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Provider Perspectives on Self-Injurious Behavior: Past, Present, and Future Directions

Laura A. Hilton
Antioch University, New England

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by

Laura A. Hilton

B.A., Smith College, 2005
M.S., Antioch University New England, 2012

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The undersigned have examined the dissertation entitled:

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by

Laura A. Hilton

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Kathi A. Borden, PhD

Dissertation Committee members:
Lorraine Mangione, PhD
Amanda Hitchings, PsyD

Accepted by the

Department of Clinical Psychology Chairperson
George Tremblay, PhD

on **September 7, 2017**

* Signatures are on file with the Registrar's Office at Antioch University New England.

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Dedication

I dedicate this paper to my amazingly kind-hearted, talented children, Samuel and Leigh, in hopes that as a result of my work as a trauma therapist, you have the ability to see the beauty within the hidden, the talent within the pain, and the light within the darkest of places.

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Abstract

Self-Injurious behavior (SIB) has received a great deal of attention in recent years. Although concern about the prevalence of this behavior has increased, some therapists feel that they cannot adequately treat those who engage in self-injurious behavior (Miller, 2005). In this study, mental health providers were asked to complete a brief survey about their experiences providing treatment to those who engage in self-injurious behavior. The goal was to gather information with respect to their experiences treating self-injurious behavior. The study explored provider perspectives with regard to attitude, prognosis, best treatment practices, clinical preparedness, and comfort level in treating individuals who engage in self-injurious behavior. Overall, participants reported positive attitudes toward clients who reported SIB. Further, a longer time in practice was significantly associated with seven domains including increased sense of competence, confidence, and comfort. A longer time in practice was also significantly associated with lower levels of feeling overwhelmed and anxious. Also, although many participants reported having attended past trainings that covered SIB, the majority were still interested in attending a SIB-specific training. In particular, they were interested in learning about treatment approaches and best practices. This was an attempt to understand whether providers felt able to respond to the challenges that self-injurious behavior presents as well as consider ways to help providers meet the needs of this particular population.

Keywords: self-injurious behavior, provider perspective, mental health, attitudes

Provider Perspectives on Self-Injurious Behavior: Past, Present, and Future Directions

Self-injurious behavior (SIB), the topic of this study, is one example of a behavior that has become a mainstream topic of discussion and concern as evidenced by its presence in television, movies, and books, both fiction and nonfiction. The behavior has been showcased in popular movies including *Girl Interrupted*, *Shame*, *Secretary*, *Thirteen*, and *The Scarlet Letter*. Several widely available nonfiction books have been written on the topic with intended audiences which include therapists, parents, friends, loved ones, and those who engage in the behavior themselves. In this study, provider perspectives were explored regarding attitude, prognosis, best treatment practices, clinical preparedness, and comfort level in treating individuals who engage in SIB.

An Overview of SIB

Definitions of SIB vary. A review of the research on the subject illustrated that there is disagreement among both providers and researchers regarding inclusion and exclusion criteria and even an agreed-upon name. Some terms that have been used interchangeably include non-suicidal self-injurious behavior (NSSI; Whitlock, Eells, Cummings, & Purington, 2009), para-suicidal behaviors or gestures (Williams & Pollock, 1993), deliberate or intentional self-harm (Maden, Chamberlain, & Gunn, 2006; Sho et al., 2009; Turp, 2003), self-wounding (Tantam & Whittaker, 1992), or self-mutilation (Favazza, 1989; Matsumoto et al., 2005). Current research still uses several of these names, and each name is indicative of a specific operational definition.

For example, Favazza (1989) used the term self-mutilation, and defined it as "the deliberate destruction or alteration of body tissue without conscious suicidal intent" (p. 137). Later, Favazza (1996) added that body modifications such as tattooing, body piercing, alcohol or

drug abuse, and self starvation should not be considered self-mutilation even though they involve altering body tissue and injuries could be a result (Favazza, 1996; Lundh, Karim, & Quilisch, 2007). In contrast, Williams and Pollock (1993) used the term parasuicidal, and stated that it could occur with or without suicidal intent. Most other researchers have agreed that behaviors that occur during a suicide attempt can be self-injurious, but should be excluded from SIB due to the significant difference in intention. According to the definition that has been adopted by most practitioners, SIB occurs with no suicidal intent (Wichmann, Serin, & Abracen, 2002). There is concern among practitioners and care providers, however, that the danger in the act itself has the potential to become fatal (Young, Justice, & Erdberg, 2006).

Some of the most common SIBs include cutting, scratching, burning, punching or hitting oneself, swallowing harmful items, inserting objects under the skin, purposefully breaking bones, hair pulling, or re-opening old wounds (DeHart, Smith, & Kaminski, 2009; Smith & Kaminski, 2011). In addition, the body modifications that result from SIB are not socially accepted or sanctioned, as is the case with tattoos or piercings (Lundh et al., 2007). The term SIB has been used to minimize the stigma attached to the term mutilation (Bachman, 1972). Henceforth, in this study, the term SIB will be used and Favazza's (1989, 1996) operational definition will be used. Thus, for the purposes of this study, SIB refers to the deliberate destruction or alteration of body tissue without conscious suicidal intent. Further, the body modifications that result from SIB are not socially sanctioned.

An Historical Perspective

There are written accounts of SIB throughout time that represent religious, spiritual, medical, and mental health beliefs and practices. One religion-based example of SIB dates as far back as Saint Anthony (251 AD–356 AD; Favazza, 1996), who was said to live in a pit in

isolation, eat only every six months, and wear garments that caused pain and discomfort. Others in religious history, such as Saint Mary Magdalene de'Pazzi, lived lives of self-sacrifice by engaging in practices like self-flagellation or wearing a crown of thorns. Self-flagellation was often used to relieve religious guilt. Members of the clergy as well as laymen and women would use the practice of self-flagellation as a means of penance (Levenkron, 1998).

Indigenous tribes, both in the past and present, utilize self-sacrificial practices to appease gods, free evil spirits, usher in adulthood, engage in Shamanic initiation, heal the sick, or show their loyalty or shared identity (Long, Manktelow, & Tracey, 2013). For example, a group of Islamic healers in Morocco practice a ritual during which they slash open their heads so that sick people from the community can dip bread or sugar cubes into their blood and ingest it in hopes of being healed. It is believed that their blood is potent medicine (Favazza, 1996). Each year, Shiite Muslims engage in matam, the practice of cutting the body with knives and swords or whipping the body with chains on the Day of Ashura during Muharram as a symbol of their mourning (Fibiger, 2010). Members of the Abidji tribe on the Ivory Coast plunge knives into their abdomens during a New Year festival to reconcile personal or communal issues (Kirtley & Kirtley, 1982). Those who choose or are called to engage in life as a Shaman must undergo an initiation that consists of torture and dismemberment; scraping away of the flesh; replacement of blood; descension into hell; and finally ascension into heaven before being resurrected and consecrated by God (Eliade, 1959).

Favazza (1996) posited that what constitutes SIB is decided within the local culture, which means it can change depending on when and where it occurs. For example, although some of the aforementioned practices are common and culturally sanctioned in the place and time they occur, they would not be considered necessary, ethical, or effective here in the United States at

this point in time. However, some examples of body modification that are common, familiar, and socially sanctioned include circumcision, tattoos, body piercing, and plastic surgery. Again, for the purposes of this study, behaviors that are culturally relevant or socially sanctioned, even in their extremes, are not considered to be within the definition of SIB.

What is the Diagnosis?

In the infancy of its research, SIB was written off as the identifying symptom of Borderline Personality Disorder (BPD; Long et al., 2013). This common misconception is largely responsible for the stigma that remains with both SIB and BPD. Those who struggle with BPD and SIB have characteristically chaotic relationships with others, simultaneously requiring acknowledgement, confirmation, and support, which further confirms the psychotherapist's fears that treatment will be difficult and overwhelming (Himber, 1994; Long et al., 2013). Often, the clients' primitive ways of getting their needs met are seen as manipulative, rather than adaptive (Miller, 2005; Wakai, Sampl, Hilton, & Ligon, 2014). This has led some providers to limit their caseloads (Levenkron, 1998; Miller, 2005), believing that clients with SIB have a poor prognosis, and are a serious strain on resources. It is important to mention the challenges of providing services to an individual with BPD due to the common association of SIB with BPD.

After many years of research on BPD, SIB, and trauma, we know that there is significant symptom overlap among them. Currently, the most recognized diagnosis that is paired with SIB remains BPD (Long et al., 2013). In fact, the *Diagnostic Statistical Manual of Mental Disorders*, 4th edition, text revision, categorized BPD as a cluster B personality disorder that has self-mutilating behavior as one of nine inclusion criteria (APA, 2000). However, we can see that clients who present with SIB may suffer from any number of psychiatric disorders, including, but not limited to depression, schizophrenia, schizoaffective, anxiety, posttraumatic stress,

dissociative identity, obsessive compulsive, eating, or personality disorders (Kameg, Woods, Szpak, & McCormick, 2013; Long et al., 2013; Suyemoto, 1998). Research on the subject has led to current thought that SIB is a reaction to perceived traumatic experiences, making trauma the common denominator rather than BPD (Herman, 1992; Levenkron, 1998; Miller, 2005). In response to this body of research, the *Diagnostic Statistical Manual of Mental Disorders*, 5th edition (DSM-5) included a condition called nonsuicidal self-injurious behavior (NSSI) in Section 3 as a condition that requires further research before being considered an official diagnosis (APA, 2013).

In the 10th anniversary edition of Miller's (2005) book, *Women Who Hurt Themselves*, the author explained that based on extensive work with individuals who engage in SIB, she believed that it was an addiction, and should be treated as such (Miller, 2005). Miller posited that in the wake of physical or sexual abuse, any activity that is powerful enough to destroy the mental and physical pain, if only for a moment, could become an addiction. She also described what she calls the Trauma Reenactment Syndrome (TRS), and illustrated how the addiction becomes all consuming, leading to isolation, shame, and self-hatred, contributing to the cycle of trauma.

Prevalence

Research has shown that SIB is not limited by class, gender, socioeconomic status, race, or age. Precise prevalence rates are extremely difficult to find and change dramatically depending on inclusion and exclusion criteria, the specific sample studied, and the time span inquired about (DiClemente, Ponton, & Hartley, 1991). For example, prevalence rates can reflect current SIB; SIB within the last six months; or over the life span. Prevalence may be assessed using a clinical or a community sample. Often when SIB is studied, a wide range of frequencies

and levels of severity are included, making it difficult to get a clear picture of prevalence. Another confounding factor in obtaining accurate prevalence rates is the fact that people who engage in SIB often do not report their behavior or seek treatment (Kameg et al., 2013; Whitlock et al., 2009). There are over two million SIB cases reported annually in the United States, but the phenomenon is thought to be severely under-reported due to its secretive nature (Kameg et al., 2013; Long et al., 2013). As a result, reports of prevalence range widely, from 4% in a community population (Briere & Gil, 1998), which has likely risen since this study was conducted, 12%–17% in college populations (Whitlock et al., 2009), 18%–40% in clinical populations (Kameg et al., 2013), and a staggering 32%–51% in incarcerated females (Borrill et al., 2003; Maden, Swinton, & Gunn, 1994). However, reported rates of SIB among trauma survivors have been estimated as high as 62% (Favazza & Conterio, 1988) and 79% (van der Kolk, Perry, & Herman, 1991).

The website HealthyPlace.com reports that each year, one in five females and one in seven males engages in SIB (Gluck, 2012). Gluck's analysis indicated that females comprised 60% of those who engaged in SIB. Researchers have concluded that being female is a risk factor consistently linked to SIB (Borrill et al., 2003). Another risk factor is childhood abuse. Nearly 50% of those who engage in SIB report having been sexually abused (Borrill et al., 2003). Other factors that have been found to be consistently associated with SIB include being Caucasian (Maden et al., 2006), unmarried, young, and having a family history of suicide or SIB (Lloyd, 1998).

The age of onset of SIB is most commonly around 13 or 14 years (Gluck, 2012; Klonsky & Muehlenkamp, 2007) and can continue through the life span. The most common form of SIB is cutting (Briere & Gil, 1998; Klonsky, 2007). Outside of clinical populations, SIB is often done

in private and hidden from others, as most individuals feel ashamed or frightened by how others may react. Some individuals report only marking skin in places that can be covered by long sleeves or pants. Further, they avoid activities, such as swimming, that typically show exposed skin (Kameg et al., 2013). In summary, although it is difficult to assess prevalence of SIB, the risk factors identified in the research thus far include being female, Caucasian, unmarried, young, having a history of abuse or having a family history of suicide or SIB (Borrill et al., 2003; Lloyd, 1998; Maden et al., 2006).

Functions That SIB Serves

Over the past 18 years, researchers have conducted meta-analyses to identify the psychological functions of SIB. Simply put, they have tried to determine precisely why people engage in SIB. Researchers studied the results of these meta-analyses and developed models to synthesize the information. There are many functional models for SIB, but it is important to note that their purpose is to help us understand the epidemiology of SIB for purposes of treatment and prognosis. The work of Suyemoto (1998), Klonsky (2007), and Paris (2005) illustrates the most common psychological functions that appear in the SIB literature.

There is significant overlap among models, and more than one may apply to one individual at a particular time. Most researchers agree that the most common precursor to an episode of SIB is a perceived interpersonal slight or loss (Suyemoto, 1998). The result of that loss is heightened anxiety, anger, frustration, or fear. The SIB is usually slow and controlled, and the anger, anxiety, frustration, or fear is either absent or significantly decreased after the act and replaced with a sense of release, relief, or calm (Suyemoto, 1998).

The following section contains a detailed description of the similarities and differences of functions in Suyemoto's (1998) and Klonsky's (2007) models as seen below in Table 1. Paris's

(2005) model is explained at the end of this section. The inclusion of this material is purposeful in order to demonstrate to the reader the often complex psychological functions of SIB and the challenges it can present in therapy.

Table 1

Models for Psychological Functions of SIB

Suyemoto (1998)	Klonsky (2007)
Affect Regulation	Affect Regulation
Dissociation	Antidissociation
Boundaries	Interpersonal Boundaries
Sexual	Self Punishment
Environmental	Interpersonal Influence
Antisuicide	Peer Bonding
	Sensation Seeking

Affect Regulation

Suyemoto (1998) and Klonsky (2007) both identified affect regulation as being the most common psychological function of SIB. Affect regulation, rooted in ego psychology, is believed to be the way people achieve a sense of control over their emotions when they feel overwhelmed (Suyemoto, 1998). This suggests that an act of SIB is one way some people manage negative feelings such as anger, fear, loneliness, or the pain of rejection (Klonsky, 2007). Suyemoto explained that in some cases, SIB is an expression of hatred turned towards the self in fear of destroying the other. Some people use SIB as a way to match their external body to their internal pain. This may help express to others how real their pain is on the inside when they cannot verbalize what they are feeling (Suyemoto, 1998). Once an episode of SIB has been completed, the negative feelings dissipate and are replaced with a sense of calm.

In contrast, antidissociation, another type of affect regulation, suggests that the negative feelings are so overwhelming that the person becomes dissociative and numb (Klonsky, 2007; Suyemoto, 1998). In this case, the SIB is used as a means to end the dissociation by feeling something physical or seeing the physical result of the SIB (e.g., seeing the red of their blood). Some who engage in SIB have stated that they felt dead inside and needed to feel something to

remind them that they were still alive. Both affect regulation and antidissociation are understood as attempts to control one's affect, but the explanations are distinctly different with one as an expression of feeling too much versus the other as an expression of feeling nothing at all.

Antisuicide

Antisuicide is another psychological function that both Suyemoto (1998) and Klonsky (2007) found. In antisuicide, SIB is seen as either an expression of or repression of various drives throughout development (Suyemoto, 1998). Klonsky suggests that the SIB is a replacement for suicide, acting as a compromise between the life and death drives. This allows individuals to carry out self-destructive feelings without ending their lives (Klonsky, 2007). Firestone and Seiden (1990) refer to these episodes of SIB as microsuicides.

Boundaries

Here, SIB can be seen as a function of needing to create a physical boundary between self and others when relationships are so enmeshed that individuals do not know where they end and someone else begins. (Klonsky, 2007; Suyemoto, 1998). This is based in object relations theory with the belief that separation and individuation from the caregiver was interrupted or incomplete, making an insecure attachment with poor or no interpersonal boundaries (Suyemoto, 1998). Therefore, when a loss or abandonment is perceived, intense negative emotions threaten to inundate the individual. Their blurred boundaries lead them to experience the loss of the other as a loss of self, and an episode of SIB helps them define their boundaries and self-reality (Klonsky, 2007).

Sexual and Self-Punishment

According to the data from a meta analysis, the self-punishment function is the second most common function of SIB after affect regulation (Klonsky, 2007). Considering that previous

abuse is a risk factor for later SIB, and 62%–79% of trauma survivors have reported engaging in SIB, Klonsky's (2007) research explained that self-punishment is often ego syntonic and familiar. The function of self-punishment is consistent with Miller's (2005) original view of SIB as part of TRS.

Suyemoto (1998) also found that SIB can be based on beliefs about sexual development. Specifically, she states that the meaning of the SIB relates to the sex drive of a person. The SIB can be sexually gratifying, an attempt to punish oneself from having sexual desires or interactions, an attempt to avoid sexual feelings or desires altogether, or an attempt to control one's sexuality or sexual development (Suyemoto, 1998).

Environmental and Interpersonal Influence

Suyemoto (1998) identified an environmental function of SIB, centered on the idea that there is an interaction between individuals who self-injure and their environment. One such place that this can be seen is in a prison, where the guards and staff view an act of SIB as an unsafe suicidal gesture with health hazards due to the presence of blood (Wakai et al., 2014). Prison staff do not make a distinction between SIB and a suicide attempt. Most inmates are aware of this, and may engage in SIB for secondary gain, such as being moved to another location within the prison to be closer to a desired individual or to be removed from a location where they feel unsafe (Wakai et al., 2014).

Others may see that the act of SIB was rewarded by a desired move and they may then imitate that behavior, desiring a similar outcome. This can create a contagion effect, which is a large concern for prisons, schools, and hospitals. The other dynamic that happens in a correctional facility is when inmates engage in SIB, they may be relocated to an isolated room, either as inpatients in the hospital or in restricted housing. Fennig, Carlson, & Fennig (1995),

recommended isolation to reduce the spread of the behavior or contagion effect. However, the isolated environment is often experienced as another abandonment, causing additional SIB, creating a recurring cycle that is difficult to stop.

SIB can be used to gain the care and attention of other people (Suyemoto, 1998). Klonsky (2007) also identified the desire to gain the care and attention of others, but he named this function "Interpersonal Influence." He also wrote about "Peer Bonding" as a function wherein people engage in SIB specifically to elicit a desired response from others (Klonsky, 2007). Engaging in SIB can elicit affection or care from, control the behavior of, or provide a bonding experience with others (Klonsky, 2007).

Sensation Seeking

After reviewing the literature on the functions of SIB, Klonsky (2007) also introduced the sensation-seeking function. For this psychological function, SIB generates excitement, elation, and exhilaration, similar to the thrills sought by people engaging in high-risk activities such as sky-diving or bungee jumping. This function has been talked about less in the literature, but has adequate evidence to justify including it as a function (Klonsky, 2007).

Paris's (2005) Multifunctional Model

It has been suggested that even if one function explains why an individual began SIB, explanations for subsequent or later episodes may be different (Suyemoto, 1998). Additionally, a single episode of SIB may be explained by two or more functions with a subsequent episode by the same individual better explained by yet another. In Paris's (2005) model, SIB concurrently offers a relief from or expression of a negative mood state such as anger, sadness, or guilt; a distraction by moving from emotional pain to physical pain; communication of distress to others; and dissociation from whatever the current mood state is (Paris, 2005), and most researchers

agree that one episode of SIB may represent many functions.

I have included Suyemoto's (1998), Klonsky's (2007), and Paris's (2005) models to illustrate that although there are several models for understanding the reasons that people engage in SIB, there is considerable overlap. These models provide us with a way of understanding some of the most common psychological functions of SIB.

Provider Perspectives

Many people reacted to the discovery of SIB with fear, curiosity, discomfort, shock, horror, and disgust (Kameg et al., 2013; Levenkron, 1998; Long et al., 2013). To those who do not engage in the behavior, it is incomprehensible and confusing that someone would do this for relief (Long et al., 2013). Many viewed SIB as solely an attention seeking or manipulative behavior (Herman, 1992). Some institutions, such as prisons and certain hospitals, viewed the behavior as a suicidal gesture with likelihood of contagion, and thus instill punishments, which often serve to increase the number of episodes of SIB (Wakai et al., 2014). Negative attitudes towards SIB served to increase the levels of shame, which in turn can increase the drive to engage in SIB.

As discussed previously, BPD remains the most common diagnosis associated with SIB. Thus, there are many negative beliefs and much stigma about individuals who engage in SIB. Therapists have described SIB and BPD clients as blameful, manipulative, messy, rageful, or provocative (Miller, 2005). Many also felt as though clients who engage in SIB are resistant to change with a very poor prognosis (Levenkron, 1998; Miller, 2005).

Drain on Resources

Resources needed to help people with SIB include time, money, and energy. However, additional resources also include medical attention and mental health treatment (Wakai et al.,

2014). Thus, SIB places an increased burden on the staff particularly in settings in which individuals reside full-time, such as residential treatment programs, inpatient units, and correctional facilities. The presence of blood signifies a health hazard, so medical attention is immediately necessary to remove the blood and clean the wound to prevent infection and the spread of bloodborne disease. Mental health staff must take time to assess the individual's intent, determine the precursor to the episode and engage the individual in treatment to prevent subsequent episodes. Unit staff must determine the level of risk for both the individual and others around them. They must abide by safety procedures that may be in place, often including moving persons from one unit to another, placing individuals on suicide watch or in a room or cell by themselves to avoid contagion effects (Wakai et al., 2014).

Time and energy are resources that can become quickly strained in outpatient therapy cases as well. For example, the client-therapist relationship may be impacted. A therapist may dedicate significantly more time and energy to clients who engage in SIB compared to clients who do not (Miller, 2005). Often, phone calls, hospitalizations, and care coordination are necessary for these clients outside of the therapy hour. Due to the nature of chaotic relationships that are often seen with clients with SIB and SIB's overlap with BPD, these clients often engage in splitting, which includes viewing people, including therapists, as either all good or bad (Blume, 1991; Kreisman & Straus, 1989). For example, a therapist may be viewed as wonderfully helpful until a time when the therapist must reschedule an appointment, leading to a sense of abandonment, which in turn may cause the client to experience extreme anger, engage in increased SIB, or abruptly leave treatment before any therapeutic change has occurred (Kreisman & Straus, 1989; Levenkron, 1998).

SIB is difficult to manage and places an increased burden on providers. The results of this

study help us understand how providers view SIB. Thus, the data collected from provider perspectives across settings and at different points of their career are integral to creating future programs and training that can decrease the strain on resources currently needed to manage SIB.

Competence and Confidence

Levenkron (1998) explains how a 24 year old young woman was referred to him for SIB treatment because two previous therapists refused to treat her due to their lack of knowledge or familiarity with SIB. Many therapists feel incompetent to treat a person who engages in SIB, believing the risk is too high (Miller, 2005).When therapists believe that the prognosis is poor, know there is a previous diagnosis of BPD, or have little or no SIB-specific training, they may refuse a case (Levenkron, 1998; Long et al., 2013).

Research suggests that providers are aware of high rates of SIB, but lack confidence and specific knowledge necessary to effectively treat it (Long et al., 2013; Whitlock et al., 2009). In addition, providers worry about other factors involved in treating SIB including the potential lethality of the behavior, poor prognosis, lack of effective treatment, and uncertainty in how to manage active SIB (Wakai et al., 2014; Whitlock et al., 2009).

Researchers believe that negative attitudes towards SIB are likely related to a lack of knowledge (Kameg et al., 2013). Provider training has been associated with improved levels of empathy and positive regard, and greater knowledge and comfort in managing SIB (Muehlenkamp et al., 2013; Wakai et al., 2014; Whitlock et al., 2009). Likewise, providers who do not receive SIB-specific training such as medical nurses or correctional officers report the lowest levels of empathy and the most negative attitudes toward individuals who engage in SIB (Muehlenkamp et al., 2013; Wakai et al., 2014).

Provider Training

Each study has illustrated the need for more thorough and specific training for providers who work with those who engage in SIB (Long et al., 2013; Muehlenkamp et al., 2013). Research also shows that providers outside of the mental health field who interact with those who engage in SIB, such as college health services and residence life staff, primary care and school nurses, and correctional officers, would benefit from specialized training in treating SIB (Wakai et al., 2014; Whitlock et al., 2009). Further, findings suggest that training should include detection, assessment, psychological functions of SIB, and collaborative treatment approaches (Muehlenkamp et al., 2013; Wakai et al., 2014).

It has been determined that SIB-specific training can increase empathy and decrease negative attitudes towards those engaging in SIB. Research has shown that the stigma and challenges that accompany SIB often left providers feeling helpless and overwhelmed (Long et al., 2013; Muehlenkamp et al., 2013; Whitlock et al., 2009). Some clients who have sought help for SIB have received ineffective treatment, or felt that their SIB was ignored by their health care provider (Muehlenkamp et al., 2013). In contrast, specialized training has been shown to reduce stigma and improve care outcomes (Crawford, Geraghty, Street, & Simonoff, 2003). Muehlenkamp et al. (2013) found that SIB-specific training increased knowledge of SIB, empathy, and effective treatment of providers. In addition, clients who were treated by providers who had attended SIB-specific training reported feeling heard and validated and had more positive attitudes towards treatment. Muehlenkamp et al.'s study further suggested that knowing which trainings practitioners had completed would be helpful in designing future studies.

The purpose of the current study was to help us better understand the perspectives of mental health providers who work with and treat individuals who engage in SIB. I gathered data

on providers' work settings, clinicians' beliefs regarding prognosis, levels of difficulty and comfort in treating those who engage in SIB, best treatment practices, whether they have received any SIB-specific training, and whether there is interest in SIB-specific training. These data will help determine the context in which treatment of those with SIB occurs, suggested content for future SIB-specific training, and where and when SIB-specific training would be useful. The information was gathered via an anonymous electronic survey.

At some point, most therapists are faced with a client who engages in SIB, an often addicting, potentially dangerous behavior that can be difficult to manage. Many therapists feel uncomfortable or incompetent to treat individuals who engage in SIB (Long et al., 2013; Muehlenkamp et al., 2013). The results of this study help us understand provider perspectives and the challenges they face with regard to SIB, which in turn, can be used to develop methods to increase the confidence and competence of professionals who work with individuals who engage in SIB.

Method

Research Questions

The survey asked providers questions about their experiences working with clients who engaged in SIB. The questions asked about time in practice, level of experience working with clients who engaged in SIB, attitudes, prognosis, level of difficulty, work setting, previous trainings, and treatment approach. The survey gathered information to address the following research questions (RQ):

Research Question 1: Approximately how long were therapists in practice before they provided services to a client who engages in SIB?

Research Question 2 (a): How did therapists perceive prognosis? (b): How difficult was it

to treat a client with SIB versus a client without SIB?

Research Question 3: What were clinicians' thoughts and feelings regarding working with a client who engaged in SIB?

Research Question 4 (a): Had therapists sought additional training in relation to SIB? (b): Would they find it helpful to receive SIB-specific training if it were accessible to them? (c): What would they hope to learn in this training?

Research Question 5: To what extent did the perceptions of the therapists regarding prognosis, comfort level, and confidence vary in relation to their total time in practice?

Participants

The inclusion criteria for the survey participants were as follows: (a) masters and doctoral level students in a program that leads to eligibility for a mental health license; licensed mental health therapists from disciplines such as social work, addictions counseling, school counseling, clinical psychology, marriage and family therapy, counseling, and general psychotherapy; (b) must currently provide therapy services to clients; and (c) must have worked with or are currently working with a client or clients who addressed or disclosed SIB in therapy.

The outcomes of the inferential statistical tests would have been compromised if the sample size was too small. A Type II error occurs when a test is declared to be statistically not significant when, in fact, it is significant. Van Voorhis & Morgan (2007) indicate that, to achieve 80% power (i.e., a probability of .8 that a Type II error will not occur), with a statistical significance level of .05, and a moderate effect size, the sample size should be at least 50 participants for correlation analysis, and at least 30 participants in each group (i.e., a total of 60) for a t-test. Therefore, in order to run inferential statistical tests, the desired sample size in this study was at least 60.

Measure

A quantitative research design was implemented involving the collection of data using an online cross-sectional survey. The general features of this design are that (a) a sample of participants was drawn from a target population; (b) although the participants may be classified into existing groups, the participants were not assigned into groups, and the participants were not exposed to any treatments or interventions devised by the researcher; (c) descriptive and inferential statistical analysis were conducted, but no causal relationships between dependent and independent variables can be identified; and (d) the data were collected to describe the current status of a target population with respect to a defined social problem (Babbie, 2010). In this study, the target population consisted of therapists providing services to clients who engage in SIB. The social problem was provider reluctance to work with people who engage in SIB. This study sought to increase our understanding of the perceptions of the mental health providers who work with and treat individuals who engage in SIB.

I designed the survey using past research as a guide to collect data that would add to the body of research on SIB. The 24 survey items are listed in Appendix B**.** The survey collected demographic information and professional background; general information about providers' settings and treatment approaches; provider attitudes towards SIB including comfort, confidence, anxiety, optimism; provider perspectives regarding their ability to identify and assess SIB and design an appropriate treatment plan; and training history and desire. The survey began by assessing demographic and professional characteristics of the respondents including degrees and licenses held, length of time providing therapy during their career so far, work setting, and number of clients on current caseload who engage in SIB. Next, I inquired about providers' attitudes toward prognosis and difficulty level of working with clients who engage in SIB.

Participants were asked to rate the degree to which they feel comfortable, confident, anxious, overwhelmed, calm, hopeless, empathic, optimistic, angry, competent, able to design an appropriate treatment plan, and able to acknowledge SIB and assess severity.

Building on the research of Muehlenkamp et al. (2013), a question was included to determine what SIB-specific training the therapist has completed to see if training is related to the level of comfort in treating and attitudes toward SIB. Survey questions inquired whether therapists would be interested in attending a SIB-specific training if it were accessible to them, and what they might hope to learn at these trainings. The last question was an open write-in response; it asked if there is anything additional they would like us to know about their work treating individuals who engage in SIB.

Procedure

Once I received approval from the Internal Review Board (IRB), the survey questions were uploaded into the online website host at http://www.surveymonkey.com. Then, I sent an email invitation to participate to a sampling frame. The sampling frame consisted of the entire Antioch PsyD list serve, as well as to each of my past supervisors and colleagues from practicum and internship sites. In addition, I contacted, via email, a rather large personal network that consists of therapists from many disciplines. All potential participants whom I contacted were asked to send the link to the survey to other clinicians they know. The purposive sample consisted of volunteers drawn from the sampling frame. The invitation to participate (as seen in Appendix A), contained the purpose and goal of the study; the voluntary nature of participation; the informed consent; contact information for me, my dissertation chair, and our school's IRB chairperson; a link to the survey; and a request to forward the survey link to other clinicians.

Participants read the invitation, which contained everything about the study including the

goal, the voluntary nature of participation, who to contact with questions or concerns, and a link to the survey. The invitation informed the participant that by clicking the link to the survey, they were giving informed consent. Once they clicked on the link, they could proceed to answer the 24 items, which took approximately 10 to 20 minutes. At the conclusion of the survey, they submitted their answers and then had the opportunity to submit their email address to enter the drawing for a $50 Amazon gift certificate. They were informed once again that their email address was not linked to their survey responses. Once they exited out of SurveyMonkey.com, their study participation was complete.

To acquire an adequate number of participants and participants from a number of disciplines, the method of snowball sampling was utilized. Snowball sampling refers to the act of identifying specific participants in the target population and then using them to further identify more participants (Biernacki & Waldorf, 1981). In this current study, an invitation to participate was sent to a large number of mental health providers I know personally or have worked with in the past. I requested that they forward the invitation to participate to other providers they know or work with. There was a drawing for a $50 Amazon gift certificate as an incentive for participating and completing the survey.

The survey was accessible online for three weeks. At the end of three weeks, the number of respondents was 113, which was sufficient to conduct my proposed analysis, which includes descriptive statistics as well as some inferential tests.

Data Analysis

The file containing the responses to the 24 items in the online survey was downloaded from http://www.surveymonkey.com and imported directly into IBM SPSS version 20.0 to conduct the data analysis. Before conducting data analysis it was essential to align the research

questions with the survey items, variables, and measures that were collected in the survey (Babbie, 2010). The survey items and measures used to address the research questions are detailed in Appendix D.

Frequency distributions using counts and percentages were computed for demographic variables including gender, age, highest degree, licenses held, and age when began providing mental health services; categorical responses to the items concerning perception of prognosis (Yes or No); ratings of perceived difficulty treating a client with SIB (More difficult, Similar, Easier, or Unsure); categorical responses to the items concerning different types of training; and categorical responses to interest in training (Yes or No). Means, ranges, and standard deviations were computed for the latency period, the total time in practice, number of current clients with SIB; and all Likert items on a scale from 1 to 5.

The final research question, which asked to what extent the perceptions of the therapist regarding prognosis, comfort level, and confidence varies in relation to their total time in practice, was addressed by testing hypotheses using the proposed inferential statistical tests defined in Appendix E. For example, a correlation analysis was used to look at how Likert scale items may relate to total time in practice, giving the data more meaning. An independent samples t-tests was used to see how perception of prognosis or difficulty treating a client varies with respect to total time in practice.

Results

The purpose of this study was to improve understanding of the perspective of mental health providers who work with and treat individuals who engage in SIB. An online cross-sectional survey was conducted to collect data on clinicians' beliefs regarding prognosis, levels of difficulty and comfort in treating those who engage in SIB, best treatment practices,

whether there was interest in SIB-specific training, and whether they had experienced an increase in SIB cases over their career span. This chapter presents statistical evidence to address the research questions.

Demographic Characteristics

Data from 118 surveys were collected. Data from five surveys were omitted due to either incomplete answer sets or a disclosure by the provider that they did not conduct therapy for individuals who engaged in SIB, such as someone engaged in testing with no further service. Hence, data were gathered from 113 completed surveys. Table 2 summarizes demographic data for 113 participants including gender, age, degree qualifications, and mental health licenses or certification.

Table 2

Demographic Characteristics of Participants (N = 113)

Characteristic	Category	*n*	%
Gender	Female	87	77.0
	Male	26	23.0
Age (Years)	< 30	21	18.6
	31–40	45	39.8
	41–50	26	23.0
	51–60	10	8.8
	> 60	11	9.7
Highest degree	Doctoral	64	56.7
	Master's	42	37.1
	Bachelor's	5	4.5
Currently a student in a degree program	Master's	3	2.7
	Doctoral	12	10.6
Mental health Licenses or Certifications (All that apply)	Licensed Psychologist	52	46.0
	None	24	21.2
	Licensed Professional Counselor (LPC)	17	15.0
	Licensed Clinical Social Worker (LCSW)	12	10.6
	Community Mental Health Center (CMHC)	5	4.4
	Licensed Marriage and Family Therapist (LMFT)	3	2.7
	Children's Advocacy Center (CAC)	1	0.9
	Advanced Practice Registered Nurse (APRN)	1	0.9
	Doctor of Medicine (MD)	1	0.9

The majority of participants were female (n = 87, 77.0%). They ranged in age from 23 to 75 years old (M = 40.84 years, SD = 23.0) and most were between 31 and 50 years of age (n = 71, 62.8%). Over half of the participants held a doctoral degree (n = 64, 56.7%) including PhD, PsyD, EdD, or MD. The remainder held Bachelor's or Master's degrees. Some of the participants (n = 15, 13.3%) were currently enrolled in a masters or doctoral degree program that led to eligibility for a mental health license. The majority of the participants (n = 89, 78.8%) held mental health licenses or certifications, of which the most frequent were Licensed Psychologist (n = 52, 46.0%), Licensed Professional Counselor (n = 17, 15.0%); and Licensed Clinical Social Worker (n = 12, 10.6%). Four of the participants held more than one license or certification.

Time in Practice

Table 3 summarizes the descriptive statistics regarding time in practice. Survey questions asked for the age when participants began to provide therapy services (M = 22.57 years, SD = 12.91); the total time working as a primary therapist (M = 12.91 years, SD = 10.18), and the latency period before working with clients engaged in SIB (M = 2 years, SD = 1.35).

Table 3

Latency Period and Time in Practice

Time (Years)	*Min*	*Max*	*M*	*SD*
Age when began to provide therapy services	22	46	22.57	12.91
Time in practice (working as a primary therapist)	1	41	12.91	10.18
Latency period (time before working with clients who engage in SIB)	<1	7	2.00	1.35

Current Practice

Participants worked in a wide range of settings. The most frequent work setting was College or University (*n* = 45, 39.8%), followed by outpatient clinic (*n* = 18, 14.9%), individual private practice (*n* = 15, 13.3%), and correctional facility (*n* = 11, 9.7%). Table 4 summarizes the responses to the question "In what type of setting is your current practice?"

Table 4

Settings of Current Practice

Setting	*n*	%
College or University	45	39.8
Outpatient clinic	18	15.9
Individual private practice	15	13.3
Correctional facility	11	9.7
Group private practice	7	6.2
VA	4	3.5
Other (please specify) [a]	3	2.7
Not currently in practice	3	2.7
Intensive Outpatient Program	2	1.8
Hospital Inpatient	1	0.9
Public Elementary School	1	0.9
Public Middle School	1	0.9
Partial Hospitalization or Day Treatment Program	1	0.9

Note:[a] Child Advocacy Center; Crisis Bed Stabilization; Other Private Practice

The participants were asked "In your current practice, how many clients on your caseload engage in SIB?" This question confused the participants, because it elicited different types of responses including a proportion, a number, or an explanation. Seven providers reported a proportion, such as 20%, at least 40%, or "Most," so those seven responses were not included for this question. The frequency distribution of the 106 numerical responses is presented in Table 5.

The number of current clients who engage in SIB ranged from zero to 25. The most frequent number (mode) of clients reported by providers (n = 26, 23.0%) was zero, therefore the skewed distribution deviated from normality. Twelve providers reported having five clients who currently engage in SIB. Two providers reported having 20 clients who engage in SIB and one provider reported having 25 clients who engage in SIB.

Table 5

Number of Current Clients Engaged in SIB

Number of Clients	*n* (% of Respondents)
0	26 (23.0)
1	11 (9.7)
2	16 (14.2)
3	18 (15.9)
4	5 (4.4)
5	12 (10.6)
6	2 (1.8)
8	3 (2.7)
10	5 (4.4)
15	4 (3.5
19	1 (0.9)
20	2 (1.8)
25	1 (0.9)

The participants were subsequently asked "If currently zero, how recently was it that you treated a client who engaged in SIB?" This question also appeared to cause confusion, because Table 6 indicates that a total of 32 therapists replied, even though only 26 replied zero for the previous question. The responses ranged from less than 12 months ago to 8–10 years ago, of which the most frequent (n = 17, 53.1%) was less than 12 months ago.

Table 6

How Recently a Client Engaged in SIB Was Treated

Time	*n* (% of Respondents)
< 12 months ago	17 (53.1)
1–2 years ago	5 (15.6)
2–4 years ago	7 (21.9)
4–6 years ago	1 (3.1)
8–10 years ago	2 (6.3)

The majority of the therapists (*n* = 81, 71.7%) replied "Yes" to the question "Would you say that your therapeutic approach has changed over time in relation to treating SIB?" Among these 81 participants, over one half (*n* = 65, 57.5%) also replied "Yes" to the question "Would you say that your most current therapeutic approach to treating SIB is different from your former theoretical orientation? The most frequent verbatim responses of the participants explaining how their therapeutic approaches had changed over time mentioned increased use of Dialectical Behavior Therapy (DBT) followed by increased use of Cognitive Behavior Therapy (CBT). Several samples of participant responses can be seen in Appendix E.

Perceptions of Prognosis

Table 7 presents the frequency distributions of the responses ("Yes, Some, or No") to the question "In your experience as a mental health provider, do clients who engage in SIB decrease those behaviors with the support of therapy?" The majority (*n* = 75, 66.4%) replied "Yes" and only one (*n* = 1, 0.9%) replied "No." The remainder of participants (*n* = 37, 32.7%) endorsed "Some."

Table 7

Perceptions of Prognosis

Perception	*n (% of Respondents)*
Yes	75 (66.4)
Some	37 (32.7)
No	1 (0.9)

Feelings

Table 8 presents the descriptive statistics computed for the 5-point responses to "To what degree do you feel the following in regards to working with clients who engage in SIB?" On a Likert scale, 1 = "Not at all"; 2 = "Slightly"; 3 = "Neutral"; 4 = "Mostly"; and 5 = "Completely." The respondents endorsed the full range of possible ratings. The highest scores corresponding to "Mostly" or "Completely," were for "Empathic" followed by "Able to acknowledge SIB and assess severity" then "Comfortable" and "Able to design an appropriate treatment plan." The lowest scores (M = 1.23 to 1.91) representing "Not at all" and "Slightly", were for "Anxious," "Overwhelmed," "Hopeless," and "Angry."

Table 8

Providers Self Ratings Regarding Working With Clients Who Engage in SIB

Feeling	*Min*	*Max*	*M*	*SD*
Empathic	2	5	4.51	0.64
Able to acknowledge SIB and assess severity	2	5	4.38	0.66
Comfortable	1	5	4.11	0.90
Able to design an appropriate treatment plan	1	5	4.02	0.81
Optimistic	1	5	3.88	0.84
Competent	1	5	3.82	0.86
Confident	1	5	3.80	0.94
Calm	1	5	3.74	0.97
Anxious	1	5	1.91	0.75
Overwhelmed	1	5	1.54	0.82
Hopeless	1	5	1.27	0.64
Angry	1	5	1.23	0.50

Feelings and Time in Practice

Table 9 presents the results of a correlation analysis that determined the extent to which the feelings of the therapists about providing treatment for clients who engaged in SIB varied with respect to their total time in practice. Seven of the Pearson's *r* coefficients were statistically significant at $p < .05$.

Table 9

Correlations between Feelings and Time in Practice

Feeling	*Pearson's r*	*p*
Competent	.368	<.001*
Confident	.342	<.001*
Comfortable	.328	<.001*
Overwhelmed	-.324	<.001*
Anxious	-.299	.001*
Able to design an appropriate treatment plan	.255	.007*
Able to acknowledge SIB and assess severity	.205	.030*
Calm	.139	.141
Hopeless	-.114	.231
Optimistic	.111	.243
Empathic	.093	.326
Angry	-.027	.778

* $p < .05$

A longer time in practice was significantly ($p < .05$) associated with increased levels of competence (Pearson's $r = .368$, $p < .001$), confidence (Pearson's $r = .342$, $p < .001$), and comfort (Pearson's $r = .328$, $p < .001$), as well as an increased ability to design an appropriate treatment plan (Pearson's $r = .255$, $p < .007$) and to acknowledge SIB and assess severity (Pearson's $r = .205$, $p = .030$). A longer time in practice also was significantly associated with lower levels of feeling overwhelmed (Pearson's $r = -.324$, $p < .001$) and anxious (Pearson's $r = -.299$, $p = .001$). Time in practice was not, however, significantly correlated ($p > .05$) with five other feelings (calm, hopeless, optimistic, empathic, or angry).

Table 10 presents the frequencies and percentages of the responses to “In thinking of providing treatment for clients who engage in SIB, which of the following statements best describes how you feel?” The most frequent response was “Clients who engage in SIB are similar to those who do not engage in SIB” (*n* = 55, 48.7%); followed by “Clients who engage in SIB are more difficult to treat than clients who do not engage in SIB” (*n* = 45, 39.8%). The least frequent responses were “I am unsure” (*n* = *10*, 8.8%) and “Clients who engage in SIB are easier to treat than clients who do not engage in SIB” (*n* = 3, 2.7%).

Table 10

Provider Responses to Level of Difficulty

Response	*n* (% of Respondents)
Clients who engage in SIB are more difficult to treat than clients who do not engage in SIB	45 (39.8)
Clients who engage in SIB are similar to those who do not engage in SIB	55 (48.7)
Clients who engage in SIB are easier to treat than clients who do not engage in SIB	3 (2.7)
I am unsure	10 (8.8)

Training

The majority of the participants (*n* = 80, 70.8%) replied "Yes" to the question "Have you ever sought out additional education or training regarding self-injurious behavior." Table 11 presents the frequency distribution of the responses to the question "What classes or trainings specifically pertaining to SIB have you completed?" The percentages do not add up to 100% because the respondents were invited to endorse more than one item.

Table 11

Classes or Training Specifically Pertaining to SIB Completed by the Participants

Classes or Training	*n* (% of Respondents)
Dialectical Behavior Therapy (DBT)	82 (72.6)
Trauma informed class or workshop	57 (50.4)
Cognitive Behavior Therapy (CBT)	55 (48.7)
Trauma-Focused Cognitive Behavior Therapy (TF-CBT)	41 (36.3)
Workshop focused on SIB	39 (34.5)
Trauma class in Graduate School	29 (25.7)
Psychodynamic Therapy	28 (24.8)
Eye Movement Desensitization and Reprocessing (EMDR)	18 (15.9)
Cognitive Processing Therapy (CPT)	12 (10.6)
Prolonged Exposure	8 (7.1)
Existential Therapy	7 (6.2)
Trauma Affect Regulation: Guidelines for Education and Therapy	2 (1.8)

The most frequent trainings, attended by about one half or more of the participants, were for DBT (*n* = 82, 72.6%); trauma informed class or workshop (*n* = 57, 50.4%); and CBT (*n* = 55, 48.7%). Over one third had attended training in TF-CBT (*n* = 41, 36.3%) and/or workshop focused on SIB (*n* = 39, 34.5%). About one quarter had participated in training in Psychodynamic Therapy (*n* = 28, 24.8%), one fifth in EMDR (*n* = 18, 15.9%), and between 2% and 10% had participated in other types of training or classes.

In response to "Would you be interested in a SIB-specific training if it were accessible to you?" the majority (*n* = 96, 85.0%) replied "Yes." Table 12 presents the frequency distribution of the responses to the question "What might you hope to learn at such training?" The percentages do not add up to 100% because the respondents were asked to endorse more than one item.

Table 12

What the Participants Hoped They Might Learn

What They Might Learn	*n*	%
Best treatment practices for SIB	89	78.8
Treatment approaches for SIB	65	57.5
Psychological functions of SIB	39	34.5
Assessment of SIB	29	25.7
Recognition and identification of SIB	19	16.8

The majority of participants hoped that they might learn about best treatment practices for SIB (*n* = 89, 78.8%) and treatment approaches for SIB (*n* = 65, 57.5%). Lower proportions of respondents hoped they might learn about psychological functions of SIB (*n* = 39, 34.5%); assessment of SIB (*n* = 29, 25.7%); and/or recognition and identification of SIB (*n* = 19, 16.8%).

Discussion

The purpose of this study was to gain understanding of the perspective of mental health providers who have worked with and treated individuals who engaged in self-injurious behavior. Results from this current study provided information and answers to address the aforementioned research questions. This section answers the research questions, presents the discussion and interpretation of the results, and highlights the clinical implications of the current findings. Some limitations of the study and recommendations for both future research as well as general guidelines for a SIB-specific training will be included.

Research Questions

Approximately how long were therapists in practice before they provided services to a client who engaged in SIB? Data from the current study indicated that the average amount of time before participants provided treatment for individuals who engaged in SIB was

approximately two years, ranging from less than one year to seven years. However, a large number of participants endorsed less than one year (48%). A meaningful interpretation of these data cannot be made because, by design, only therapists who had already seen a client with SIB participated in the survey. So, although current data indicated that practitioners who were newer to the field, with five or fewer years in practice, reported a shorter period of time in practice before treating SIB than therapists who had been in practice for twenty or more years, calculations for newer therapists who have not yet seen a client with SIB were not included in this study. This limited the range of possible latency times for newer therapists. Therefore, current data cannot test whether the latency period before seeing a client with SIB has changed over time. While we do not know the percent of therapists overall who have seen a client with SIB, the finding that this study's participants with over twenty years of experience saw their first client with SIB after an average of 2.67 years in practice has both training implications as well as clinical implications. This finding suggests it would be beneficial to include SIB-specific training for all degree programs that lead to therapist licensure. Then, therapists with little or no experience would have background knowledge of SIB, know what to expect, and be prepared to assess for and treat SIB efficiently and effectively.

How did therapists perceive prognosis? How difficult was it to treat a client with SIB versus a client without SIB? The current study found that 66% of respondents reported that they believed clients could decrease SIB with the support of psychotherapy. On the other hand, 33% of respondents reported that only some clients can decrease SIB with the support of psychotherapy, which suggested additional influencing factors. For example, one response to the final open survey question was, "My countertransference reactions to clients with SIB highly vary depending on the individual patient." It is true that there is very little context to properly

understand the meaning of this comment. However, it raises some good questions. For example, did the level of countertransference depend on previous or current diagnosis? More specifically, did it mean that there was an assumption of a BPD diagnosis? A diagnosis of BPD could be an example of how countertransference influences a clinician's opinion of prognosis at the beginning of the treatment relationship (Miller, 2005). Then again, it could simply mean that clients who engage in SIB have a tendency to make us reflect on our own issues or limitations. If therapists do not effectively manage their own issues, countertransferences abound.

In addition to prognosis, participants were also asked about the relative difficulty of working with clients with and without SIB. While a plurality indicated no difference (48.7%), more felt that clients with SIB were more difficult (39.9%) than less difficult (2.7%). Some addressed this in the final open ended question. One participant responded, "I wouldn't say that they are more difficult to treat; that was a hard question to answer. The treatment itself is more challenging because as a DBT therapist I am available for skills coaching by phone after hours. That can become draining if the calls are frequent, which they can be, especially until the person builds up a skills repertoire." This illustrates the extra time and energy spent outside of the therapy hour for clients with SIB (Levenkron, 1998). Another participant stated, "In relation to the question about individuals who engage in SIB being more difficult than clients who do not, it's not so much that they are more 'difficult' in a personal or negative way as that they require more on-going risk assessment." This reflects the conundrum that SIB is not done with suicidal intent, but serious injury can be a result of SIB (Young et al., 2006), thus requiring constant monitoring. These responses demonstrate therapist perception of the time and energy required to treat clients who engage in SIB.

What were clinicians' thoughts and feelings regarding working with a client who engaged in SIB? Current findings demonstrated that therapists had fairly positive attitudes towards SIB. Participants endorsed both high scores on the positive feelings, and low scores on the negative feelings. Still, there were a few participants who endorsed negative attitudes.

Clinicians who work in residential settings often have contact with each client for a few hours per week at the most. The remainder of their client's time is spent with peers, staff, or alone (Sarkar, 2005). Research from past studies (DeHart et al., 2009; Kameg et al., 2013; Whitlock et al., 2009) illustrated the degree to which staff members, who were not therapists, with little to no clinical training, felt overwhelmed or incompetent interacting with clients who engaged in SIB. Those studies were focused on residential settings that employed large numbers of staff, such as nurses, teachers, orderlies, correctional officers, or mental health workers without advanced mental health clinical training, often working in prisons, schools, hospitals, and residential treatment centers. This suggests that even if clients have a well-trained, competent, confident clinician with a positive attitude towards SIB, they may still experience negative attitudes regarding SIB from other staff members. Clients have reported feeling unheard or ignored, and had negative attitudes towards treatment when surrounded by staff with negative attitudes about SIB (Muehlenkamp et al., 2013). Therapists, who work in a milieu where staff members feel helpless and overwhelmed, may feel ineffective and have negative attitudes towards prognosis and the treatment relationship. On a metalevel, the way a provider feels about treating SIB might parallel the ambivalence clients feel when they engage in SIB or treatment for SIB (Castellano, 2013; Muehlenkamp et al., 2013). All of these incongruencies illustrate the complicated nuances of treating SIB.

Had therapists sought additional training in relation to SIB? Over 70% of participants reported having sought out additional training in the past related to SIB (Long et al., 2013; Muehlenkamp et al., 2013). The current data support prior research which found that more training is associated with more positive attitudes toward working with clients who engage in SIB. The respondents in this study had a significant amount of advanced training, and endorsed high levels of empathy, optimism, and confidence. Over half of the participants already held doctoral degrees, and 12 more reported they were enrolled in a doctoral program. Most doctoral programs include three to four years of full time classes, along with multiple clinical practicums and internship. So, not only were participants highly trained to begin with, many of them sought out addition training related to SIB.

Would they find it helpful to receive SIB-specific training if it were accessible to them? What would they hope to learn in this training? In this study, 85% of participants endorsed interest in taking an additional SIB-specific training if it were available. Participants were most interested in learning about best treatment practices. This was followed by treatment approaches, psychological functions, assessment, and finally, recognition and identification of SIB.

One of the most interesting results of this current study was the discrepancy between self-reported knowledge, attitude, or competence and the desire to learn more and treat more effectively. Providers reported high levels of empathy, comfort, as well as ability to assess SIB and design an appropriate treatment plan, but nonetheless were interested in learning more about best treatment practices in a SIB-specific training. This discrepancy highlights the providers' desire to stay informed due to the time, energy, knowledge, training, and planning that goes into treating individuals who engage in SIB.

One possible explanation for the discrepancy could be socially desirable responding (SDR; van de Mortel, 2008). Self-report measures can be affected by SDR, particularly when a survey contains socially sensitive content (King & Bruner, 2000), such as whether therapists were motivated to get as much training as possible. Clinicians may employ SDR to avoid criticism, present a positive self-image, or conform to what they believe is a socially desirable norm. This current study asked about provider attitudes and training, and providers may have wanted to appear more empathic, more confident, and more open to training than they actually were when treating clients who engaged in SIB. Researchers can use a social desirability (SD) scale to minimize, detect, and account for SDR (van de Mortel, 2008), but an SD scale was not used in this study.

To what extent did the perceptions of the therapists regarding prognosis, comfort level, and confidence vary in relation to their total time in practice? Current data suggest that participants who had been in practice longer, had more positive feelings about treating SIB. As stated previously, a longer time in practice was significantly associated with increased feelings of competence, confidence, and comfort, as well as an increased confidence in an ability to design an appropriate treatment plan and to acknowledge and assess SIB severity. A longer time in practice also was significantly associated with lower levels of feeling overwhelmed and anxious. This finding may be due to therapists with more experience having been exposed to more clients and behaviors, including SIB, which makes them less anxious and more comfortable and confident (Lynch, 2012).

Elaborations on Findings

In exploring why some clients may not disclose SIB or why therapists may not properly acknowledge or assess their clients for SIB, the topic of language came up. One participant

answered the final open survey question stating, “SIB is different from suicidal ideation. Some therapists seem to confuse the two and it makes people less likely to admit to SIB.” Therapists often notify clients of the limits of the confidentiality early in treatment. Most treatment agreements state that one circumstance that may warrant breaking confidentiality is when clients are in danger of hurting themselves or someone else. Earlier, it was discussed that SIB occurs without suicidal intent, but it does involve harming or hurting oneself (Favazza, 1989). Clients may be concerned about the limits to their confidentiality and purposely choose not to disclose their SIB in an attempt to avoid hospitalization or other repercussions. Even at the beginning of the therapeutic process, language can play a key role in keeping the lines of communication open so that clients feel safe to discuss their SIB. Therefore, it may be helpful to clarify the confidentiality agreement by stating that plans to kill oneself or suicidal intent would cancel the agreement and require further action. Further, disclosure of SIB would not nullify the agreement, but may warrant further assessment and therapeutic goals.

As previously stated, the most common diagnosis that is paired with SIB is BPD (Long et al., 2013). The DBT treatment protocol was originally designed to treat BPD. In DBT, SIB is referred to as a target behavior. These current data reflect that association. When providers were asked how their approach to treating SIB has changed over the course of their practice, many providers mention moving from CBT to DBT, especially after Linehan (1993) released her first DBT treatment manual. Most participants referenced now using some form of DBT. In addition, 82 out of 113 respondents endorsed having received some DBT training. The survey did not ask participants to report the associated diagnoses for clients who engaged in SIB. However, current data reflected respondents’ preference for using a DBT treatment approach with a belief that it is very useful in treating SIB (Cook & Gorraiz, 2016).

The risk factors for SIB included being female, Caucasian, unmarried, young, and having a history of abuse or having a family history of suicide or SIB (Maden et al., 2006), all of which are common demographics among college students. Most college students are older adolescents or young adults. College is also a time of huge adjustments regarding social, living, and economic status, which can be stressful and overwhelming to students who may already be experiencing depression or anxiety. Students may feel overwhelmed with emotion and separation from family and close friends may cause an urge to engage in SIB. As discussed earlier, SIB can be a drain on resources and each treatment setting faces its own set of resource challenges. The drain on resources that SIB can cause is discussed in the literature review. The most frequently reported work setting in this study was College or University (n = 45, 39.8%). The majority of students who reside at colleges and universities do not seek clinical services, but there were different influences for why SIB has become a challenging population for colleges and universities (Whitlock, 2009).

For example, college students are influenced daily by social media that encourages them to compare themselves to others and informs them as to what is socially acceptable and what is socially desirable. Social media makes it easy to find information on SIB, watch and talk online with others who engage in SIB (Purington & Whitlock, 2010; Whitlock, Eckenrode, & Silverman, 2006). Increased use of social media heightens the risk for rumination and low self-esteem depending on the audience's feedback or lack thereof (Yang & Brown, 2016). Lack of feedback may be seen as a personal slight, which has been identified as a psychological function of SIB (Klonsky, 2007; Suyemoto, 1998). The personal slight is experienced as a loss of connection to or abandonment by others and increases the urge to engage in SIB.

Limitations

An acknowledgement of the limitations of this research is necessary. This survey used the method of snowball sampling. While the design was successful in recruiting a large number of participants, snowball sampling does not give the researcher control over who is invited to participate beyond the first invitation list. My list of primary invitations included therapists from many disciplines. Still, 64 participants held doctoral degrees, 52 participants were licensed psychologists, and 12 participants reported that they were enrolled in a doctoral level degree program. Although providers from multiple disciplines participated, licensed psychologists were the majority, potentially skewing the results.

There were other limitations regarding the data collection as well. Survey Monkey allows the use of "logic," which allows the researcher to force a specific answer. For example, the question "In your current practice, how many clients on your caseload engage in SIB?" elicited responses in whole numbers, percentages, or qualifiers such as "most." If logic was used in survey design, only whole numbers and no percentages would have been allowed.

You can also employ logic to automatically direct the respondent to the next appropriate question based on their previous answer. For example, when asked if they would be interested in attending a SIB-specific training if it were available to them, some respondents answered "No" but still proceeded to choose what they most hoped to learn. These examples highlight how more use of logic in the survey design would have elicited data that were more clear and precise.

Recommendations

These recommendations for the future have been formulated a result of data gathered from this study combined with recommendations from past literature. These recommendations are for both clinical and training purposes. The goal of this study was to make recommendations

that would be helpful in designing both future research studies regarding prevalence of and attitudes about SIB, and a comprehensive SIB-specific training for clinicians. In addition, some recommendations will assist clinicians in feeling confident and competent providing treatment when they encounter a client who engages in SIB. Lastly, there are some recommendations that will help residential staff work together with a common goal of decreasing negative attitudes toward SIB as well as reducing the total number of SIB episodes.

There were some data points that, upon analysis, would have been useful. One suggestion for future research on the topic SIB is to include a question for providers to disclose the diagnosis of the clients who engage in SIB. As research and perspective can move quickly in the field of psychology, it would be helpful to know if BPD remains the most common diagnosis paired with SIB, or if there are other diagnoses that are similarly associated. It may be especially helpful to identify any additional risk factors associated with SIB. Another recommendation for future research concerns learning whether prevalence is actually higher and collecting longitudinal data to learn whether therapists are treating SIB earlier in their careers than therapists were twenty years ago. Participants in this study reported a latency period ranging from less than one to seven years. Future research could follow clinicians from various settings and collect longitudinal data in order to see if there has been a shift in mean latency periods. This information is important to know because education and training should prepare providers for what they will encounter in the field. Thus, the research informs the practice and vice versa.

In clinical practice, one recommendation is for clinicians to clarify the conditions under which the confidentiality agreement may be breached through use of language, as discussed earlier. For example, therapists might explain that a disclosure of SIB will not immediately negate the confidentiality agreement because SIB is different than suicidal intent. However, it

may require further assessment and specific treatment goals. If the limits of the confidentiality agreement are clear from the beginning, clients may not be as fearful of hospitalization, and be more inclined to disclose SIB.

Training recommendations include time and content components. First, actual prevalence still remains a question. It could be that the actual prevalence of SIB has increased and is higher now than it was before because we have more awareness now, so therapists ask about it earlier in the therapeutic process as part of an overall assessment. It is also a possibility that the stigma associated with SIB has decreased, thus making it easier for clients to disclose SIB. People talking about or engaging in SIB have been showcased in mainstream media including movies, books, and television shows. Social media and widespread use of the internet have afforded people an inside look at what was previously information disseminated to and meant for people working in the clinical realm (Lagoe & Atkin, 2015). Today, people can do an internet search for symptoms, behaviors, or diagnoses and gather a plethora of information that was unavailable prior to access to the Internet (Buhi, Daley, Fuhrmann, & Smith, 2009). A plethora of information about self injury found on the internet is both a good and bad thing; it can help to decrease shame and stigma but it can also serve to normalize the behavior (Purington & Whitlock, 2010). Whether it is due to actual higher prevalence or to more awareness, the topic of SIB often appears in mainstream media and many people who work with adolescent and young adult populations report high prevalence (Klonsky & Muehlenkamp, 2007; Whitlock et al., 2009). It would be helpful to have SIB-specific training in all masters and doctoral level degree programs that lead to eligibility for a mental health license. Having a SIB-specific training during the education and training phase will ensure that clinicians entering the work force have some familiarity with SIB. This is important because past research has already shown

that more training leads to a decrease in negative attitudes and more positive treatment outcomes (Crawford et al., 2003; Muehlenkamp et al., 2013).

Second, I recommend that SIB-specific training include recognition, identification, and assessment of SIB and its severity, the psychological functions of SIB, and best treatment practices and effective treatment approaches for SIB. The recognition, identification, and assessment of SIB is the evaluation phase of treatment. Including this in a SIB-specific training is important so that providers learn how to talk to and ask clients about their SIB. The information the therapist gains from this dialogue is what helps the therapist determine whether the behavior is indeed SIB or whether the client has suicidal intent, which is treated in a different manner. The psychological functions of SIB are important to include in a SIB-specific training because understanding the motivation behind the behavior can have the power to evoke empathy and decrease negative attitudes. Understanding the psychological functions allows the provider to understand how the client may be suffering and what challenges they face most often. The final components that are recommended for a comprehensive SIB-specific training include best treatment practices and effective treatment approaches for SIB. The reasons for including these components directly relate to how therapists view prognosis as well as how confident and competent they feel while providing treatment. Most participants in the current study, even those participants that reported having already taken trainings that included SIB, wanted to learn best treatment practices and the most effective treatment approaches for SIB. Although this study did not look at the efficacy of various treatment protocols, many participants specifically reported that DBT was a very useful and effective treatment for clients who engaged in SIB.

Lastly, findings from past literature posit negative attitudes on the part of any staff members can contribute to poor treatment outcomes or an increase in the number of SIB

episodes (Kameg et al., 2013; Wakai et al., 2014). Hence, it is recommended that a comprehensive SIB-specific training include time for clinical and nonclinical staff to collaborate on designing a protocol for managing SIB that is appropriate for their unique setting. These settings may include integrated medical practices, prisons, hospitals, colleges, and residential programs. Having a protocol that everyone understands and is comfortable with, helps clinicians and staff present a unified front to their clients. This may help to decrease negative attitudes for all staff as well as facilitate a more collaborative approach. In turn, staff may not feel overwhelmed because they know all of their colleagues have the same goal. This can help to decrease episodes of SIB, and eventually improve treatment outcomes. Putting each of these recommendations into practice will help those who provide services to clients who engage in SIB feel more confident and competent, and bridge the gap between trained clinicians and overwhelmed front line workers.

Summary

The phenomenon of SIB has often been misunderstood and associated with negative provider attitudes. It has typically been associated with BDP, a diagnosis that carries its own stigma and negative prognosis. We have come a long way in understanding the origins and psychological functions of the behavior. Current data show that providers have kinder perceptions and increased levels of empathy for clients who engaged in SIB in comparison to what was reported in early literature (Kreisman & Straus, 1989; Levenkron, 1998). However, even today, there is no universal name or operational definition to describe the behavior. Regardless of the reasons, this is a complicated behavioral phenomenon that many clinicians are treating, which means clinicians entering the field should participate in SIB-specific trainings.

A comprehensive SIB-specific training would provide an effective path to move from this

taboo, misunderstood topic to a more practical, collaborative approach to treating SIB. Creating and providing a useful and appropriate SIB-specific training is essential. Participants indicated that useful training would include information on how to recognize and identify SIB, assess its severity, and describe the psychological functions. In addition, they wanted a component to address best treatment practices and effective treatment approaches for clinicians. Finally, a comprehensive SIB-specific training should include time for clinical and nonclinical staff to work together to create an appropriate protocol that works and is adaptable for their particular setting. In larger residential clinical or forensic settings where SIB can be a significant drain on resources, a collaborative approach, in which every staff member understands the mechanisms of SIB, can unite staff to provide more consistent and effective treatment. Clients who engage in SIB often suffer, and feel out of control and unheard. Comprehensive, collaborative training will not only help staff and therapists approach clients with SIB more positively and effectively, it will help the clients successfully engage in treatment where they may finally begin to decrease their SIB.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Rev. 4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Babbie, E.R. (2010). *Basics of social research* (12th ed.) Belmont, CA: Wadsworth.

Bachman, J. A. (1972). Self-injurious behavior: A behavioral analysis. *Journal of Abnormal Psychology, 80,* 211–224. https://doi.org/10.1037/h0033736

Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research, 10(2),* 141–163.

Blume, E. S. (1991). *Secret survivors: Uncovering incest and its aftereffects in women.* New York, NY: Ballantine.

Borrill, J., Burnett, R., Atkins, R., Miller, S., Briggs, D., Weaver, T., & Maden, A. (2003). Patterns of self-harm and attempted suicide among white and black/mixed race female prisoners. *Criminal Behaviour and Mental Health, 13(4),* 229–240. https://doi.org/10.1002/cbm.549

Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry, 68(4),* 609–620. https://doi.org/10.1037/h0080369

Buhi, E. R., Daley, E. M., Fuhrmann, H. J., & Smith, S. A. (2009). An observational study of how young people search for online sexual health information. *Journal of American College Health, 58,* 101–111. https://doi.org/10.1080/07448480903221236

Castellano, D. L. (2013). Trauma triangles and parallel processes: Geometry and the supervisor/trainee/patient triad. *Psychoanalytic Dialogues, 23(6),* 720–732. https://doi.org/10.1080/10481885.2013.851566

Cook, N. E., & Gorraiz, M. (2016). Dialectical behavior therapy for nonsuicidal self-injury and depression among adolescents: Preliminary meta-analytic evidence. *Child and Adolescent Mental Health, 21(2),* 81–89. https://doi.org/10.1111/camh.12112

Crawford, T., Geraghty, W., Street, K., & Simonoff, E. (2003). Staff knowledge and attitudes towards deliberate self-harm in adolescents. *Journal of Adolescence, 26(5),* 619–629. https://doi.org/10.1016/S0140-1971(03)00060-5

DeHart, D. D., Smith, H. P., & Kaminski, R. J. (2009). Institutional responses to self-injurious behavior among inmates. *Journal of Correctional Health Care, 15(2),* 129–141. https://doi.org/10.1177/1078345809331444

DiClemente, R. J., Ponton, L. E., & Hartley, D. (1991). Prevalence and correlates of cutting behavior: Risk for HIV transmission. *Journal of the American Academy of Child & Adolescent Psychiatry, 30(5),* 735–739. https://doi.org/1.1097/00004583-199109000-00006

Eliade, M. (1959). *Sacred and the profane: The nature of religion*. New York, NY: Harcourt.

Favazza, A. R. (1989). Why patients self-mutilate? *Hospital & Community Psychiatry, 40(2),* 137–145.

Favazza, A. R. (1996) *Bodies under siege: Self-mutilation and body modification in culture and psychiatry.* Baltimore, MD: John Hopkins University Press.

Favazza, A. R., & Conterio, K. (1988). The plight of chronic self-mutilators. *Community Mental Health Journal, 24(1),* 22–30. https://doi.org/10.1007/BF00755050

Fennig, S., Carlson, G. A., & Fennig, S. (1995). Contagious self-mutilation. *Journal of the American Academy of Child and Adolescent Psychiatry, 34(4),* 402–403. https://doi.org/10.1097/00004583-1995040000-00005

Fibiger, T. (2010). 'Ashura in Bahrain: Analyses of an analytical event. *Social Analysis, 54(3),* 29–46. https://doi.org/10.3167/sa.2010.540302

Firestone, R. W., & Seiden, R. H. (1990). Suicide and the continuum of self-destructive behavior. *Journal of American College Health, 38(5),* 207–213. https://doi.org/10.1080/07448481.1990.9936189

Gluck, S. (2012). Self injury, self harm statistics and facts. Retrieved from http://www.healthyplace.com/abuse/self-injury/self-injury-self-harm-statistics-and-facts/

Herman, J. L. (1992). *Trauma and recovery.* New York, NY: Basic Books.

Himber, J. (1994). Blood rituals: Self-cutting in female psychiatric inpatients. *Psychotherapy, 31(4),* 620–631. https://doi.org/10.1037/0033-3204.31.4.620

Kameg, K. M., Woods, A. S., Szpak, J. L., & McCormick, M. (2013). Identifying and managing nonsuicidal self-injurious behavior in the primary care setting. *Journal of the American Association of Nurse Practitioners, 25(4),* 167–172. https://doi.org/10.1111/1745-7599.12006

King, M., & Bruner, G. (2000). Social desirability bias: A neglected aspect of validity testing. *Psychology and Marketing, 17(2),* 79–103.

Kirtley, M., & Kirtley, A. (1982). The Ivory Coast. *National Geographic, 162,* 94–124.

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27(2),* 226–239. https://doi.org/10.1016/j.cpr.2006.08.002

Klonsky, E. D., & Muehlenkamp, J. J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology: In Session, 63,* 1045–1056. https://doi.org/10.1002/jclp.20412

Kreisman, J. J., & Straus, H. (1989). *I hate you, don't leave me: Understanding the borderline personality.* New York, NY: Avon Books.

Lagoe, C., & Atkin, D. (2015). Health anxiety in the digital age: An exploration of psychological determinants of online health information seeking. *Computers in Human Behavior, 52,* 484–491. https://doi.org/10.1016/j.chb.2015.06.003

Levenkron, S. (1998). *Cutting: Understanding and overcoming self-mutilation.* New York, NY: W.W. Norton.

Linehan, M. (1993). *Skills training manual for treating borderline personality disorder.* New York, NY: The Guilford Press.

Lloyd, E. E. (1998). Self-mutilation in a community sample of adolescents. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 58(9-B),* 5127.

Long, M., Manktelow, R., & Tracey, A. (2013). We are all in this together: Working towards a holistic understanding of self-harm. *Journal of Psychiatric and Mental Health Nursing, 20(2),* 105–113. https://doi.org/10.1111/j.1365-2850.2012.01893.x

Lundh, L. G., Karim, J., & Quilisch, E. (2007). Deliberate self-harm in 15 year-old adolescents: A pilot study with a modified version of the Deliberate Self-Harm Inventory. *Scandinavian Journal of Psychology, 48(1),* 33–41. https://doi.org/10.1111/j.1467-9450.2007.00567.x

Lynch, M. M. (2012). Factors influencing successful psychotherapy outcomes. *Master of Social Work Clinical Research Papers, Paper 57.*

Maden, A., Chamberlain, S., & Gunn, J. (2006). Deliberate self-harm in sentenced male prisoners in England and Wales: Some ethnic factors. *Criminal Behavior and Mental Health, 10(3),* 199–204. https://doi.org/10.1002/cbm.357

Maden, A., Swinton, M., & Gunn, J. (1994). A criminological and psychiatric survey of women serving a prison sentence. *British Journal of Criminology, 34(2),* 172–191.

Matsumoto, T., Akiko, Y., Yasuhiko, C., Takeshi, A., Eizo, I., & Yoshio, H. (2005). Self-burning versus self-cutting: Patterns and implications of self-mutilation; a preliminary study of differences between self-cutting and self-burning in a Japanese juvenile detention center. *Psychiatry and Clinical Neurosciences, 59(1),* 62–69.

Miller, D. (2005). *Women who hurt themselves: A book of hope and understanding* (10th anniversary ed.). New York, NY: Basic Books.

Muehlenkamp, J. J., Claes, L., Quigley, K., Prosser, E., Claes, S., & Jans, D. (2013). Association of training on attitudes towards self-injuring clients across health professionals. *Archives of Suicide Research, 17(4),* 462–468. https://doi.org/10.1080/13811118.2013.801815

Paris, J. (2005). Understanding self-mutilation in borderline personality disorder. *Harvard Review of Psychiatry, 13(3),* 179–185. https://doi.org/10.1080/10673220591003614

Purington, A., & Whitlock, J. (2010). Non-suicidal self-injury in the media. *The Prevention Researcher, 17,* 11–13.

Sarkar, S. P. (2005). The 'other 23 hours': Special problems of psychotherapy in a 'special' hospital. *Psychoanalytic Psychotherapy, 19(1),* 4–16.

Sho, N., Oiji, A., Konno, C., Toyohara, K., Minami, T., Arai, T., & Seike, Y. (2009). Relationship of intentional self-harm using sharp objects with depressive and dissociative tendencies in pre-adolescence-adolescence. *Psychiatry and Clinical Neurosciences, 63(3),* 410–416. https://doi.org/10.1111/j.1440-1819.2009.01959.x

Smith, H. P., & Kaminski, R. J. (2011). Self-injurious behaviors in state prisons: Findings from a national survey. *Criminal Justice and Behavior, 38(1),* 26–41. https://doi.org/10.1177/0093854810385886

Suyemoto, K. L. (1998). The functions of self-mutilation. *Clinical Psychology Review, 18(5),* 531–554. https://doi.org/10.1016/S0272-7358(97)00105-0

Tantam, D., & Whittaker, J. (1992). Personality disorder and self-wounding. *The British Journal of Psychiatry, 161,* 451–464.

Turp, M. (2003). *Hidden self-harm: Narratives from psychotherapy.* London, England: Jessica Kingsley Publishers.

van de Mortel, T. F. (2008). Faking it: Social desirability response bias in self-report research. *Australian Journal of Advanced Nursing, 25(4),* 40–48.

Van der Kolk, B. A., Perry, J. C., & Herman, J. L. (1991). Childhood origins of self-destructive behavior. *The American Journal of Psychiatry, 148(12),* 1665–1671. https://doi.org/10.1176/ajp.148.12.1665

Van Voorhis, C.R.W., & Morgan, B.L. (2007). Understanding power and rules of thumb for determining sample sizes. *Tutorials in Quantitative Methods for Psychology, 3,* 43–50.

Wakai, S., Sampl, S., Hilton, L., & Ligon, B. (2014). Women in prison: Self-injurious behavior, risk factors, psychological function, and gender-specific interventions. *The Prison Journal, 94(3),* 347–364. https://doi.org/10.1177/0032885514537602

Whitlock, J. (2009, December). The cutting edge: Non-suicidal self-injury in adolescence. *Act for Youth Center of Excellence: Research Facts and Findings.* Ithaca, NY: Cornell University.

Whitlock, J. L., Eckenrode, J. E., & Silverman, D. (2006). Self-injurious behavior in a college population. *Pediatrics, 117(6),* 1939–1948. https://doi.org/10.1542/peds.2005-2543

Whitlock, J., Eells, G., Cummings, N., & Purington, A. (2009). Nonsuicidal self-injury in college populations: Mental health provider assessment of prevalence and need. *Journal of College Student Psychotherapy, 23(3),* 172–183. https://doi.org/10.1080/87568220902794366

Wichmann, C., Serin, R., & Abracen, J. (2002). *Women offenders who engage in self-harm: A comparison investigation.* Ottawa, Ontario: Research Branch Correctional Service Canada.

Williams, J. M. G., & Pollock, L. R. (1993). Factors mediating suicidal behavior: Their utility in primary and secondary prevention. *Journal of Mental Health, 2(1),* 3–26. https://doi.org/10.3109/09638239309016951

Yang, C., & Brown, B. B. (2016). Online self-presentation on Facebook and self development during the college transition. *Journal of Youth and Adolescence, 45(2),* 402–416. https://doi.org/10.1007/s10964-015-0385-y

Young, M. H., Justice, J. V., & Erdberg, P. (2006). Risk of harm: Inmates who harm themselves while in prison psychiatric treatment. *Journal of Forensic Sciences, 51(1),* 156–162. https://doi.org/10.1111/j.1556-4029.2005.00023.x

Appendix A: Letter of Recruitment

Dear Clinician,

My name is Laura Hilton, and I am a doctoral candidate in clinical psychology at Antioch University New England. I am completing my dissertation, which focuses on mental health providers' perspectives on treating persons who engage in self-injurious behavior (SIB).

I am requesting your participation in my dissertation research, which consists of an online survey, and will take approximately 20 minutes.

I'm seeking participants who are in a masters or doctoral level degree program that leads to eligibility for a mental health license **or** are or were a licensed therapist **and** have treated or are currently treating someone who engages in SIB. In addition, I request that you please forward this invitation to participate to any other therapists you may know or work with.

The attached document contains the Informed Consent as well as a link to the survey.

Thank you in advance for your consideration,

Laura A. Hilton, M.S.
Doctoral Candidate in Clinical Psychology
Antioch University New England

Appendix B: Invitation to Participate/Informed Consent

Dear Clinician,

My name is Laura Hilton, and I am a doctoral candidate in clinical psychology at Antioch University New England. I am completing my dissertation, which focuses on mental health providers' perspectives on treating persons who engage in self-injurious behavior (SIB).

I am requesting that you take about twenty minutes to complete the survey that can be found by clicking on the hyperlink below. Your participation in this study is completely voluntary and you may withdraw at any time without prejudice. However, should you complete the survey, you may choose to be linked to an additional, one question survey that asks for an email or phone number in order to enter into a drawing to receive a $50.00 gift certificate to Amazon. There is no connection of your survey responses to you personally even if you submit your email or phone number at the end to enter into the drawing.

Please answer all the survey questions in the next three weeks at a time and place convenient for you. If you have any questions about the survey items, feel free to contact me by email for clarification (xxxxxxx@xxxxxxx.xxx). There are no known risks associated with participation in this research. There are no benefits to you personally other than the chance to win an Amazon gift certificate. However, your participation in this research may help us get a deeper understanding of provider perspectives with regard to treating persons who engage in SIB and the challenges they may face. This information will have implications for determining the most helpful, desired content for future SIB-specific training.

Your answers to the survey will be anonymous. You are not asked to provide any identifying information. The information that you provide will only be used for research purposes. The online survey does not track IP or email addresses.

If you are interested in receiving a summary of the results of this study, please send a request to my email address below, with "Request for Results" in the subject line, and I will send a copy as soon as it is available. If you have any questions about your rights as a research participant, you may contact either Dr. Kevin Lyness, Chair of the Antioch University New England Institutional Review Board, at (603) 283-2149 or klyness@antioch.edu or Melinda Treadwell, Antioch University New England Provost at (603) 283-2444 or mtreadwell@antioch.edu. If you have any questions or concerns related to this study, please contact me at xxxxxxx@xxxxxxx.xxx or my dissertation chair, Dr. Kathi Borden, at kborden@antioch.edu.

If you click on the link below, it means that you have read the information contained in this letter, and agree to participate in this research study.

https://www.surveymonkey.com/r/providerperspectivesSIB

Thank you for your participation!

Laura A. Hilton, Principal Investigator
Doctoral Candidate in Clinical Psychology
Antioch University New England
xxxxxxx@xxxxxxx.xxx

Appendix C: Survey

Self-injurious behavior (SIB) is defined as "the deliberate destruction or alteration of body tissue without conscious suicidal intent" (Favazza, 1989). Not included in this definition are body modifications such as tattooing, body piercing, alcohol or drug abuse, and self starvation, even in their extremes, even though injuries can be a result. The most common examples of SIB are cutting, burning, scratching, punching or hitting oneself, swallowing harmful items, inserting objects under the skin, purposefully breaking bones, hair pulling, or re-opening old wounds.

Please proceed with the survey if you are in a masters or doctoral level degree program that leads to eligibility for a mental health license **or** are or were a licensed therapist **and** have treated or are currently treating someone who engages in SIB.

*By completing and submitting this survey, I am providing implied consent to participate in this study.

1. Please indicate your gender. Male Female Other

2. What is your current age? _____

3. What is your highest degree?

BA BS MA MS PsyD PhD EdD MD

4. Are you currently a student in a degree program that leads to eligibility for a mental health license?

Master's Student Doctoral Student Not a Student

5. What license(s) or certification do you hold? (Please check all that apply)

LMFT CMHC LPC LCSW CAC LDC APRN Psychologist MD None

6. What was your age when you began providing therapy services? (Specifically, when you acted

as primary therapist with your own caseload, even if under supervision, as with a clinical practicum or internship.) ____

7. For how many years have you been providing or for how many years did you provide therapy services? (Specifically, since you began acting as primary therapist with your own caseload, even if under supervision, as with a clinical practicum or internship.) ____

8. To the best of your recollection, how many years into your career were you before working with a client who engaged in self-injurious behaviors that were addressed in therapy?

< 12 months 1-2 years 2-4 years 4-6 years 6-8 years 8-10 years > 10 years

9. Have you ever sought out additional education or training regarding self-injurious behavior due to working with a client who engaged in self-injurious behaviors? Yes No

10. Regarding your first client who engaged in self-injurious behaviors that were addressed in therapy, to the best of your recollection, what treatment approach best describes your therapy with this particular client?

DBT CBT Interpersonal therapy Gestalt Cognitive Therapy Person-Centered Relational-Cultural Psychodynamic therapy Psychoanalysis Family Therapy Hypnotherapy EMDR Group therapy Eclectic Integrative Therapy Rational-Emotive Feminist Narrative Therapy Existential Behavior Therapy Internal Family Systems Transtheoretical Object-Relations Rogerian Other

11. Would you say that your therapeutic approach has changed over time in relation to treating SIB? Yes No

12. If yes, would you say that your most current therapeutic approach treating SIB is different from your former theoretical orientation? Yes No

13. If yes, please **briefly** explain how your approach to treating SIB has changed. (Maximum

100 characters). _____

14. In your experience as a mental health provider, do clients who engage in SIB decrease those behaviors with the support of therapy? Yes No Some

15. To what degree do you feel the following in regards to working with clients who engage in SIB?

	Not at All 1	Slightly 2	Neutral 3	Mostly 4	Completely 5
Comfortable					
Confident					
Anxious					
Overwhelmed					
Calm					
Hopeless					
Empathic					
Optimistic					
Angry					
Competent					
Able to design an appropriate treatment plan					
Able to acknowledge SIB and assess severity					

16. In thinking of providing treatment for clients who engage in SIB, which of the following statements best describes how do you feel?

a. Most clients who engage in SIB are more difficult to treat than most clients who do not engage in SIB

b. Most clients who engage in SIB are similar to most clients who do not engage in SIB

c. Most clients who engage in SIB are easier to treat than most clients who do not engage in SIB

d. I am unsure

17. In what type of setting is your current practice?

Individual private practice

Group private practice

Hospital Inpatient

Outpatient Clinic

Primary Care Practice

VA

Elementary School - public

Middle School - public

High School - public

Elementary School - private

Middle School – private

High School - private

College or University

Forensic Hospital

Correctional Facility

Intensive Outpatient Program

Partial Hospitalization or Day Treatment Program

Specialized Residential Program

Outdoor Therapy Program

Consultation based medical program

Consultation based (various locations)

Not currently in practice

Other_____

18. In your current practice, how many clients on your caseload engage in SIB? _____

19. If currently zero, how recently was it that you treated a client who engaged in SIB?

< 12 months ago 1-2 years ago 2-4 years ago 4-6 years ago 6-8 years ago

8-10 years ago > 10 years ago

20. If currently zero, in what setting was it that you treated your most recent client who engaged in SIB?

Individual private practice

Group private practice

Hospital Inpatient

Outpatient Clinic

Primary Care Practice

VA

Elementary School - public

Middle School - public

High School - public

Elementary School - private

Middle School – private

High School - private

College or University

Forensic Hospital

Correctional Facility

Intensive Outpatient Program

Partial Hospitalization or Day Treatment Program

Specialized Residential Program

Outdoor Therapy Program

Consultation based medical program

Consultation based (various locations)

Other_____

21. What classes or trainings **specifically pertaining to SIB** have you completed? Please check all that apply. If SIB was specifically addressed as at least one part of the class or training, please include that experience even if SIB was not the main focus of the entire class or training.

__Cognitive Behavior Therapy (CBT)

__Trauma-Focused Cognitive Behavior Therapy (TF-CBT)

__Dialectical Behavior Therapy (DBT)

__Eye Movement Desensitization & Reprocessing (EMDR)

__Cognitive Processing Therapy (CPT)

__Prolonged Exposure (PE)

__Psychodynamic Therapy

__Existential Therapy

__Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET)

__Trauma Class in Graduate School

__Trauma Informed Class or Workshop

__Workshop focused on Self-Injurious Behavior

22. Would you be interested in a SIB-specific training if it were accessible to you?

Yes No

23. What might you hope to learn at such a training?

___Recognition and Identification of SIB

___Assessment of SIB

___Psychological functions of SIB

___Treatment approaches for SIB

___Best treatment practices for SIB

24. Is there anything else you would like us to know about your work treating individuals who engage in SIB? (write-in response)

_____

_____

_____

Appendix D: Key of Acronyms Contained in this Document

APA	American Psychiatric Association
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioral Therapy
CPT	Cognitive Processing Therapy
DBT	Dialectical Behavioral Therapy
DSM	Diagnostic and Statistical Manual
EMDR	Eye Movement Desensitization and Reprocessing
IRB	Internal Review Board
NSSI	Non-Suicidal Self-Injury
PE	Prolonged Exposure
PTSD	Posttraumatic Stress Disorder
SDR	Socially Desirable Responding
SIB	Self-Injurious Behavior
TF-CBT	Trauma Focused Cognitive Behavioral Therapy
TARGET	Trauma Affect Regulation: Guide to Education and Training
TRS	Trauma Reenactment Syndrome

Appendix E: Sample of Participant Responses Explaining How Therapeutic Approaches Had Changed Over Time

- "Almost always use DBT or integrate DBT skills into work."
- "Became intensively trained in DBT and primarily use this method now."
- "Better understanding or etiology leads to better outcomes. Use of DBT, trauma-informed approaches."
- "Combination of psycho-ed for teen and parents, DBT, CBT, and family systems, if applicable, or Internal Family Systems."
- "Currently use more DBT, CBT, and more of a trauma focus."
- "Engaged in more DBT skills while also using Relational Cultural Theory."
- "Focus more on using DBT principles."
- "I actively use DBT now and all of its tenets (mindfulness, coping skills, distress tolerance, etc.)"
- "I am more likely to conceptualize it from a DBT perspective. I did seek DBT training but not for SIB. I sought it to work with dysregulation of Borderline individuals. But the way SIB is conceptualized in DBT is helpful in working with individuals who engage in SIB."
- "I am now an intensively-trained DBT therapist and use the full DBT protocol with people who have NSSIB."
- "I am still generally integrative, but I start with SIB being more CBT in general and work towards more interpersonal as the work proceeds."
- "I now incorporate more DBT into my approach."
- "I now use DBT primarily."

- “I now use DBT strategies with person-centered approach.”
- “I tend to follow an eclectic that incorporates DBT and CBT as needed.”
- “I use a combination of approaches now to include CBT and DBT.”
- “I use a more DBT oriented approach with clients who engage in SIB.”
- “I use CBT and DBT techniques more frequently.”
- “I use DBT now.”
- “More integrative, incorporate DBT, CBT, and Mindfulness approaches along with Gestalt.”
- “Now use more DBT skills and strategies.”
- “Prior to seeing my first client with SIB I wasn't familiar or trained in DBT/TFCBT, now I use a combination of both.”
- “Use CBT combined with DBT and neurosequential model of therapeutics.”
- “Use DBT.”
- “Utilize DBT techniques.”
- “I utilize more DBT skills.”

Appendix F: Measures Used to Address the Research Questions (RQ)

RQ	Survey Item	Measures
1(a)	6. How many years have you been providing therapy services? 7. How many years into your career were you before working with a client who engaged in self-injurious behaviors that were addressed in therapy?	Years
2(a)	11. In your experience as a mental health provider, can clients who engage in SIB decrease those behaviors with the support of therapy?	Yes or No
2(b)	13. In thinking of providing treatment for clients who engage in SIB, which of the following statements best describes how you feel?	a. More difficult b. Similar c. Easier d. Unsure
3	12. To what degree do you feel the following in regards to working with clients who engage in SIB? Comfortable, confident, anxious, overwhelmed, calm, hopeless, empathic, optimistic, angry, competent, able to design an appropriate treatment plan, and able to acknowledge SIB and assess severity	1. Not at all 2. Slightly 3. Neutral 4. Mostly 5. Completely
4(a)	16. What classes or trainings pertaining to SIB have you completed?	Different types of training (listed in Q.16)
4(b)	17. Would you be interested in a SIB-specific training?	Yes or No
4(c)	18. What might you hope to learn in these trainings?	1. Recognize/Identify SIB 2. Assess SIB 3. Functions of SIB 4. Tx approaches for SIB 5. Best tx practices for SIB
5	6., 11., 12., 13.	All the above