# Self-injurious behaviors, diagnoses, and treatment methods: What mental health professionals are reporting

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## Abstract:
Self-injurious behaviors are gaining increased attention in both the media and the professional literature. Despite increased interest, little is actually known about prevalence, diagnoses, and treatment considerations, specifically with outpatient mental health populations. This ankle presents the results from a national survey of American Mental Health Counselor Association (AMHCA) members regarding the rate at which they see clients who self-injure and their clinical opinions of related diagnoses. Finally the treatment methods used by counselors with clients who self-injure are also reported.

## Article:
For the past few decades, self-injurious behaviors (SIBs) have been a focus of research and writings in professional literature (e.g., Favazza & Conterio, 1988; Naomi, 2002; Stone, 2003; Trepal & Wester, 2006; Wester & Trepal, 2005). A possible reason for the focus on SIB is the increasing prevalence across various settings, including inpatient units, outpatient settings, colleges and universities, and the general public (e.g., Briere & Gil, 1998; Gratz, 2001; Hawton et al., 1997). While prevalence rates are increasing, there remains a dearth of information regarding diagnoses that are associated with non-suicidal self-injury, or information regarding how mental health professionals work therapeutically with clients who sell-injure. This article takes a first step in beginning to answer those questions.

## PSYCHOLOGICAL, CORRELATES OF SELF-INJURY
There is no specific DSM-IV-TR diagnoses for SIB (American Psychiatric Association [APA], 2000,; White-Kress; 2003); thus, when working with a self-injuring client, a counselor typically determines if the client exhibits additional characteristics that would qualify him or her for a Borderline Personality Disorder (BPD) diagnosis or if the self-injury is specific enough for a diagnosis of Trichotillomania (i.e., hair-pulling). It has also been argued that a diagnosis of Impulse Control Disorder, not otherwise specified, seems a good match for characteristics associated with non-suicidal self-injury (Favazza, 1996, 1998). Otherwise, the counselor must assign one of a number of other diagnoses to assist in the creation of a treatment plan, refer the client out for other services, or for insurance and payment purposes. However, outside of the relationship found between BPD and self-injury (Clarkin, Widiger, & Frances, 1983; up to 75% of BPD clients self-injure, keeping in mind that not up to 75% of clients who self-injure are diagnosed with BPD), little is known about the relationship between psychological symptoms and SIBs in a community population, specifically among those individuals seeking counseling services.

Although the research is scant regarding diagnosing S1B clients, researchers have examined psychological correlates and have found SIBs to be associated with other diagnoses, such as eating disorders (Favazza, DeRosear, & Conterio, 1989; Stein et al., 2004), adjustment disorder, depression, substance abuse, and anxiety (e.g., Milnes, Owens, & Belnkiron 2002: Yaryura-Tobias, Neziroglu, & Kaplan, 1995). While various diagnoses have been found to co-exist among clients who self-injure, very little is known about the diagnoses or psychological symptoms related to SIB, specifically among clients who reside in the community and are

seeking outpatient services by mental health professionals. The information that is known about diagnoses come from studies that have been conducted in inpatient settings (e.g., Clarkin et al., 1983; Milnes et al., 2002) or among mentally retarded or developmentally delayed populations (e.g., Yang, 2003). The few outpatient studies that have been conducted involve military recruits (Klonsky, Oltmanns, Turkheirner, 2003), clients with eating disorders (Stein et al., 2004), or have extremely small sample sizes (Yaryura-Tobiaset al., 1995), and typically include self-injury as a secondary variable. In addition, a formally accepted definition of non-suicidal self-injury does not exist, thus making it a difficult variable to compare across studies (Muehlenkamp, 2005).

Researchers have neglected to ask mental health professionals what they are seeing in terms of clients who self-injure; thus, it is imperative that we seek this information from those working in outpatient settings. Specifically, asking mental health professionals the prevalence of clients they see who self-injure, along with the types of diagnoses they see, use, or associate with self-injury is important for increasing our understanding in this area.

## TREATMENT OF SELF-INJURY

Counselors should provide evidence-based practices to their clients. Although many authors have provided treatment plans or ways of working with clients who self-injure (e.g., Contelio, Lader, & Bloom 1998; Cooper & Milton, 2003; Demchak & Halle, 1985; Linehan, 1987a1b; Muehlenkamp, 2006; Wester & Trepal, 2005; White, Trepal-Wollenzier, & Nolan, 2002), repeatedly these are based solely on clinical experiences. Few empirical studies have been conducted to examine how counselors are working with clients who self-injure and of those treatment methods are effective. One study that did empirically examine the effectiveness of a treatment method with clients who self-injure was conducted by Guthrie, Kapur, Mackway-Jones, Chew-Graham, Moorey et al. (2001). Guthrie et al. found that patients who received four sessions of a home-based psychoclynamic-interpersonal therapy provided by nurse therapists were less likely to report SIBs at follow-up (5 of the 58 reported self-injury at follow-up) then the medical-treatment-only control group (17 of the 61 clients reported self-injury). This community-based study, however, was not conducted in the United States and did not use the SIB-behaviorally based treatments typically suggested today.

Behaviorally based treatment methods include behavior modification, problem-solving, behavior-substitution, and relaxation. It is believed that alternative behaviors that mimic the effects of SIBs (e.g., snapping a rubber band, rubbing a toothbrush on the skin) may help clients decrease behaviors that cause actual tissue damage (Alderman, 1997; Linehan, I 987b, Wester & Trepal, 2005). Specifically, Linehan (1987b) mentioned the use of Dialectic Behavior Therapy (DBT), an approach that provides clients with problem-solving strategies while using validation strategies to encourage use of newly learned behaviors. In addition, clients work on the ability to communicate and enhance relationships with others (Linehan). Researchers have studied DBT in inpatient psychiatric populations (e.g., Simpson, Pistorello, Begin, Costellow, Levinson, Mulberry, et al., 1998) with positive findings; however, this research has not been conducted with clients who report self-injury as a primary concern, and again, no research has been conducted on clients seeking services by mental health counselors in outpatient settings.

Demchak and Halle (1985), who also suggested behaviorally based methods, proposed using reinforcements to increase adaptive forms of coping and problem-solving, while using negative reinforcements to decrease the use of SIB. Kehrberg 0997) and Daliana (1997) suggested implementing self-soothing strategies using relaxation and imagery to help a client be able to control, stop, and manage unwanted or intense emotions, as well as a behavioral plan to identify triggers, stopping points, and physical cues to S1B. Wester and Trepal (2005) discussed replacing SIB with non-damaging alternative methods that provide the same stimulus to clients who self injure until the underlying reasons for the behavior can be found. For example, they suggested that if a client tends to stop self injuring when seeing the blood on his or her arm from cutting, then have the client use a red marker on their arm to simulate the red aspect of blood; or if they like the sensation that burning creates, suggest they use an ice cube or toothbrush to nib on their skin to experience a similar sensation without causing tissue damage.

In addition to behaviorally based interventions, other authors have discussed the use of cognitive therapy to help clients realize the connection between their thoughts and SIBs (Zila & Kiselica, 2001), while others have proposed more creative approaches, such as art therapy, to help clients who self-injure express their needs in other ways (Cooper 8z Milton, 2003). Although behaviorally based interventions seem to be the most frequently recommended, no one has asked practicing mental health professionals in the community what treatment modalities they use in the natural setting (i.e.. not an experimental study) when working with clients who self-injure.

Since little is known about what actually occurs in outpatient clinical practice with clients who self-injure, the purpose of this study was to survey a national sample of mental health counselors regarding the percentage of clients who report self-injury each month in their clinical practices. In addition, the goal was to find out what types of diagnoses mental health counselors see associated with self-injury, as well as to identify the treatment modalities they use when working with clients who self-injure.

## METHODS

### *Procedure*

A random sample of 1,000 clinical members from the current American Mental Health Counselor Association (AMHCA) membership database (N=5,421, with approximately 3,790 clinical members) was selected. Each participant was mailed a survey packet including a cover letter outlining procedures for the survey, a consent form, a two-page survey, and a business reply envelope in which to return their response. Two weeks later a reminder postcard was sent out to the members of the sample who had not yet responded. A small grant from the first author's university provided funding for this project. This study was approved by the University of Texas at San Antonio Institutional Review Board.

### *Instrument*

The instrument was a two-page survey designed by the authors. Questions included items regarding basic demographic information as well as items specific to SIBs. A total of 23 questions were on the survey.

To ensure that respondents were practicing as counselors or therapists, participants were asked to identify their “current primary role in the counseling field,” and to select only one option. To ensure that respondents understood what was meant by "self-injury" a definition was provided on the survey form. This definition, provided by Simeon and Favazza (2001), was "Self-injurious behaviors are defined as: All behaviors involving the deliberate infliction of direct physical harm to one's own body without the intent to die as a consequence or the behavior." To answer the question about the prevalence of SIB in their practice, counselors were asked to indicate the typical number of self-injury incidents seen or reported by their clients on their caseload per month. They were also asked if, in their professional opinion, they believed that the number of incidents identified reflected the actual prevalence of 5113, or did they feel that the actual prevalence was higher or lower than what was reported.

Participants were also asked to rank order 10 types of self-injurious behaviors that were typically reported in their practice setting using numerical values from 1 (most frequent) to 10 (least frequent), leaving blank those self-injuring behaviors they have not seen. The 10 behaviors that were included were taken from published literature and research on self-injury. They included cutting, burning, hair-pulling, pin-pricking, hitting oneself, head-banging, skin-picking, biting, swallowing foreign objects, and other — which allowed counselors to identify any other self-injurious behavior that was not listed.

lf counselors indicated they had worked with a client(s) who had self¯injured they were asked to respond to the following open-ended questions: “What is/are the most common DSM-IV-TR diagnostic categories that you associate with self-injurious behaviors?" and “What are the treatment modalities that you frequently use with self-injuring clients?" The latter question was followed by inquiring if the treatment modalities used were successful.

## RESULTS

### *Participants*

Of the 1,000 participants mailed packets, 59 packets were undeliverable due to incorrect mailing addresses. From the remaining survey packets successfully mailed, 81 packets were returned (9% response rate). In the final sample, 6% were currently enrolled in a master's or doctoral program, 6% indicated their primary role was a counselor educator, and 75% indicated they were currently a practicing counselor. Eleven respondents (13%) indicated their primary role was "other." Within this other category, they indicated they were a clinical man-alter, art therapist, behavioral specialist, private practitioner, psychologist/psychotherapist, clinical director, or worked in both school and private practice, with two individuals indicating they were recently retired. Since the goal of this project was to determine the number of SIB incidents practicing counselors see in their clinical work, educators and students were dropped from the remaining analyses, leaving a total sample size of 74 practitioners.

The final sample consisted of 67.6% females and 32.4% male. The sample was primarily Caucasian (95.9%), with 1.4% each reporting Hispanic/Latino/a, Native American, and Other. The majority reported having a master's or specialist degree (86.3%), with 1.4% reporting a bachelor's degree (n=1), and 12.3% reporting having completed a doctoral degree. The age of participants ranged from 26 to 71 years old with an average age of 51.08 (SD=9.57).

Sixty-three of the respondents reported they were currently licensed (e.g., LPC), with 54% of respondents holding a National Certified Counselor certification from NBCC. The range of years in which respondents were licensed was 1 to 25 years (*M*=10.09 years; SD=5.93). Respondents indicating practicing between 1 and 37 years as a counselor, with an average of 16.50 years *(SD*=10.11). Seventy five percent of the sample indicated they worked as a counselor full-time. When asked to indicate the primary setting in which they worked, 51.4% reported private practice, 36% reporting in a community agency, 5.6% in a school setting, 1.4% in a psychiatric unit hospital and 5.6% in "other." "Other" responses included church settings, EAP panels, crisis-line services, prison, county mental health departments, hospice, and "multiple locations" was reported by one counselor. Respondents were also asked to indicate the clientele they worked with, with some working with more than one population. Forty-six percent indicated working with children, 63.5% with adolescent, 8.1% with geriatric populations, 51.4% with college age/young adults, 48.6% with couples, 54% families, and 75.7% with adults. Thirty-two of the 50 states were represented by the responses.

### *Frequency Rankings*

Of the 74 counselors, only 60 counselors (81%) indicated that they had seen or had clients on their caseload report SIB incidents. Overall, counselors reported an average of 11.97 incidents of SIB in their counseling setting per month (SD=28.05) with a range from 0 incidents to one counselor in a community setting reporting 180 incidents per month. It needs to be noted that 180 incidents was an outlier. The modal number of incidents reported per month was one (reported 15 times). Frequency of incident reports was compared across counseling settings. Due to the low number of respondents in a number of settings (e.g., 1 in psychiatric units, 4 in school settings and 4 in "other"), counselors' responses were compared between private practice (n=35, M=3.26 incidents reported/month, *SD*= .92) and community agency settings (n25, M=26.66 incidents reported/month, *SD*= 8.46). A significant difference existed between the two settings, with counselors at community agencies reporting significantly more incidents of client self-injury per month than private practitioners ($t(1, 58)=3.25$, $p < .01$). Eighty-five percent (85%) of all participants reported that they believed the actual prevalence of self-injury was higher than what they saw currently in their practice, 5% reported they felt the actual prevalence was the same, while 7% reported they felt actual prevalence was lower than what was seen in their clinical practice.

When examining the type or method of self-injury presented by clients, counselors were asked to rank order 10 different methods of self-injury (e.g., cutting, burning, hair-pulling) from 1 (most frequently) to 10 (least frequently). If they did not see a particular method, counselors were asked to leave the method blank on the survey. The most frequent method of self-injury reported by practitioners in any setting was cutting (73% of all practitioners). Cutting was followed by skin-picking (14.9%), pin prinking, (10.8%), hitting self (9.5%),

head-banging (6.8%), hair-pulling (5.4%), biting (4.8%), and burning and swallowing foreign objects (1.4% each). Behaviors identified in the "other" category (2.7%) included body throwing, deliberate "accidents," using motor vehicles and large maintenance equipment, insertion of dangerous items into vagina, scratching. drugs, overdose, eating disorder, purging, hanging oneself, suicide, and starving.

### *Diagnoses*

When asked about diagnoses associated with SIB, 54 (73%) of the counselors responded to this question. Of those who responded, most reported more than one diagnosis (60%), indicating that SIB can be related to several diagnoses. The average number of diagnoses listed by counselors was 2.78 (SD=1.64), with a range from 1 to 9. Diagnoses ranged from Axis I to Axis II, and very specific (e.g., trichotillomania) to more generalized (e.g., mood disorder NOS, personality disorder NOS). The most common diagnosis provided by counselors was Borderline Personality Disorder (39.2%), followed by depression (38%; Major Depression specifically noted by 9.5%, Dysthymia by 9.5%), Post Traumatic Stress Disorder (23%), anxiety disorders (17.6%), Bipolar Disorder (15%), and substance abuse/use (10.8%). The other diagnoses were reported by less than 10% of practitioners and included: eating disorders (9.5%), childhood disorders (e.g., Autism, MDD; 6.8%), Conduct Disorder (6.8%), psychotic/schizoaffective/schizophrenia (5.4%), personality disorders NOS (5.4%), Dissociative Identity Disorder (5.4%), Oppositional Defiant Disorder (4.1%), Mood Disorders NOS (4.1%), and Depersonalization Disorder, Stereotypic Movement Disorder, Body Dysmorphic Disorder, Pica, Fictitious Disorder/Malingering (1.4% each). Practitioners also reported that SIB was related to other clinical issues such as abuse and trauma (1.4%).

### *Treatment Modalities*

Seventy-eight percent (n=58) of counselors reported the treatment modalities they use to work with clients who self-injure. On average, counselors listed 2.31 different treatment modalities (*SD= 1.*20), with the number of treatments listed between 1 and 7, An equal number of counselors reported using individual counseling or group counseling (8.1% each), with no counselor reporting using family counseling with clients who self-injure.

In terms of specific treatment modalities, the most frequently used was Cognitive Behavioral Therapy (40.5%), followed by Dialectic Behavior Therapy (DBT) (17.6%), Behavioral (10.8%), Cognitive (6.8%), Psychoanalytic/Object Relations (6.8%), Gestalt (5.4%), Narrative (4.1%) Humanistic (2.7%), Solution-Focused (2.7%), Rational Emotive Behavior Therapy (REBT) (2.7%), Reality Therapy (2.7%), Eclectic approaches (2.7%) and Psychodrama (1.4%). Additional treatments included pharmacology (9.5%), safety contracts (8.1%), creative or expressive arts (8.1%), relaxation training or imager), (6.8%), self-care/health (4.1%) coping/problem-solving (4.1%), psychoeducation (17%), mindfulness (2.7%), attachment or relations counseling (2.7%), and inpatient treatment., motivational interviewing, crisis intervention, substance abuse counseling, and movement/exercise (1.4% each). Of all the modalities listed above, 86.5% of counselors reported they believed their treatment methods were successful in decreasing the severity or frequency of clients' SIBS.

## DISCUSSION

This national study was one of the first to examine the extent to which mental health counselors are seeing clients engaging in SIB within outpatient mental health settings, as well as related diagnoses and treatment approaches for SIBs. The results indicate that counselors are seeing a range of incidents of self-injurious behaviors, with an average of 12 incidents reported per month. Included in this average was one counselor who reported close to 200 reports per month. There are many possible explanations for this outlier. For example, if this counselor worked in a trauma setting or group setting instead of counseling individuals, the number of SIB clients seen per month could be higher than a typical caseload. Alternatively, the practitioner may have reported not what was on his or her actual caseload, but the number of SIB incidents seen at the agency as a whole. Removing this outlier from the total, the average number of SIB incidents seen per month was 9.41 (SD=18.96). It is important to keep in mind that the majority of mental health counselors in this sample reported approximately one to two cases of self-injury per month. In addition, the frequency of reports seemed to vary depending upon the type of setting. Specifically, counselors in community agencies reported higher numbers of

SIB incidents as compared to counselors in private practice. This may be related to a difference in clientele seen across these settings; however, more information is needed.

In addition to a wide range of SIB incident reports per month, counselors are reporting various diagnostic categories used or associated with clients who self-injure. This suggests that more information regarding psychological symptoms associated with clients who self-injure needs to be assessed from clients seeking services in outpatient settings. As reported before, the majority of studies that have examined the relation between psychological symptoms and diagnosis to SIBs have found relations between eating disorders, anxiety, and Borderline Personality Disorder (e.g., Clarkin et al., 1983; Milnes et al., 2002). The most common diagnosis reported in the current study was BPD, which may be related to the fact that BPD is one of the only diagnostic categories that includes self-injury in its criteria (APA, 2000). However, the results of this study also indicated that a diagnosis of depression was almost as common as the diagnosis of BPD. Furthermore, multiple other diagnostic categories were also reported as being associated with Sins, ranging from Axis I to Axis II and more mild and general forms of diagnoses (e.g., mood disorder NOS; personality disorder NOS) to more specific (e.g., Major Depression; Trichotillomania), This suggests that SIBs are not just related to BPD, but can be found across a variety of presenting concerns and diagnoses, making it more imperative that SIBs are assessed at intake, regardless of presenting concern.

Very little is known about the methods of treatment that counselors use when working with clients who self-injure. The results of this survey indicated that the majority of respondents are using the behaviorally based treatment methods that have been suggested by other authors and researchers (e.g., Cognitive-Behavioral Therapy, Behavioral Therapy, Dialectic Behavioral Therapy): however, a wide range of other treatment methods were used. While information regarding how and why a specific treatment method or modality was selected is not available in this current study, it may be that counselors are selecting treatments based on the uniqueness or individual needs of their clients, along with selecting treatments that they feel wed to. Regardless of treatment modality, the majority of counselors reported that they felt the treatment methods they used were successful in minimizing or decreasing SIB. It may be the case that, despite our best efforts to validate a treatment protocol for self-injury, just the fact that clients in outpatient mental health settings are being seen in counseling, makes treatment effective. There is some research (e.g., Miller, Duncan. & Hubble, 1997; Wampold, 2001) that suggests that the actual theoretical approach a clinician uses tends to only be a small portion of what clients attribute to counseling effectiveness. Indicating that counseling in general, specifically the client's motivation and external support systems may have a larger impact than the counseling method itself: However, more information needs to be known about treatments for self-injury and their effectiveness before theoretical orientation or modality can be ruled out as having an impact.

### *Implications for Future Research and Practice*

Given the results of this survey, including some ideas about what treatment methods mental health counselors are actually using with clients, and especially the fact that they feel *successful* in their treatment interventions, it is important to follow through with research regarding what actually works from both the counselor and the client's perspectives. While counselors are reporting feeling successful with the various treatments they use in counseling clients who self-injure, future research needs to focus on clients who self-injure and are being treated in outpatient mental health settings, and investigate both client and counselor perspectives. These perspectives would begin to provide a sense of what psychological symptoms are related to self-injury, if clients are being diagnosed correctly, and what treatments work best for working with SIBS-from both a counselor and client perspective. In addition, determining if specific treatments used differ based not on reports of SIBs, but instead on psychological symptoms and/or diagnoses would be useful. Thus, studies examining diagnosis, treatment, and theoretical approaches from the counselor as well as the client perspectives are warranted. This would include longitudinal studies that examine clients in treatment and the causal factors that may relate to decreases in SIBS (e.g., is it counseling in general, do psychological symptoms decrease before SIBS do, or is it the increase in coping skills that occur before SIBs decrease?).

### *Limitations*

Some limitations exist in the current study. The first is the low response rate, which inhibits generalization of the results to the larger population of counselors. It may have been helpful to actually mail a second version of the survey or provide some incentive for counselors to respond to the survey. While the response rate was low, it should be noted that this is the first study to inquire about diagnoses and treatment methods of clients seeking services in outpatient settings. While the sample is small and may not be representative of the larger population of counselors seeing clients who self-injure, it does provide new information regarding the variety of diagnoses and treatment methods being used by counselors. In addition, it encourages future research to explore some of the new questions arising from these results.

Another concern is that even though a definition of self-injury was provided on the survey, a few counselors still seemed unclear of what behaviors constitute self-injury. Specifically, those counselors (n=9) who reported behaviors such as eating disorders, suicide, and substance abuse on the "other" category, none of which constitute or are part of the definition of SIB. While this may be related to the lack of a common and widely accepted definition (Muehlenkamp, 2005)., the definition of self-injury was provided in the current survey—one in which either some counselors misunderstood, may not have read, or whose preconceived ideas of SIBs overruled the actual definition provided, Thus, it seems that continuing education on self-injury, including establishing a common definition of non-suicidal self-injury, and behaviors that comprise SIB, is important for the successful understanding and treatment of self-injury.

## CONCLUSION

Counselors, regardless of outpatient setting, are seeing clients who report self-injurious behaviors. And SIBs seem to occur within the context of various diagnoses and presenting concerns, suggesting that counselors should assess for SIBs regardless of presenting concern and diagnosis. Finally, based on clients' presenting concerns, diagnoses, and counselor preference, it appears that a variety of treatment methods can be used and be effective (based on counselor report) in decreasing or minimizing self-injurious behaviors. Thus, the treatment method itself may not be as important as the therapeutic relationship or client motivation to stop self-injuring. While the results from this study begin to inform the counseling profession about diagnoses and possible treatment modalities for working with clients who self-injure, it is just that—a beginning. More research needs to be conducted longitudinally to see what truly works for clients who self-injure, along with studies that include larger sample sizes of mental health professionals in order to compare the results of this study so that generalizations can eventually be made.

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