emotion dysregulation; improvements in global functioning

DBT
- Dialectical Behavior Therapy (DBT) adapted for adolescents in an inpatient unit (Tebbett-Mock, Saito, McGee, Woloszyn, & Venuti, 2019); Reduced constant observation, SI, suicide attempts, and days hospitalized

DBT-A
- Hunnicutt-Hollenbaugh and Lenz (2018) conducted a meta-analysis of DBT-A outcome studies and found insufficient outcome research to adequately support DBT-A as an effective treatment for SI in adolescents at this time.

MDT
- Swart and Apsche (2014) found preliminary support for Mode Deactivation Therapy (MDT) with adolescents who self-injure.

ERGT
- Emotion Regulation Group Therapy has shown to be effective with adult populations (Gratz et al., 2014, Gratz, Levy & Tull, 2012).

T-SIB
- Treatment for Self-Injurious Behaviors, a brief bx intervention, shows some promise with young adults, particularly those with comorbid anxiety (Andover et al., 2020)

Future
- According to Flaherty (2018) research does not yet significantly support any specific treatment approach for successfully addressing SI with adolescents

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Plener's (2020) proposed approach to treating adolescents who self-injure.

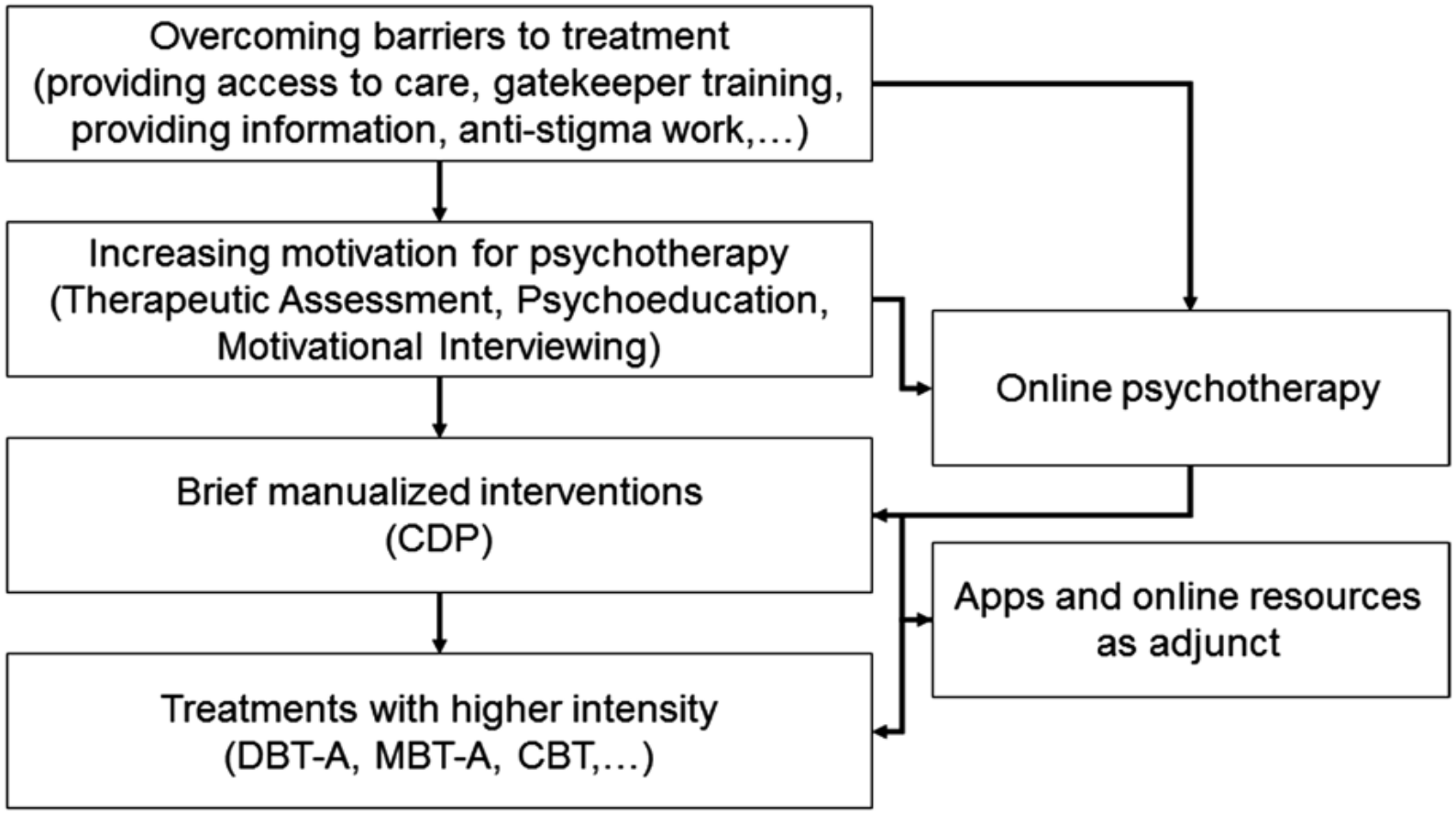

Fig. 1 Proposed stepped-care approach to treat NSSI in adolescents

Treatment of SI

- In general, treatments for SI should (a) focus on relationships and interpersonal functioning; (b) involve skills training; (c) address other maladaptive behaviors, and (d) be intensive (Glenn et al., 2015)
- Treatments should directly target SI (Harris et al., 2022)

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Using Assessment Data to Inform Treatment: History

Inquire into the onset, frequency, severity, and duration of SI. Earlier onset and longer duration (Brager-Larsen et al, 2022), use of multiple SI methods (Wester et al, 2016) and severity of SI may be related to higher suicide risk.

Clients who self-injure and have a history of suicide attempts may underestimate the lethality of their suicide attempts (Toprak et. al. , 2011)

Take a trauma history (Chapman, Gratz, Turner, 2014; Gunter, Chibnall, Antoniak, Philibert, & Hollenbeck, 2011; Kakhnovets et al., 2010) and use a trauma-informed approach (Kaess et al., 2013).

- *Childhood sexual abuse and SI may correlate to a higher risk for suicide attempts* (Chapman, Gratz, & Turner, 2014)
- *Multiple studies demonstrate a link between trauma history and SI (see Briere & Eadie, 2016; de Kloet et al., 2011; Holden et al. 2022; Holiday et al., 2018; Wan, Chen, Sun & Tao, 2015).*
- *Incorporate trauma resolution into treatment*

Identify substance misuse and/or abuse, and seek to minimize them, as intoxication may be related to greater risk of suicide attempts (see Galway et al., 2016)

Using Assessment Data to Inform Treatment: Relationships

- Poor family relationships increase the risk for SI (Toprak et al., 2011; Wester et al., 2016)
  - *Focus on strategies to improve relationships that can be repaired and minimize the impact of toxic relationships*
- Some clients who self-injure may struggle to utilize social supports as a means of coping (Andover, Pepper, & Gibb, 2007)
  - *Work to help client build supportive, positive peer relationships*
- When possible, involve family and loved ones in treatment to help them understand SI

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Using Assessment Data to Inform Treatment: Frequency and Severity

Pay

Pay attention to frequency of SI, because repeated SI is more closely related to suicidal ideation (Kakhnovets et al., 2010)

Consider

Consider severity of self-injury behaviors and methods

- Severe SI may be more closely related to severe psychopathology

Consider

Consider using psychoeducation about the potential risks of SI (Whisenhunt et al., 2013)

Consult

Consult with and/or refer to medical personnel when SI is severe and could cause unintentional severe harm or medical complications

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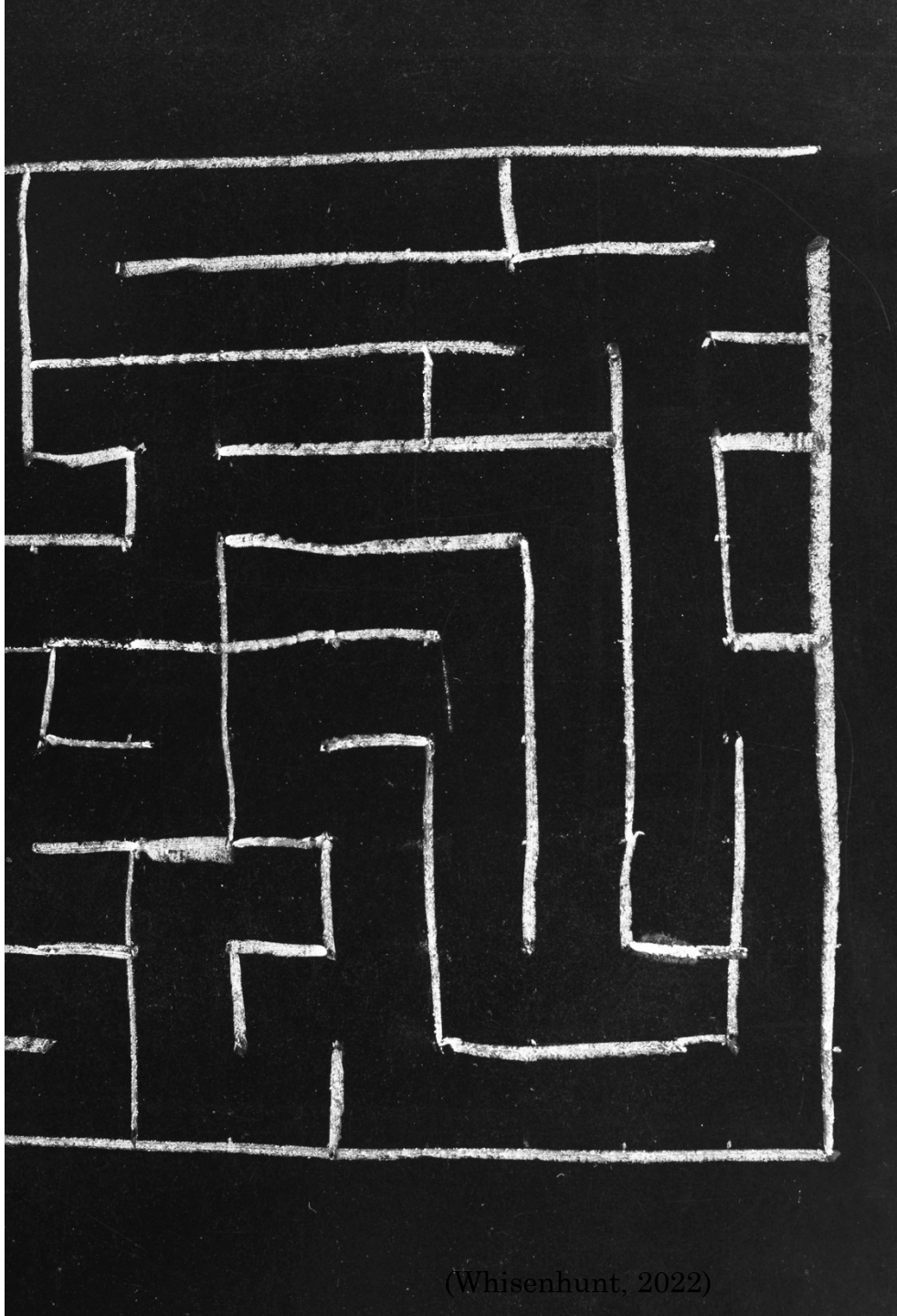
Using Assessment Data to Inform Treatment: Dysphoria

- Monitor for hopelessness, which is more closely related to suicide attempts (Chapman, Gratz, Turner, 2014)
- Address critical self-talk—persecutory self-criticism and deserving to suffer (Gilbert et al., 2010; Ramsey et al., 2021)—and other indications of distorted self-image (Kerr & Muehlenkamp, 2010) because this dysphoria can increase suicide risk
- Work to address maladaptive cognition that contributes to hopelessness (Chapman, Gratz, & Turner, 2014) and distorted self-image
- Consider the role of body image in the initiation and/or continuation of SI (Muehlenkamp & Brausch, 2012).
- Help clients learn to identify and express emotions, as many clients who self-injure struggle with alexithymia (Norman & Borrill, 2015)



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Using Assessment Data to Inform Treatment: Suicide

- There is a potential that prolonged suicidal thinking can habituate a person toward suicidal behavior (Czyz & King, 2013)
- Addressing hopelessness may facilitate faster declines in ideation for those experiencing thoughts of suicide (Czyz & King, 2013)
- Individuals who self-injure may have higher rates of depression and more accepting views of suicide (Park et al., 2022). Address depression, attitudes towards suicide, and interpersonal connections (Park et al., 2022).
- Primary Care/Behavioral Health follow-up are essential after hospitalization

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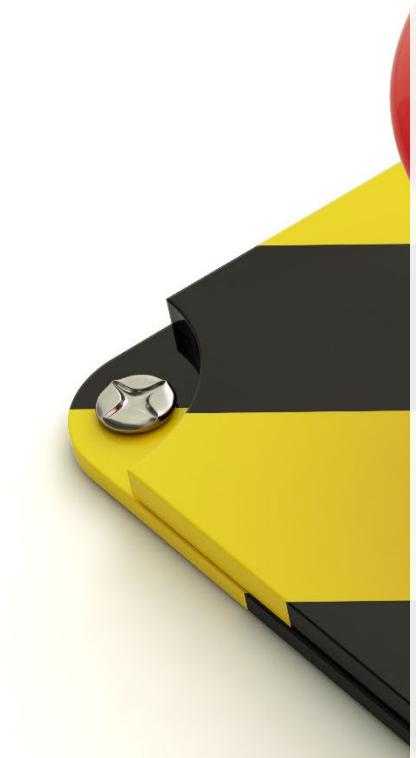
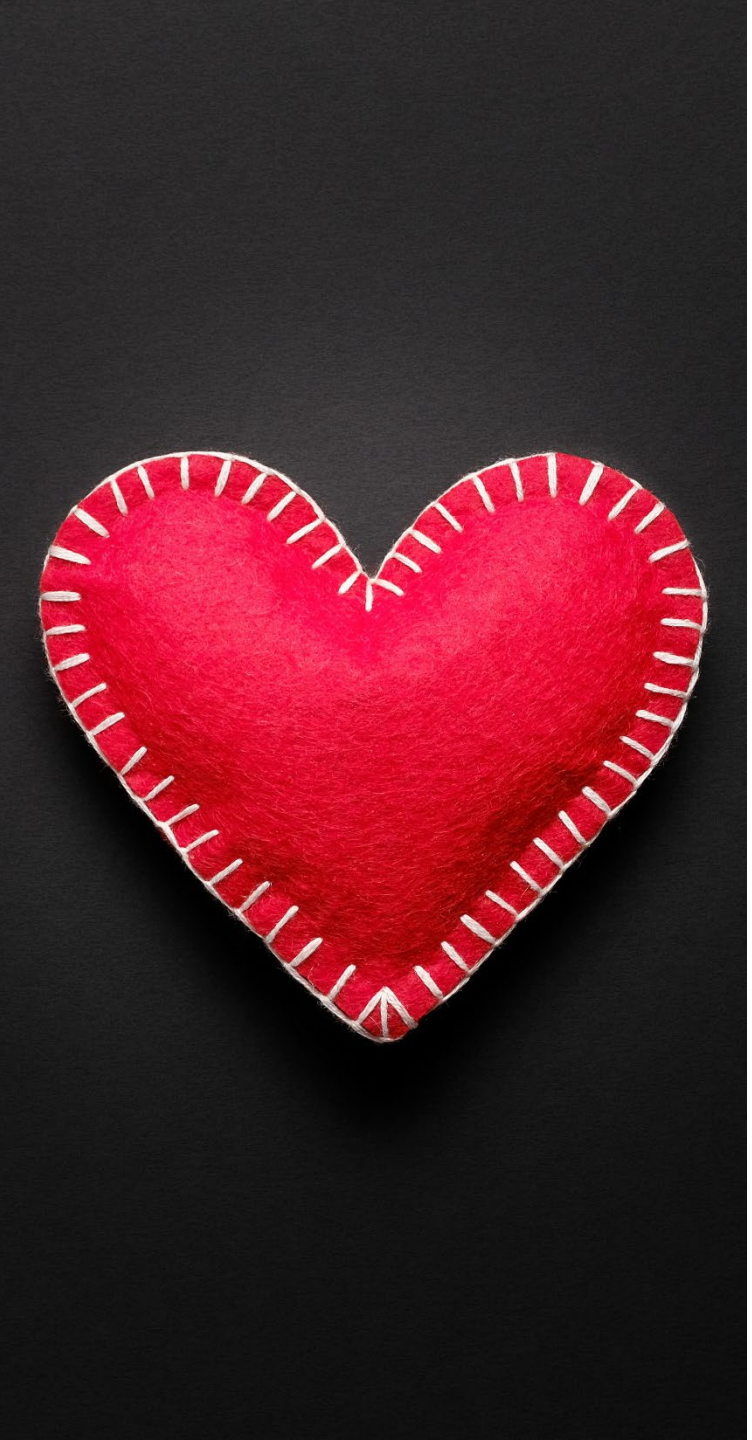


Using Assessment Data to Inform Treatment: Triggers

- Explore ways to minimize triggers
  - *Environmental, interpersonal, intrapersonal, physiological* (Walsh, 2014)
- Anger may play a role in perpetuating SI, particularly through emotion regulation (Kılıçaslan et al, 2022). Consider ways to identify and address anger when present.
- Inquire about use of websites that encourage SI because they can increase risk of suicidal thoughts and actions (Mitchell et al., 2014; see Lewis et al., 2012) and provide psychoeducation accordingly (Lewis & Knoll, 2015; Mitchell, Wells, Priebe, & Ybarra, 2014)
  - *List of questions to guide conversation about online presence related to SI*
- Those who experience more intense urges may have more difficulty reducing SI frequency during treatment (Slesinger et al., 2021).



Using Assessment Data to Inform Treatment: Coping

- Help clients to identify active coping strategies, particularly those that serve a similar function as SI, as active coping appears to be inversely related to SI (Andover et al., 2007; Chapman, Gratz, & Turner, 2014)
- Work to develop problem solving skills, as people who self-injure may struggle to utilize problem solving to cope with emotional distress (Andover, Pepper, & Gibb, 2007)
- Remember that SI may be the client's only effective coping skill. Building new coping skills is a process.

Using Assessment Data to Inform Treatment: Functions

- **Emotion regulation**
  - Mindful breathing skills
  - Visualization techniques
  - Playing/listening to music
- **Anti-Suicide**
  - Communicating with others
  - Reasons for living list
  - Safety plan
- **Interpersonal influence and communication**
  - Writing
  - Artistic expression
  - Communicating with others
- **Self-punishment**
  - Alternative behaviors (controversial)
  - Thought replacement & reframing
- **Feeling generation/ antidissociation**
  - Physical exercise (non-competitive; non-dangerous)
  - Mindfulness skills
  - Sensory techniques
- **Sensation seeking**
  - Physical exercise (non-competitive; non-dangerous)

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Working with Adolescents who Self-Injure

- Begin with comprehensive psychosocial and risk assessments and identify treatment goals (Flaherty, 2018).
- Assess for impulsivity to assist with monitoring for suicide risk, particularly with adolescents who also experience depression and hopelessness (Dougherty et al., 2009).
- Utilize a family systems approach to address the underlying contributors to SI and enhance supportive family dynamic (Miner, Love, & Paik, 2016).
- Work to support clients' identity exploration beyond SI (see Breen, Lewis, & Sutherland, 2013; Claes, Luyckx, & Bijttebier, 2014).
- Work to enhance pro-social behavior and connections (see Hankin & Abela, 2011; Muehlenkamp et al., 2012).

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Managing Therapists' Reactions

- Common reactions to SI include shock, sadness, anger, anxiety/frustration, and diminished professional self-confidence (Fleet & Mintz, 2013)
- Therapists may experience emotional reactivity to SI, feelings of incompetence, and difficulty resolving ethical dilemmas (De Stefano et al., 2012)
- Novice school counselors report a limited of understanding of the causes and symptoms of SI and a lack of confidence in their ability to intervene therapeutically (Simpson et al., 2010)
- Recommendations may include:
  - *ongoing consultation/supervision*
  - *practicing of intrapersonal awareness skills (e.g., meditation, mindfulness, introspective journaling) to process challenging clinical issues*
  - *self-monitor for factors that can limit effectiveness (e.g., compassion fatigue, burnout, countertransference, biases),*
  - *actively seeking client feedback to monitor the working alliance*

RESOURCES AND CONTACT

Resources

Trauma inventories and assessments

- NCTSN website

Cornell University SI webpage

Substance abuse screening tools

- National Institute on Drug Abuse website

C-SSRS

ISSS

Klonsky webinar on understanding SI

Walsh webinar on treating SI

Lewis Ted Talk on personal experience of SI

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Questions

Contact Me

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