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Parent Response to Adolescent Self-Injurious Behavior: A Collective Case Study

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Parent Response to Adolescent Self-Injurious Behavior: A Collective Case Study

by

Kylee S. Tuls

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
Department of Psychological and Social Foundations
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Dedication

This dissertation is dedicated to my husband and my parents. Your never-ending support
and encouragement will never be forgotten. Thank you.

Acknowledgements

It is important for me to express my gratitude and to acknowledge the unique contributions that several individuals have given to me while pursuing my doctoral degree. My husband, Mark, has been my strength and foundation in times of celebration and success as well as in times of vulnerability and discouragement. I do not know of many men who would have endured the long journey of their wife's doctoral program with the patience, fortitude, and support that you have given to me. You have wiped away many tears, run many stressful miles, endured sleepless nights, and rejoiced in many successes all in the effort to help and encourage me to be the best that I can be. For all of this and so much more, I thank you.

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Parent Response to Adolescent Self-Injurious Behavior: A Collective Case Study

Kylee S. Tuls

Abstract

Research in the area of self-injurious behaviors and the family context is still emerging. The majority of research available is quantitative in nature. The limited qualitative research available in this area has been conducted outside of the United States. A collective case study was conducted with four parents with an adolescent that had been admitted to an inpatient psychiatric residential facility with a presenting problem of self-injurious behavior. The purpose of this study was to gain an in-depth, qualitative understanding of the parent perspective and comprehension of adolescent self-injurious behavior including the parents' ideas on how the parent-child relationship or other family relationships may have influenced the self-injury. With-in case and cross-case analyses were utilized from the collected data including field notes, interview scripts, member checking sessions, and medical record reviews. Themes identified using an inductive content analysis were discussed based on each primary interview question. Clinical implications included the importance of providing parental education, encouraging parent participation in therapy, treating self-injurious behavior from a trauma-informed perspective, and others were considered. Limitations of the present study, directions for the use of the present research, as well as implications for future research were reported.

Chapter 1: Introduction

Self-injurious behavior is a problem that affects the lives of a large number of individuals (Briere & Gil, 1998; Klonsky, Oltmanns, & Turkheimer, 2003; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Nock & Prinstein, 2004; Ross & Heath, 2002; Whitlock, Eckendore, & Silverman, 2006). Menninger (1935) was the primary contributor to the introduction of self-injurious behaviors in research literature. He used the terms “focal suicide” and “localized self-destruction” to define the use of self-injury in order to avoid actual suicide. Menninger hypothesized that individuals who self-injure intentionally focused their attention on the destruction of one body part as a substitution for the desecration of the whole body through suicide completion (Conterio & Lader, 1998; Favazza, 1996). However, Favazza (1996) noted that Menninger “was ahead of his time...No one was ready to deal with or think about self-mutilation back then” (p. 232). It was not until the late 1970s that research began to explore more specifically these actions as conditions different from suicide (Conterio & Lader, 1998; Favazza, 1996).

Self-injurious behavior is an important issue that affects individuals in clinical and community settings (Briere & Gil, 1998; Klonsky et al., 2003; Lloyd-Richardson et al., 2007; Nock & Prinstein, 2004; Ross & Heath, 2002; Whitlock et al., 2006). Lloyd-Richardson et al. (2007) found that up to 46% of sampled adolescents in a community setting had participated in self-injurious behaviors within the last 12 months. Nock and Prinstein (2004) found that as many as 82.4% of adolescents within an inpatient

psychiatric setting had participated in at least one act of self-injurious behavior within the last 12 months.

In adult community settings, research has shown that up to 4% of individuals have participated in this type of behavior over various periods of time (Briere & Gil, 1998; Klonsky et al., 2003). In adult clinical populations, research has shown as many as 21% of individuals had participated in self-injurious behavior within the past six months (Briere & Gil, 1998). Among adults, self-injurious behavior is not as frequently reported as it is in adolescents. However, it remains an important clinical issue.

A correlation between the quality of family life and the occurrence of self-injury has been documented indicating that a negative family emotional climate is often present (Conterio & Lader, 1998; Crowell, Beauchaine, & Lenzenweger, 2008; Crowell et al., 2008; Favazza, 1996; Hawton, Rodham, & Evans, 2006; Levenkron, 1998; Ng, 1998; Sim, Adrian, Zeman, Cassano, & Friedrich, 2009; Strong, 1998; Walsh & Rosen, 1988; Wedig & Nock, 2007; Yates, Tracy, & Luthar, 2008; Yip, Ngan, & Lam, 2003). Literature based primarily on clinical experiences of therapists has discussed the diverse cognitive and emotional reactions of families when they learn about a family member's self-injury. These emotional responses may include worry, shock, anger, guilt, and sympathy. Parental cognitive reactions may vary from blaming themselves, believing the behavior is an adolescent phase, or thinking the child is punishing them for something (Alderman, 1997; Conterio & Lader, 1998; Levenkron, 1998; Plante, 2006; Walsh & Rosen, 1988). Identifying and understanding these diverse emotional and cognitive reactions is important for effective therapeutic treatment planning and intervention.

Statement of the Problem

Although there is evidence within the literature that self-injurious behaviors affect the lives of many individuals and their families; there is limited research that examines the occurrence and influences of this behavior from a family systems' perspective. This is perhaps due in part to self-injurious behavior being an emerging area of study.

Considering this in addition to the development of family systems' thinking in the mid-1950s (Goldenberg & Goldenberg, 2005), there has been little time for the exploration of this clinical issue using this conceptual framework.

The limited research that is available also has been primarily quantitative (Yip et al., 2003). Two noteworthy qualitative studies have examined the reactions of family members to their adolescent's self-injury. Yip et al. (2003) conducted qualitative interviews with adolescents who participated in self-injury as well as their parents and one of their peers. The focus was to examine the responses these individuals had to the knowledge of the adolescent's self-injury. They also sought to study how the individuals perceived the parent-child relationship to have affected this behavior. Additionally, Rissanen, Kylma, and Laukkanen (2008) conducted qualitative interviews with parents who had adolescents that participated in self-injurious behaviors. The parents' conceptualizations of this behavior were analyzed and discussed. To add to the contributions of these two studies and the emerging field of self-injurious behavior and family systems, the present study sought to take a qualitative look at the reactions of parents in response to their adolescent's self-injurious behavior by obtaining an in-depth exploration of this experience within a clinical population in the United States.

Historically, the therapeutic treatment of self-injurious behaviors typically has been primarily in response to a specific mental health diagnosis such as Borderline Personality Disorder or Major Depressive Disorder (Klonsky & Muehlenkamp, 2007). Although self-injury is often an associated feature of these disorders, it does require an additional set of treatment challenges. Specific treatment methods might include safety planning and contracting, functional analysis of the behavior, impulse control journaling, coping skills training, and self-injury education (Conterio & Lader, 1998). Thus, focusing treatment interventions on the specific issue of self-injurious behavior is important. This study determined themes in the responses of parents who have adolescents that have self-injured that may be linked to treatment. This information may be used for clinical applications including assessment of the functions and motivations of self-injury and determining treatment interventions necessary for the individual and the family unit.

Purpose of the Study

The purpose of this study was to explore the cognitive, emotional, and behavioral responses of parents who have an adolescent that participates in self-injurious behaviors through a qualitative framework. More specifically, this study examined how caregivers understand and interpret the dynamics of self-injurious behaviors. The cognitive, emotional, and behavioral reactions of parents were explored individually. Additionally, how parents perceived the impact of their caregiver-child relationship on adolescent self-injurious behavior was also examined. This study not only promoted an in-depth qualitative understanding of adolescent self-injury and the reactions of their caregivers, but it also provided themes that hold more transferable implications to families in the United States.

Research in the area of self-injury and family context is still emerging. More specifically, Yip et al. (2003) noted that the majority of research in the area is quantitative. Qualitative studies that examined the responses of parents to the knowledge of their adolescent's self-injury have been conducted in diverse cultures outside of the United States (Rissanen et al., 2008; Yip et al., 2003). This study contributed to the developing area of family systems and self-injurious behavior by providing an in-depth understanding of parents' experiences in response to their adolescent child's self-injury.

Significance of the Study

The goal of this study was to add to existing research in the developing area of adolescent self-injurious behavior within the family context specifically focusing on the reactions of parents in response to learning their adolescent has self-injured. This study should add to the knowledge base of clinical experiences and scholarly research developed on self-injury and family context. Implications for clinical practice and future research were determined by analyzing themes of the discussed reactions of parents who have adolescents that self-injure.

In treating adolescents, it is often necessary to include family members. By understanding the family system, therapists can gain valuable assessment information which relates to the functions and motivations of the adolescent's self-injury. The need for psychoeducation on self-injury can also be determined. Further, interventions that are specific to the self-injurious behavior such as safety planning, coping skills training, and impulse control journaling might be implemented and taught to the entire family unit.

Research Questions

Three primary questions guided this qualitative study. The questions addressed were:

1. What are parents' understandings of the dynamics of self-injurious behavior?
2. How do parents respond cognitively, emotionally, and behaviorally to an adolescent's self-injurious behavior?
3. How do parents perceive the impact of the caregiver-child relationship on adolescent self-injurious behavior?

These questions were explored through a semi-structured interview format in order to obtain a thorough and comprehensive record of the identified parents' responses.

Conceptual or Substantive Assumptions

Two primary assumptions provided a foundation for this study. First, it was assumed that parents would have a variety of responses to finding out that their adolescent has participated in self-injury. These responses should include various cognitions, emotions, and behaviors. The second assumption was that parents would believe that their caregiver-child relationship does influence their adolescent's self-injury, but the extent of the perceived affect would differ among participants.

Conceptual Framework

Systems theory within a family setting provided the conceptual framework for this study. This theory examines the behaviors of individuals within a family context. Systems theory assumes that the individual acts in response to the behavior of others within the family unit. This individual, in turn, influences the action of others as well.

Within this family system of functioning, a change in one member creates a change in the other members and therefore the entire system. To understand the individual, it is appropriate to understand the family system because no person acts in isolation (Becvar & Becvar, 1982; Goldenberg & Goldenberg, 2005; Klein & White, 1996).

Systems theory, as viewed in a family context, focuses on continuous family processes that occur. Through understanding established family feedback loops, boundaries, rules, and homeostasis, the theory seeks to comprehend “what” is happening and “how” every family member affects and is affected by these experiences and individuals. Additionally, problem behaviors or emotions within certain members of the family are viewed as symptoms of family dysfunction and not individual psychopathology (Becvar & Becvar, 1982, 1993; Foley, 1974; Goldenberg & Goldenberg, 2005; Klein & White, 1996).

Through using systems theory as a conceptual framework, therapists may comprehend self-injurious behaviors as actions that not only affect the individual who commits these behaviors but also actions that influence the entire family system. In turn, the family affects the occurrence of these behaviors as well. The occurrence of self-injury by a member of the system might signify some sort of family dysfunction. Hence, in order to more fully understand the dynamics and occurrence of self-injurious behaviors, it is crucial to gain the perspectives and responses of the entire family unit.

Definitions of Major Terms

Parent. A term applied to a biological mother, biological father, adoptive mother, or adoptive father of a child (Department of Children & Families, 2010). Within this study,

the parents interviewed were custodial parents who have legal custody of their adolescent child. Otherwise stated, these parents have the right to make legal decisions, including medical decisions, regarding their child.

Adolescent. A term used to describe individuals between the approximate ages of 10 to 22. This time period is often distinguished into early (ages 10-13), middle (ages 14-18), and late (ages 19-22) adolescence (Steinberg, 2002). For the purposes of this study, the adolescents used to identify parent participants were between the ages of 13 and 17.

Self-Injurious Behaviors. For this study, self-injurious behavior was defined as “the intentional destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (Klonsky, 2007a, p. 1039). Simeon and Favazza (2001) noted that the term self-injurious behavior “is purely descriptive, suggests that a diversity of such behaviors exists, makes no allusion to motivation, and is not sensationalistic and derogatory” (p. 1). Therefore, for the sake of this paper and study, the term self-injurious behavior was used throughout to provide consistency of thought and material. The more concise term, self-injury, which is synonymous with self-injurious behaviors, was also used interchangeably throughout this paper and study.

Clinical Population. Individuals involved in mental health care by participating in current outpatient counseling, inpatient psychiatric hospitalization, or psychiatric residential care (Briere & Gil, 1998).

Non-clinical, Community Population. A term to describe individuals within the general population (Briere & Gil, 1998). These participants are often taken from school settings

or community advertisements when studying adolescents (Hilt, Cha, & Nolen-Hoeksema, 2008).

Systems Theory. A conceptual framework for understanding the interactions of elements as they form an organized whole. The focus is on the interrelatedness among these elements as opposed to the elements themselves in isolation (Goldenberg & Goldenberg, 2000, 2005).

Family System. A set of interacting and interrelated individuals that together make up an organized whole (Goldenberg & Goldenberg, 2000, 2005).

Cognitive Response. A term to discuss how an individual mentally thinks about and visualizes information or an experience (Ormrod, 2008).

Emotional Response. A response that involves physiological arousal, verbal and nonverbal expressions, and a conscious interpretation of an experience (Myers, 1998).

Behavioral Response. A term to discuss the specific activities of a person (Martin & Pear, 2007).

Caregiver-Child Relationship. Emotional connections and interdependence among parents and their children. This interaction involves behavioral and cognitive attachment and security (Collins & Laursen, 2004).

Scope and Delimitation of the Study

This study explored the responses of parents to their adolescent's participation in self-injurious behavior. The sample was taken from an inpatient psychiatric residential facility and excluded parents within a community, non-clinical setting. Additionally,

parents who had children younger than age 12 or older than age 18 were not studied.

Parents who had adolescents that self-injure and had a developmental disability also were not included in the study.

The presence of self-injury as a presenting problem upon admission to an inpatient psychiatric residential facility was a criteria for inclusion in this study. The self-injury did not have to be a current and present behavior at the time of interview. It might be a symptom of other mental health issues or a primary problem which depended on the individual case.

Summary

This chapter has sought to introduce the issue of adolescent self-injurious behaviors and the importance of understanding the family's perspective of these actions. The lack of scholarly research in this area and the significance of this study have been noted. Chapter Two reviews the literature available on self-injurious behaviors, adolescents and self-injurious behaviors, systems theory, and families and self-injurious behaviors. Chapter Three discusses the research methods that were utilized to study parents' responses to their adolescent's self-injurious behaviors. Chapter Four focuses on the themes identified through data analysis and Chapter Five provides a summary of the data within the research literature as well as discusses limitations, clinical implications, and future directions for this research.

Chapter Two: Literature Review

To understand self-injury as a behavior and in context, it is important that many issues are explored. A thorough comprehension of what self-injurious behaviors are, who typically participates in these actions, why self-injury is performed, and treatment interventions are important considerations. The unique developmental stage of adolescence is another factor to note particularly when focusing on adolescent self-injurers. To understand self-injurious behaviors in context, knowledge of systems theory within a family context is a crucial component. A basic review of this framework is necessary. Additionally, specific research and literature that factors the occurrence of self-injury within the family unit is important to review. All of these aspects of self-injurious behaviors and the family environment are discussed in the following sections to address and point out the necessity and importance of the proposed study.

Self-Injurious Behavior

Self-injurious behaviors encompass many factors and considerations. In understanding these actions, it is important to note what self-injury is and how it is classified within the clinical and research community. It is also important to comprehend the nature of self-injurious behaviors as it occurs across ages, genders, ethnicities, psychiatric diagnoses, and certain psychological characteristics. Additionally, the reasons an individual self-injures, how adolescent development plays a role, and available treatment modalities are all crucial aspects to gaining a more thorough scope of the issue.

These factors along with corresponding research and literature are addressed in the following sections.

Definition of self-injurious behavior. Within research on self-injurious behaviors, the action itself has been identified using a variety of terms. Self-mutilation (Favazza, 1996), self-inflicted violence (Alderman, 1997), deliberate self-harm (Klonsky et al., 2003), non-suicidal self-injury (Muehlenkamp, 2006), and self-injurious behavior (Simeon & Hollander, 2001) are all common expressions found within the literature to describe this behavior. They all seek to identify the action of self-injury, hint at its function, and can impart an emotional message to those who learn or read about it.

In addition to the numerous terms used to discuss self-injurious behaviors, there are varying definitions of the action itself. Klonsky (2007a) provided a comprehensive and current view of self-injurious behavior by defining it as “the intentional destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (p. 1039). This definition implies that there is a deliberate attempt to damage one’s physical body by participating in this action with no motivation to die as a result.

The aspect of culturally and “socially sanctioned” behaviors noted in this definition was explored by Favazza (1996). He explained acts that are socially and culturally acceptable can be present in the “rituals and practices” of a community. Rituals are behaviors “that are repeated in a consistent manner over at least several generations and that reflect traditions, symbolism, and beliefs of a society” (p. 226). Cultural and social practices are acts “that may be faddish and that often hold little underlying significance” (p. 226). To illustrate this idea, Favazza (1996) explained how male

circumcision would be classified as a cultural practice among the Gentile nation, but is a ritual amongst the Jews. Considering this information and utilizing Klonsky's (2007a) definition, self-injurious behavior is not something that is valued in the traditions and practices of a cultural or social setting nor is it an action that has meaning and usefulness within the customs and traditions of a community.

In comparison to Klonsky (2007a), Williams and Wallace (2006) conceptualized self-injurious behavior as "acts deliberately performed to inflict immediate physical damage to one's body" (p. 620). Due to the exclusion of the suicidal intentions of the individual within this definition, the authors further discussed how in its most devastating forms self-injurious behavior could include suicide (Tyrer et al., 2003), eating disorders (Conterio & Lader, 1998; Favaro & Santonastaso, 2002), or even substance abuse and dependence. Williams and Wallace (2006) specifically distinguished self-injurious behavior as it occurs in individuals who have mental disorders, individuals who have developmental disabilities, or individuals who have both a mental disorder and a developmental disability. It should be noted that in using this definition they failed to explore self-injurious behavior as it occurs within a community or non-clinical setting.

Although there is some variability among the definitions used to identify self-injurious behaviors, there are common features that can be identified within all of these descriptions. Self-injurious behavior is clearly destructive to one's body. As noted above, Alderman (1997) coined the term "self-inflicted violence" which accurately describes the harmful nature of the act. It is a physical act and creates damage to the physical body. Irrational thoughts or emotionally ridiculing oneself would be considered self-deprecating; however, these are not examples of self-injury. It is a conscious action

where destruction is caused to one's body. This damage may be visible (e.g. cutting) or not (e.g. hitting one's self without bruising or broken skin). Regardless of the outward portrayal of the damage, the behavior is physical and harmful.

Although there are similarities, there is a clear distinction between these noted definitions of self-injurious behavior. This difference is relevant and important to consider when reviewing research and studying the aspects of this behavior. The reader must carefully note the specific definition that the author or researcher is using to characterize self-injurious behavior within all written works. One should also consider the population that is being studied or described as well as the specific actions that are being looked at when observing self-injury (e.g. cutting, ingestion of poisonous substances, hitting one's self).

Forms and categories of self-injurious behaviors. Self-injurious behavior can occur by a variety of different methods. Typical forms of self-injurious behaviors include cutting the skin, pulling hair, scratching scabs so they do not heal, burning skin, hitting one's self, and biting (Klonsky, 2007a; Klonsky & Muehlenkamp, 2007). In more serious documented cases, self-injury has taken the form of ingesting sharp objects, poking out one's own eye, and breaking one's own bones (Alderman, 1997; Conterio & Lader, 1998). As suggested, depending on the definition being used, suicide (Tyrer et al., 2003), eating disorders (Conterio & Lader, 1998; Favaro & Santonastaso, 2002), or even substance abuse and dependence could be methods of implementing self-injurious behaviors as well (Williams & Wallace, 2006).

In the book, *Bodies Under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry*, Favazza (1996) distinguished between different categories of self-injurious behaviors. As mentioned previously, “culturally sanctioned” self-injurious behaviors in the form of communal rituals and practices were discussed as one classification. Additionally, Favazza (1996) introduced “deviant-pathological” self-injurious behaviors. He discussed how self-injurious behaviors can be present in one of three categories within this specific classification – major, stereotypic, and moderate/superficial. He further delineated the last category of moderate/superficial self-injurious behavior into three subtypes – compulsive, episodic, and repetitive.

Favazza (1996) described major self-injurious behavior as an action that does not occur regularly, but the action does produce a great deal of body damage. Examples of major self-injurious behavior might be poking out one’s own eye, removing a body limb, or mutilating one’s sexual organs. Major self-injurious behavior is often a feature of another condition such as psychosis or severe intoxication. Stereotypic self-injurious behaviors were discussed as being “repeated acts, such as head banging...that have a fairly fixed pattern of expression, seem to be devoid of symbolism, and are often rhythmic” (p. 233). Moderate/superficial self-injurious behavior, the most prevalent form of this action, is repetitive and results in minimal tissue damage. This form of self-injurious behavior has low lethality or a low chance of death to occur. It “lacks rhythmicity, usually has symbolic referents, and often requires the use of implements such as matches and a razor” (p. 233). Cutting, burning the skin, picking scabs or sores to prevent healing, hair pulling, and skin scratching are all behaviors that are considered moderate/superficial forms of self-injurious behavior.

There are three types of moderate/superficial self-injurious behavior that Favazza (1996) discussed. Compulsive self-injurious behavior occurs frequently throughout a single day and has an associated ritual attached to it. Symptoms of this type of self-injurious behavior are minor and often individuals who participate in this type of action do not seek professional help. Episodic self-injurious behavior occurs on an irregular basis. Typically, this type of self-injurious behavior is done to relieve one's self from distressing emotions and thoughts. It is often a feature of another condition such as anxiety, depression, personality disorders, or dissociative disorders. Finally, repetitive self-injurious behavior is when an individual is distracted and consumed with thoughts of and participation in the action of self-injury. He or she finds identity as a "cutter" and would be considered addicted to the act of harming his or her body. Favazza (1996) further distinguishes the difference between episodic self-injurious behavior and repetitive self-injurious behavior by adding that repetitive self-injurious behavior is often an additional or separate mental health disorder with impulse control difficulties as opposed to episodic self-injurious behavior being only a feature or symptom of another mental health issue.

Prevalence of self-injurious behaviors. In understanding self-injurious behavior, it is not only important to be able to define the action, but it is also crucial to understand the scope of the problem. Research has shown that among the adult community in non-clinical populations approximately 4% of individuals have participated in some form of self-injurious behavior (Briere & Gil, 1998; Klonsky et al., 2003). Within adult clinical populations, research has shown that as many as 21% of individuals have personal experience with self-injurious behavior (Briere & Gil, 1998).

Among teens and young adults, these percentages vary, but nonetheless increase dramatically as compared to the adult population. Lloyd-Richardson et al. (2007) found that as many as 46% of community 9th and 10th graders had utilized some form of self-injury within the past 12 months. Whitlock et al. (2006) found comparable percentages when looking at college students. Ross and Heath (2002) reported that 13.9% of their sample of community adolescents in a high school setting participated in some form of self-injurious behavior at one point in time. Among adolescent psychiatric populations, Nock and Prinstein (2004) found that 82.4% of adolescents in mental health inpatient settings had engaged in at least one act of self-injurious behavior within the last year. This exceeds the estimates of 40%-61% that were earlier identified by Darche (1990) and DiClemente, Ponton, and Hartley (1991).

Among individuals who participate in self-injurious behaviors, cutting appears to occur most commonly (Clarke, 1998; Conterio & Lader, 1998; Hawton et al., 2006; Muehlenkamp & Gutierrez, 2004; Ross & McKay, 1979). Favazza and Conterio (1989) surveyed 240 females who responded to receive information for a self-injury support group and identified themselves as having participated in low lethal, direct, and frequent self-injurious behaviors. The researchers found that 72% of their subjects self-injured in the form of cutting. Thirty-five percent of the sample was shown to utilize burning, 30% self-hit, 22% interrupted normal bodily healing, 10% pulled hair, and 8% fractured bones. Of the sample, 75% used multiple methods of self-injurious behaviors. Briere and Gil (1998) provided in-depth questionnaires to 93 individuals who had participated in self-injurious behaviors. The researchers found that the majority of their sample, 71% cut their arms or legs. Forty-four percent of the sample punched themselves, 31% burned

themselves, 30% pulled out head hair, 17% pulled out eyelashes or eyebrows, and 19% participated in more severe stabbing methods. It should be noted that the majority of participants involved in these two noted studies were Caucasian females.

Most research does not distinguish between the prevalence of specific self-injurious methods used by males and females as two exclusive groups. Subjects are typically combined and the prevalence of self-injurious methods used is based on a percentage of the total sample size. The research that does decipher between the two sexes is mixed on this matter. Claes, Vandereycken, and Vertommen (2007) assessed the occurrence, prevalence, and function of self-injurious behaviors within adult patients (265 females and 134 males) admitted to an inpatient psychiatric unit in Belgium. Their research found that females participated in cutting most frequently while males most commonly burned themselves. Laye-Gindhu and Schonert-Reichl (2005) researched community adolescents who self-injured. They found that females reported cutting as a main method of self-injury. For males, cutting was ranked second. Instead, males were found to hit, bite, and punch themselves in order to cause bodily harm.

To contrast these findings, Hawton et al. (2006) reported on their research looking at self-injurious behaviors within a school setting. By surveying students ages 15 and 16, the researchers gathered information pertaining to the prevalence of self-injury and issues contributing to self-injury. They found that cutting was the dominant method of self-injury used by both males (50%) and females (57.2%). The second most frequent method of self-injury for males was overdosing (24.7%) and for females was other single methods (28.6%) such as punching walls or burning one's self.

Who participates in self-injurious behaviors.

Age. The presentation of self-injurious behavior can occur over several developmental time spans. Self-injury often begins in early adolescence, increases in middle to late adolescence and into young adulthood, and then decreases in one's late twenties to early thirties (Alderman, 1997; Whitlock et al., 2006; Yip, 2005). In an 11-year study conducted in Oxford looking at the patient characteristics of individuals presenting to a general hospital for self-injurious behaviors, these behaviors were most notable among females ages 15-24 and males ages 25-34. Furthermore, after the age of 35 for both males and females, the presence of self-injurious behaviors occurs at a decreased rate from earlier ages and continues to decline within the over 55 age group for both sexes (Hawton et al., 2003).

Conterio and Lader (1998) noted that self-injurious behaviors are occurring in earlier age groups and even note the occurrence of self-injury in childhood. Hilt et al. (2008) found that the average age of the first occurrence of self-injury was 10.2 years. This study was conducted with only adolescent girls with diverse cultural and economic backgrounds. Conterio and Lader (1998) discussed this phenomenon by noting that in today's culture the onset of menstruation in females is happening sooner than in past generations and this developmental milestone often "corresponds with the beginning of self-injury" (p. 23). Klonsky and Muehlenkamp (2007), in a review of self-injurious behavior literature, noted that the typical age of the first occurrence of self-injury was around 13 or 14 years old. In studying habitual self-injury in females, Favazza and Conterio (1989) reported that 14 years of age was the average age for the first occurrence of self-injury. As noted previous, cutting, the most prevalent form of self-injurious

behavior, has been found to peak between ages 16 and 25 for males and females (Yip, 2005).

Gender. Research is mixed on the prevalence of self-injurious behaviors between men and women. Historically, self-injurious behavior has been noted to occur in females more frequently (Klonsky & Muehlenkamp, 2007; Muehlenkamp, 2005; Plante, 2007). Laye-Gindhu and Schonert-Reichl (2005) studied self-injurious behavior among non-clinical, community adolescents. They found that females (20%) were more likely to self-injure than males (9%). Among clinical populations, Claes et al. (2007) also noted a higher amount of females (46.2%) participating in self-injury than males (31.3%). However, it should be noted that this study had a mean age of 30.8 years which potentially could influence the noted statistics.

In contrast to the above findings, recent research has shown males decreasing the discrepancy between female self-injury and male self-injury (Plante, 2007). Briere and Gil (1998) found that among clinical and community samples “neither sex is more likely than the other to engage in self-mutilation” (p. 617). This study was conducted with adult samples over age 17. This finding was supported by Nock, Joiner, Gordan, Lloyd-Richardson, and Prinstein (2006) who studied adolescents with a history of self-injury over the past 12 months. Their research found that males and females did not vary in the number of times participating in self-injurious behavior, length of self-injurious history, amount of methods used, or the pain experience. The authors of this study noted that there have been researched distinctions between males and females in areas such as suicidal ideations, suicide attempts, and death by suicide, but available research has not

sufficiently shown any differences between the genders when looking specifically at self-injurious behaviors.

Conterio and Lader (1998) discussed the noted discrepancies among male self-injury and female self-injury. Males exhibit their emotions with more externalizing behaviors such as physical aggression toward others. Additionally, males are less likely to admit to psychiatric issues and less likely to seek professional help. These actions often result in males being placed in criminal institutions rather than mental health facilities or self-medicating with drugs or alcohol. Thus, self-injury among males might be less likely to be noted among clinical or community samples. Women, in contrast, show more internalizing of their emotions which often results in depression and low self-esteem. Women are also more likely to ask for help and admit to their mental health difficulties. This, in turn, creates a higher proportion of females reporting the occurrence of self-injury and seeking professional help in community and clinical settings.

More research is needed to distinguish the differences in the prevalence of self-injurious behaviors for clinical and non-clinical populations throughout developmental stages based on gender. Ng (1998) suggested that in adolescence males and females self-injure at equal rates. She further discussed how as males age their rates drop and females begin to participate in self-injurious behaviors at a higher frequency. However, in analyzing the research, this is not always the finding. As noted previously, Hawton et al. (2003) found that among individuals admitted to a general hospital in Oxford between 1990 and 2000, female self-injury peaked between the ages of 15-24 and male self-injury peaked between the ages of 25-34; thus, reinforcing the importance of more research in this area.

Overall, as noted previously, the difference between males and females seems to be in the type of self-injury completed. Females typically cut. Males burn, bite, hit, or punch themselves (Claes et al., 2006; Laye-Gindhu & Schonert-Reichl, 2005; Whitlock et al., 2006).

Ethnicity. Research appears to consistently find that Caucasians participate in self-injurious behaviors at a higher rate than non-Caucasians (Hawton, Rodham, Evans, & Weatherall, 2002; Lloyd-Richardson et al., 2007; Muehlenkamp & Gutierrez, 2004; Ross & Heath, 2002). This finding is reported to occur “across psychiatric, forensic, and nonclinical populations” (Klonsky & Muehlenkamp, 2007, p. 1047). Although this has been shown time and time again, one might question the statistical conclusion validity and external validity of this information. The majority of research participants within all noted studies have been Caucasian. Thus, the degree to which this research can accurately determine whether there is a relationship between self-injurious behaviors and ethnicity as well as the degree to which the results can be generalized to different persons, settings, and cultures might be questionable. More research needs to be conducted where there is more equality among the ethnicities of study participants.

Psychiatric diagnoses. Self-injurious behavior is not currently a represented diagnosis within the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision* (DSM-IV-TR; American Psychiatric Association, 2000). Instead, it is often an associated feature or symptom of another diagnosis. Research has reported a high prevalence of psychiatric diagnoses with the presence of self-injurious behaviors.

Self-injurious behaviors are most commonly associated with Borderline Personality Disorder (Alderman, 1997; Conterio & Lader, 1998; Muehlenkamp, 2005; Nock et al., 2006; Trepal & Wester, 2007). In fact, self-injury is one of the nine criterion noted in the *DSM-IV-TR* for this diagnosis. Trepal and Wester (2007) reported that up to 75% of individuals diagnosed with Borderline Personality Disorder participate in self-injurious behaviors.

Numerous other psychiatric disorders have been associated with self-injurious behaviors. There has been a noted connection between eating disorders such as Anorexia Nervosa and Bulimia Nervosa and self-injurious behaviors (Alderman, 1997; Conterio & Lader, 1998; Favazza, DeRosear, & Conterio, 1989; Sansone & Levitt, 2004). Substance-related disorders have also been shown to be common diagnoses among individuals who participate in self-injurious behaviors (Haw, Hawton, Houston, & Townsend, 2001; Nock et al., 2006; Olfson, Gameroff, Marcus, Greenberg, & Shaffer, 2005). Mood disorders such as Major Depressive Disorder and Bipolar Disorder have shown a high occurrence among this population (Haw et al., 2001; Nock et al., 2006; Olfson et al., 2005). Personality disorders other than Borderline Personality Disorder, including Schizotypal, Dependent, and Avoidant Personality Disorder, additionally have been shown to be linked to individuals who self-injure (Klonsky et al., 2003; Nock et al., 2006). Posttraumatic Stress Disorder has also been a noted diagnosis among this population (Briere & Gil, 1998; Nock et al., 2006). Nock et al. (2006) additionally reported on the presence of an externalizing disorder such as Conduct Disorder or Oppositional Defiant Disorder among individuals who self-injure as well. Finally, Favazza (1996) discussed

how in certain cases and classifications of self-injury a diagnosis of Impulse Control Disorder is also necessary.

Individuals who have developmental disabilities, including mental retardation, have been shown to participate in self-injurious behaviors (Pomeroy, Mitchell, Roerig, & Crow, 2002; Williams & Wallace, 2006). Although these disorders are considered psychiatric in nature based on their inclusion in the *DSM-IV-TR* (2000), they will not be further addressed within the focus of this research study. The research reviewed is based on sample sets that do not have a diagnosis of a developmental disability. However, to be fully inclusive for the purpose of this literature review, it is important to note all of the diagnoses that have been associated with self-injurious behaviors in the research. The choice to exclude developmental disabilities within this study should not minimize the occurrence and importance of self-injury among this specific population.

Psychological characteristics. Regardless of diagnosis, individuals who participate in self-injurious behaviors share certain psychological features. These characteristics often relate to an individual's negative emotionality, a deficiency in emotional awareness and skills, presence of negative self-criticism, and impulse control issues. The experience of childhood abuse or neglect is also evident among a large proportion of individuals who report participating in self-injurious behaviors.

Negative emotionality involves individuals experiencing more intense and more frequent negative emotions. Research has shown that individuals who participate in self-injurious behaviors experience more anxiety, depression, and anger (Brunner et al., 2007; Klonsky & Muehlenkamp, 2007; Klonsky et al., 2003; Laye-Gindhu & Schonert-Reichl,

2005; Muehlenkamp, 2005; Ross & Heath, 2002). Not only do these individuals experience these negative emotions more commonly, they also experience these feelings and mood states more profoundly with emotional, behavioral, and physiological reactions (Deiter, Nicholls, & Pearlman, 2000; Gratz, 2006; Klonsky & Muehlenkamp, 2007; Nock & Mendes, 2008). These characteristics have been found among clinical and non-clinical samples.

Although individuals who participate in self-injurious behaviors experience more frequent and heightened emotions, research has shown that these individuals have deficits in being aware of their personal emotional experiences, appropriately communicating their emotions, and positively coping with these feelings (Klonsky & Muehlenkamp, 2007). The inability to verbally communicate one's emotions has been a common feature found among this population (Gratz, 2006; Zlotnick et al., 1996). Furthermore, poor problem-solving skills, with regards to coping with intense emotions, have also been characteristic of individuals who participate in self-injurious behaviors (Webb, 2002).

Nock and Mendes (2008) studied adolescent and young adult self-injurers and non-injurers and looked at the social problem-solving skills of each group of participants. The researchers found that the adolescents who participated in self-injurious behaviors identified more negative solutions to the presented scenarios. These participants also had a diminished sense of their own ability to succeed at navigating flexible solutions.

Self-criticism, self-punishment, and self-hatred are also typical characteristics found in individuals who self-injure. All of these issues lend themselves to low self-esteem (Conterio & Lader, 1998; Klonsky & Muehlenkamp, 2007). In studying self-

injury within community adolescent populations, Hawton et al. (2002) as well as Laye-Gindhu and Schonert-Reichl (2005) found that negative self-esteem was evident among male and female individuals who participated in these behaviors. Deiter et al. (2000) found similar results regarding self-injury and low self-worth among a clinical sample; however, it should be noted that this study was predominately female and adult.

Walsh and Rosen (1988) discussed the experience of “body alienation” among adolescent self-injurers which presented in unhealthy and inappropriate behaviors and issues including disordered eating, poor personal hygiene or appearance, sexual identity issues, and physical illness issues. These aspects of self-hatred and low self-esteem were noted as being “the strongest predictors of adolescent SMB (self-mutilating behavior)” (p. 70). Conterio and Lader (1998) further wrote that all individuals who participate in self-injurious behaviors have “a tortured relationship between their minds and their bodies, particularly their sexual organs” (p. 105).

Impulse control issues are often a corresponding psychological feature of individuals who participate in self-injurious features (Favazza, 1996, 1998). Research has shown between 70%-78% of self-injurers claim they have no control over the behavior (Bennum, 1983; Favazza & Conterio, 1989). These impulsive actions are not only in the form of self-injury, but often present as antisocial behaviors including drug use and other illegal activities (Hawton et al., 2002; Laye-Gindhu & Schonert-Reichl, 2005).

Childhood trauma in the form of family dysfunction, child abuse, or child neglect also appears to be a common factor among individuals who self-injure. This childhood maltreatment can be in the form of physical, psychological, or sexual abuse (Briere &

Gil, 1998; Favazza, 1996; Gratz, 2006). Several studies have shown that the greater the childhood mistreatment the more severe the issue of self-injurious behavior becomes (Deiter et al., 2000; Gratz, 2006).

Conterio and Lader (1998) discussed common dysfunctional family patterns that are found among individuals who self-injure. Loss, sickness, and instability are often reported among family members. Abuse or neglect is present. Rigid expectations and beliefs are set, but they are maintained inconsistently or with different expectations depending on the individual. Finally, family roles are often confused with the parent and child being friends or the child parenting the adult.

In contrast to these discussions and findings, Klonsky and Moyer (2008) conducted a meta-analysis of the associations between childhood sexual abuse and non-suicidal self-injury. Their results found that despite the frequent claim that childhood sexual abuse is a determinant for self-injury, their findings showed a “relatively small” association. Rather, the research concluded that the noted relationship is often a result of “psychiatric risk factors” such as depression and anxiety that are notably associated with both childhood sexual abuse and self-injurious behaviors.

There are numerous factors that contribute to an individual participating in self-injurious behavior. These factors additionally might serve as criteria for assessing who is inclined to self-injure. Research has found that most individuals first self-injure when they are in early adolescence. This behavior increases through middle and late adolescence and eventually declines in one’s 20s (Alderman, 1997; Whitlock et al., 2006; Yip, 2005). Although females have historically been identified as the gender that self-

injures most frequently (Klonsky & Muehlenkamp, 2007; Muehlenkamp, 2005; Plante, 2007), recent studies have suggested that men self-injure at similar rates (Briere & Gil, 1998; Plante, 2007). The difference between the genders appears to be more related to the setting of treatment and the actions that are used to self-injure (Claes et al., 2007; Conterio & Lader, 1998; Laye-Gindhu & Schonert-Reichl, 2005; Whitlock et al., 2006). Research has shown that Caucasians are more frequent to participate in self-injurious behaviors (Hawton et al., 2002; Lloyd-Richardson et al., 2007; Muehlenkamp & Gutierrez, 2004; Ross & Heath, 2002). However, the majority of sample participants used in these studies are Caucasian so the statistical conclusion validity and external validity of these findings might be questionable.

Research has also shown that there are numerous mental health disorders that are associated with an individual participating in self-injurious behaviors. These diagnoses include personality disorders, mood disorders, Posttraumatic Stress Disorder, substance-related disorders, and eating disorders (Haw et al., 2001; Nock et al., 2006; Sansone & Levitt, 2004). Finally, certain psychological characteristics have been found to be commonly present among individuals who self-injure. These features include negative emotionality, a lack of emotional awareness and expression, a deficiency in problem-solving skills, self-criticism, impulse control problems, and a trauma experience (Klonsky & Muehlenkamp, 2007). All of the identified factors have been shown to be prevalent among individuals who self-injure. Although, it should be noted that these factors do not guarantee an individual will self-injure.

Functions of self-injurious behaviors. Self-injurious behaviors are done for a variety of identified reasons. These actions have several functions and motivations

(Alderman, 1997). In reviewing why individuals self-injure, Plante (2007) discussed its purpose as “doing all the wrong things for the right reasons” (p. 47). The author further noted, “Although cutting [and other self-injurious behaviors] is clearly a negative and destructive means of achieving these goals [discussed below], the positive nature of the goals themselves must not be overlooked” (p. 47). Overall, individuals who participate in self-injurious behaviors identify with a number of perspectives as to why they partake in this type of action.

Nock and Prinstein (2004) researched the functions of self-injurious behaviors among adolescents within a clinical, inpatient setting. The researchers broke down the functional motivations of self-injurious behaviors into four main categories. “Automatic negative-reinforcement” was considered the utilization of self-injurious behavior to spontaneously remove an unpleasant force such as tension or depression. “Automatic positive-reinforcement” was hypothesized as being used to produce a pleasant consequence such as feelings of calm or euphoria. “Social negative-reinforcement” in terms of self-injurious behaviors functions was viewed as a means to get out of doing certain responsibilities including avoiding school work, chores, or punishment. Finally, “social positive-reinforcement” was viewed by the authors as being utilized to receive attention or get something. In studying 108 adolescents, ages 12-17, Nock and Prinstein (2004) found that adolescents primarily addressed automatic means, positive and negative, as a reason for their self-injury. The authors discussed this finding as possibly being due to “adolescents who engage in SMB [self-mutilating behavior] are more socially isolated from the outset (Guertin et al., 2001 as cited in Nock & Prinstein, 2004) and thus lack the opportunity for social influence” (p. 889).

Affect regulation, an automatic positive- or negative- reinforcement depending on the context and individual motive, is one of the most frequently noted goals for individuals, adolescent or adult in clinical or non-clinical settings, to participate in self-injurious behaviors (Alderman, 1997; Gratz, 2007; Kamphuis, Ruyling, & Reijntjes, 2007; Kleindienst et al., 2008; Klonsky & Meuhlenkamp, 2007; Machoian, 2001; Nixon, Clouter, & Aggarwal, 2002; Plante, 2007; Rodham, Hawton, & Evans, 2004). Individuals choose self-injurious behavior to provide relief from strong negative emotions such as anger, depression, or anxiety. In looking at adolescent self-poisoners and self-cutters in a community setting, Rodham et al. (2004) found that 73.3% of self-cutters and 72.6% of self-poisoners were seeking “relief from a terrible state of mind” (p. 82). It should further be noted that in comparing the two groups, self-poisoners were more likely to report that they wanted to die as a result of their actions which is contrary to the definition of self-injurious behavior defined within this paper.

Machoian (2001) conducted clinical interviews with three white, upper middle class adolescent females. Among the themes represented in these sessions, cutting as a form of affect regulation was noted. However, the small sample utilized as well as the limited diversity in the demographic features of these adolescents needs to be considered when determining the generalizability of this information. In looking at hospitalized adolescents who self-injure with an overall mean age of 15.7 years, Nixon et al. (2002) found that the two most common reasons for engaging in this behavior was “to cope with feelings of depression (83.3%)” and “to release unbearable tension (73.8%)” (p. 1337). However, as noted by the authors, the measure used to assess self-injury, the Ottawa/Queen’s Self-Injury Questionnaire (Epstein, personal communication, 1998, as

cited in Nixon et al., 2002) does not have established validity and reliability.

Additionally, Kleindienst et al. (2008) looked at the motives of women who participated in self-injurious behaviors with ages ranging from 18 to 51 and diagnosed with Borderline Personality Disorder. The most frequently reported reasons were “tension relief” and “reduction of unpleasant feelings” (p. 232).

The second most prevalent reason for self-injuring is to self-punish, an automatic positive-reinforcement (Alderman, 1997; Klonsky, 2007b; Klonsky & Muehlenkamp, 2007; Plante, 2007). Individuals who self-injure will often explain their actions as a means “to express anger at myself” or “to punish myself” (Klonsky & Muehlenkamp, 2007, p. 1050). Alderman (1997) wrote on this purpose being found often in response to the abuse histories that individuals who self-injure commonly have. She noted that these individuals often blame themselves and feel they deserve punishment. Plante (2007) further discussed this goal as being “a declaration of war on the unwanted aspect of self” (p. 53). Briere & Gil (1998) studied 93 participants who participated in self-injurious behaviors, 96% were female and the mean age was 35 years of age. Of this sample, the most common reason for self-injury was “self-punishment” (83%) and the second most frequent purpose for self-injury was “distraction from painful feelings”.

Lloyd-Richardson et al. (2007) looked at self-injury among a sample of adolescents within the community. They reported that females were more likely than males to use self-punishment as a motivation for their self-injury. These results were also found among male and female self-cutters by Rodham et al. (2004).

Another notable answer for why individuals self-injure is to gain the attention or nurturing of other people, a social positive-reinforcement. This is described as a way to obtain reinforcement from, closeness to, or the caring of another individual (Klonsky & Muehlenkamp, 2007). Although not the most frequent purpose noted for participating in self-injurious behaviors, Rodham et al. (2004) found among their sample that 21.7% of adolescent self-cutters and 28.8% of adolescent self-poisoners in a community setting promoted wanting to get attention as a reason for their actions. This was also found by Lloyd-Richardson et al. (2007) who found that up to 24.6% of community adolescents who participated in minor non-suicidal self-injury and 35.6% of who participated in moderate/severe non-suicidal self-injury identified getting attention as a function for their behaviors. Among adolescent psychiatric populations, this finding is not as noteworthy. Nixon et al. (2002) found that only 9.5% of their sample of 42 self-injuring adolescents admitted to a psychiatric hospital identified to “get care or attention from others” as a reason for their actions. Additionally, this response was only noted among female participants. In contrast, Claes et al. (2007) looked at male and female psychiatric patients and found that males reported wanting to get attention from others as a function of their self-injury more frequently than females. It should be noted, however, that this study was conducted with adults who had a mean age of 30.8 years.

Self-injurious behaviors as a means to communicate one’s personal distress or feelings have been noted (Alderman, 1997; Conterio & Lader, 1998; Lloyd-Richardson et al., 2007; Machoian, 2001; Nixon et al., 2002; Nock & Prinstein, 2004; Plante, 2006; Rodham et al., 2004). This could be referred to as a social positive-reinforcement. In conducting interviews with three adolescent females who participated in self-injurious

behaviors, Machoian (2001) identified three themes related to the purpose of self-injury being a method of communication. These themes included getting a reaction when words did not work, “communicative cutting” is a coping strategy for emotions, and adult attentiveness is crucial. With the inability to verbally communicate one’s emotions being a common feature found among this population (Gratz, 2006; Zlotnick et al., 1996), this function of self-injurious behaviors is understandable. Alderman (1997) discussed how

wounds and scars can express to others what you are thinking, feeling, or experiencing...the intended messages generally reflect the great amount of psychic pain which the individual is experiencing: ‘I hurt.’ ‘I need help.’ ‘I’m in great pain.’ ‘I’m scared.’ (pp.42-3).

In the book, *A Bright Red Scream: Self-Mutilation and the Language of Pain*, Strong (1998) reported that in her interviews and observations with individuals who self-injure, drawing blood was a language only understood within this population. It was compared to the communication of tears for most people. Further, individuals who self-injure “are either too numb to cry or find tears woefully inadequate to express and release the overwhelming, pent-up emotions they feel” (p. 44). Additionally, Strong (1998) found that the majority of these individuals have had childhoods where expression of emotions was avoided or criticized. These individuals, in turn, find that “words seem to take on terrifying proportions; they are both too powerful and completely useless” (p. 44).

Reconnecting with one’s body during a sense of dissociation has also been shown to be a reason for self-injury. Again, this is an automatic negative- or positive-reinforcement depending on the individual context. “To stop feeling numb” or “to feel

something even if it is pain” are common explanations from individuals who self-injure for this purpose (Klonsky & Meuhlenkamp, 2007, p. 1050; Favazza, 1996). Alderman (1997) explained this purpose by noting “the state of high tension that precedes SIV [self-inflicted violence] tends to alter consciousness, often sending the person into a dissociated state in which physical pain and sensation is reduced” (p. 37). Nock and Prinstein (2004) found that 30.6% of their sampled psychiatric inpatient adolescents self-injured “to relieve feeling numb or empty”. Thirty-four point one percent reported participating in self-injurious behaviors “to feel something, even if it was pain” (p. 888). Similar rates were noted by Lloyd-Richardson et al. (2007) among community adolescents with moderate/severe non-suicidal self-injury. Thirty-three percent of their sample identified “to relieve feeling numb or empty” as a function of their self-injury. Forty-one percent of the sample reported participating in self-injurious behaviors “to feel something, even if it was pain” (p. 1189).

Trauma reenactment has been reported as an additional purpose for individuals to participate in self-injurious behaviors (Alderman, 1997; Clarke, 1998; Ng, 1998). As noted previously, past physical, emotional, or sexual abuse and maltreatment are common characteristics found among individuals who self-injure (Briere & Gil, 1998; Gratz, 2006). Reasons for this reenactment have included feeling more in control of one’s personal situation, to respond to a post-traumatic stress flashback, to act in a dissociative state or identity, or to punish one’s self over feelings of guilt regarding the past abuse (Alderman, 1997). Clarke (1998) in the book, *Coping with Self-Mutilation: A Helping Book for Teens who Hurt Themselves*, further explained trauma reenactment by saying:

People who suffer from traumatic reenactment syndrome engage in self-mutilating behavior that represents the abuse they suffer in childhood. When children are repeatedly abused, and nothing is done to help them, they can take on the role of abuser, victim, and the non-protecting bystander. Self-mutilation lets them act out the feelings of the abuser (by attacking themselves), the feelings of the victim (shame for what happened), and the feelings of the bystander (being powerless to stop this behavior) (p. 31).

Briere and Gil (1998) found that 17% of their sample who self-injured participated in this behavior to “remember prior abuse”. However, this function of self-injurious behavior needs to be further researched. It could be argued that trauma reenactment is related to or a secondary function of other purposes for self-injury. This could be hypothesized by noting Alderman’s (1997) description of trauma reenactment and its ability to be interchanged with many of the other identified functions of self-injurious behaviors in this paper (i.e. self-hatred, self-punishment, or communication of feelings).

There are numerous other noteworthy functions of self-injurious behaviors. Attempting to gain control over one’s self has been noted (Alderman, 1997; Conterio & Lader, 1998; Kleindienst et al., 2008; Lloyd-Richardson et al., 2007; Nixon et al., 2002; Nock & Prinstein, 2004). Self-injury as a means to experience an endorphin rush or high has also been found (Alderman, 1997; Klonsky & Muehlenkamp, 2007; Levenkron, 1998). Additionally, protecting one’s self from committing suicide has also been reported (Klonsky & Muehlenkamp, 2007; Nixon et al., 2002).

Self-injurious behaviors as a social contagion has been explored and discussed by the research as a reason for participating in this action (Cerel, Roberts, & Nilson, 2005; Clarke, 1998; Derouin & Bravender, 2004; Hawton et al., 2002; Laye-Gindhu & Schonert-Reichl, 2005; Lloyd-Richardson et al., 2007; Nixon et al., 2002; Nock & Prinstein, 2004; Plante, 2006; Ross & McKay, 1979). Cerel et al. (2005) looked at a large sample of community adolescents and looked at the occurrence of risky behaviors following exposure to a peer's suicide attempt or death by suicide. Their research showed that individuals having this exposure were more likely to participate in risky behaviors including self-injury. Hawton et al. (2002) also supported this finding when looking at the presence of deliberate self-harm among community adolescents in England. Their research found that the presence and knowledge of self-harm by friends or family members and suicidal behavior by friends and family members were associated with an increased likelihood of personal self-injury. Derouin and Bravender (2004) explained the social contagion factor as being the "trying on" of different roles that is an aspect of the adolescent developmental period. Teens are "searching for acceptable behaviors, coping mechanisms, and support systems" (p.15). This aspect was further supported by Lloyd-Richardson et al. (2007), Laye-Gindhu and Schonert-Reichl (2005), Nixon et al. (2002), and Nock and Prinstein (2004). Although not a dominant reason for participating in self-injurious behaviors among clinical and non-clinical adolescent populations, these studies all had participants who noted "to feel more a part of a group" or "to belong to a group" as a function of their self-injury.

In conclusion, it should be noted that there are numerous functions that self-injurious behaviors may serve. There is often not only one reason why an individual

chooses this type of behavior. Additionally, there is considerable overlap among all of the identified purposes. It is important to look at and consider the individual person and the individual circumstances in which each act of self-injury occurs in order to gain an appropriate and more thorough understanding of these behaviors.

Adolescent development and self-injurious behaviors. Adolescence as a developmental stage is marked with numerous physical, emotional, and social changes. Even among so-called “normal” adolescents, this stage can involve turmoil, distress, and challenges. Among individuals who are “less well-adjusted”, these experiences can create distress resulting in risky, defiant behaviors and overwhelming feelings that are difficult to tolerate (Plante, 2007).

There are three “universal challenges of adolescence” (Plante, 2007, p. 27). “Identity formation”, striving for “autonomy and independence”, and “intimacy and sexuality” are common issues that emerge and progress throughout this developmental stage (Plante, 2006, 2007). “Identity formation” involves adolescents identifying who they are in the world including what their morals, interests, strengths, and limitations are as well as how they interact with other individuals in their environment. This sense of self will ideally be stable and confident. Problems with this task and its progression has the potential to cause “depression, anxiety, moodiness, anger, school failure, and self-doubt” (Plante, 2006, p. 191). It is important to note that this developmental challenge occurs at a point in time when adolescents focus on their peers’ approval more than how they feel about themselves personally (Plante, 2007). This only adds to the complexity and sometimes stressfulness of this task. The developmental task of “identity formation” was also supported by Erikson (1950).

Adolescence is often characterized by its unique position between childhood and adulthood and the increasing responsibility to become more independent in life. Adolescents are not yet old enough to separate from their parental or caregiver attachments, but need to progressively become more autonomous in order to function as a competent future adult. This second issue of adolescence often creates conflict and tension among adolescents and their caregivers as well as within the adolescent him- or herself. It is very common for adolescents to demand that they are capable and responsible enough to handle life's tasks and challenges. However, Plante (2007) argued that school difficulties and problem behaviors such as self-injury uncover the real weakness of this resolve and communicate the adolescent's need for continued support and lack of preparation to be fully independent. Plante (2007) discussed how the presence of self-injurious behaviors has two distinct messages which emphasize the adolescent struggle, "I want you to understand me" and "stay out of my business" (p. 33). This directly refers back to the noted functions of self-injury which include communicating what words could not and getting the attention of others (Alderman, 1997; Claes et al., 2007; Conterio & Lader, 1998; Klonsky & Muehlenkamp, 2007; Lloyd-Richardson et al., 2007; Machoian, 2001; Nixon et al., 2007; Nock & Prinstein, 2004; Plante, 2006; Rodham et al., 2004).

The final issue present in adolescence involves navigating romantic and sexual relationships and intimacies. Plante (2006) discussed that this task evolves over a lifetime. However, it is particularly noteworthy among adolescents who experience biological and pubertal changes as they begin to take part in more overtly intimate personal interactions.

Adolescents are caught in the throes of intense sexual desires, needs for acceptance and affiliation, and the often confusing task of defining one's sexual orientation and identity. These challenges during a time of decreasing parental connection and increasing freedom make for an often tumultuous and stressful period of development (p. 192).

Again, this task is challenging for the most sensible and well-balanced adolescent. Going back to the common characteristics of self-criticism and low self-esteem that are noted among individuals who participate in self-injurious behaviors as well as the hatred of sexual organs (Conterio & Lader, 1998), this developmental theme becomes particularly difficult among those who self-injure. The task is compounded in difficulty by the inability to effectively communicate one's thoughts and feelings that is also frequently found among individuals who participate in self-injurious behaviors. These characteristics among this population make it extremely difficult to attain and maintain healthy relationships with any individual, let alone a romantic or sexual relationship.

Gardner (2001) discussed five characteristics that are typical of the developing adolescent. These features found among most adolescents additionally explain how self-injurious behaviors within this age group might occur. The first characteristic involves aggressiveness and impulsiveness intensifying during this stage of development. As noted previously, self-injurious behaviors are sometimes explained as a lack of impulse control (Bennum, 1983; Favazza, 1998; Favazza & Conterio, 1989). If impulses increase during this time, then lacking the ability to control even the most basic urges might produce acting on these impulses or finding inappropriate methods of trying to cope with

these impulses. Gardner (2001) explained that the aggressive feelings associated with adolescents are turned inward in those individuals who self-injure.

The second characteristic present among adolescents is narcissism. Gardner (2001) argues that this feature characterizes self-injurious behaviors because “there is a belief that the solution found is the only one, inflicted alone” (p. 59). This aspect of narcissism is supported in adolescent development literature with the concepts of an imaginary audience and adolescent egocentrism. In these situations, individuals in this stage of development are unable to see situations outside of their own experience. Additionally, adolescents have a heightened awareness of their own presence in a setting and believe everything is directed toward them (Ormrod, 2008; Pipher, 1994; Steinberg, 2002).

Third, there is a hypersensitivity and heightened feeling toward the world and other individuals that comes into play during this developmental stage. Again, as noted before, individuals who participate in self-injurious behaviors already have characteristics of emotional dysregulation and use self-injury as a way to cope with distressing feelings (Alderman, 1997; Gratz, 2007; Kamphuis et al., 2007; Kleindienst et al., 2008; Klonsky & Meuhlenkamp, 2007; Machoian, 2001; Nixon et al., 2002; Plante, 2007; Rodham et al., 2004). Thus, if adolescence increases this sensitivity to emotions and experiences, the presence of self-injury as an attempt to cope is understandable particularly among individuals who already have heightened sensitivity to emotional experiences.

The fourth characteristic noted pertains to adolescents having a tendency to take action either as a coping strategy or a quest for independence. Gardner (2001) stated,

“cutting is obviously an action that takes precedence over thinking and reflecting” (p. 30). Conterio and Lader (1998) discussed how individuals who self-injure are prone to quickly act in order to rid themselves of intense emotions. In fact, treatment is often targeted to get individuals to feel instead of act when emotions are present. With this consideration, if adolescence heightens this feature and individuals who self-injure are also prone to this characteristic, then the combination of the two factors makes self-injurious behaviors in this developmental stage more understandable.

Finally, adolescents have a “preoccupation with death”. Gardner (2001) argues that adolescents get “both reassurance and excitement in the knowledge that mortality can be manipulated” (p.60). Gardner (2001) does acknowledge that self-injurious behaviors, by definition, are not about death, but “there is an aspect of the destruction that is linked to the preoccupation with death and the death instinct” (p. 60).

Arnett (1999) addressed the aspect of adolescent storm and stress as it relates to developmental tasks and challenges. He specifically noted, “Not all adolescents experience storm and stress, but storm and stress is more likely during adolescence than at other ages” (p. 317). Arnett (1999) discussed three elements of adolescence including conflict with parents, mood disruptions, and risky behavior. In regards to conflict with parents, there is a marked increase in adolescent resistance to parental authority. This resistance creates irritation which in turn adds to the stress of this developmental stage. Mood disruptions are also noted occurrences among adolescents. However, Arnett (1999) noted that mood disruptions are more likely to occur when there are more frequent negative life events that are experienced by an adolescent. Risky behavior was the final element discussed in Arnett’s (1999) revised view of adolescent storm and stress.

Although more risky behavior is noted in this developmental stage, individual differences are again noted. Personal characteristics and behavior issues in childhood may have a greater influence to participation in risky behaviors during this time rather than just the developmental stage itself. Ultimately, Arnett's (1999) modified theory on storm and stress in adolescence emphasized that this is a time in which parental conflict, mood disturbances, and risky behavior is evident. However, individual differences are notable and storm and stress is not a necessary experience of this developmental stage for all adolescents.

Adolescence involves numerous tasks, challenges, and changes that are often navigated with no lack of distress. These developmental issues are frequently demanding for stable and secure adolescents. For adolescents with features of negative emotionality, the inability to verbally express emotions, self-criticism, impulsiveness, or past trauma, these tasks are overwhelming and confusing. Negative emotionality makes the stress of this stage even more intense and hard to handle. The inability to speak about emotions leads to difficulty communicating experiences, thoughts, and feelings that one has through these developmental challenges. Self-criticism hinders the ability to develop a confident and positive sense of self as well as to develop healthy intimate relationships. The presence of impulsivity endorses acting on both positive and negative urges with no regard for long-term or short-term consequences. Past or present trauma in the form of abuse, neglect, or maltreatment influences all aspects of the adolescent development as it thwarts growth of a positive sense of self, it inhibits the personal sense of confidence one needs to be effectively independent and autonomous, and it devalues the importance of healthy attachments and relationships. Based on the noted characteristic features of those

who participate in self-injurious behaviors and the functions of the behavior, self-injury seems to be an understandable problematic effect of the adolescent developmental stage. These considerations also may further explain the research that suggests self-injurious behaviors begin in early adolescence, increases in middle to late adolescence into young adulthood, and decreases in one's late twenties to early thirties (Alderman, 1997; Conterio & Lader, 1998; Hilt et al., 2008; Klonsky & Muehlenkamp, 2007; Whitlock et al., 2006; Yip, 2005).

Treatment of self-injurious behaviors. Although self-injurious behaviors are often treated as a feature or condition of another mental health disorder, there are therapeutic modalities that have shown to be beneficial in decreasing the occurrence of these actions. Cognitive behavioral therapy in the form of dialectical behavior therapy and problem-solving therapy has shown promising results. Psychodynamic therapy has also exhibited positive effects at reducing self-injurious behaviors. The use of medications is often used to treat the identified mental health disorder and the accompanying emotions and behaviors such as impulsivity or aggressiveness (Klonsky & Muehlenkamp, 2007). Family therapy alone has been not been an identified treatment for self-injurious behaviors; however, involving family members in the process of therapy has been discussed to have benefits (Hawton et al., 2006; Miller, Rathus, & Linehan, 2007; Walsh & Rosen, 1988).

Cognitive behavioral therapy. A great deal of research is available on the effectiveness of utilizing cognitive-behavioral therapies in the treatment of self-injurious behaviors (Crowe & Bunck, 2000; Muehlenkamp, 2006; Raj, Kumaraiah, & Bhide, 2001; Townsend et al., 2001; Tyrer et al., 2003). Not only have cognitive-behavioral

therapies been shown as being effective in treatment, but clinicians are using this type of therapy more frequently with clients (Trepal & Wester, 2007). In surveying 58 clinical members of the American Mental Health Counselor Association, Trepal and Wester (2007) found that 40.5% of the respondents utilized Cognitive Behavioral Therapy, 17.6% used Dialectical Behavior Therapy, 10.8% used Behavioral Therapy, 6.8 % used Cognitive Therapy, and 6.8% utilized Psychoanalytic/Object Relations Therapy. Respondents were from a variety of settings including outpatient practices, community agencies, inpatient units, and school settings which assists in the generalizability of these results.

Whether standard Cognitive Behavioral Therapy, Dialectical Behavior Therapy, or Problem-solving Therapy is the focus, Klonsky and Muehlenkamp (2007) identified therapeutic interventions that emerge within each therapeutic approach. The use of functional assessments, skill teaching, behavioral techniques, and cognitive reframing are elements found in each modality to some extent. Klonsky and Meuhlenkamp (2007) discussed how each specific modality might have “the effective ingredient”, but the noted common interventions are present to some extent in each therapeutic modality and might be the reason for change among individuals who self-injure and participate in these forms of treatment.

Dialectical Behavior Therapy was created by Linehan (1993) primarily for the treatment of Borderline Personality Disorder. It has also been documented to help in the treatment of suicidal and non-suicidal self-injury among inpatient and outpatient populations (Katz, Cox, Gunasekara, & Miller, 2004; Muehlenkamp, 2006; Nock, Teper, & Hollander, 2007; Rathus & Miller, 2002). This therapy includes “intensive therapist

support...recognition of emotional reactions, distancing from emotions, problem-solving and development of interpersonal skills" (Hawton et al., 2006, p. 155).

In comparing the use of DBT and Psychodynamic Therapy within an adolescent inpatient program, Katz et al. (2004) found that those participants in the Dialectical Behavior Therapy program had significantly fewer dysfunctional behaviors when assessed against the psychodynamic group. The study did not note specific diagnoses of the participants only that participants were admitted to treatment based on a suicide attempt or suicidal ideation. The issue of psychiatric diagnosis might be an important consideration when reviewing the results of this research and in determining the generalizability of its findings. The authors did note that individuals with developmental disabilities or psychosis were not included. It would be useful to further look at this form of treatment in an outpatient setting with individuals who participate in self-injurious behaviors.

Problem-solving Therapy has shown varied results in the research in regards to its effectiveness with individuals who participate in self-injurious behaviors (Muehlenkamp, 2006). The therapy seeks to assist clients in identifying main life issues and potential solutions by educating the individual in coping skills and problem-solving skills. Research originally identified the therapy as being effective in working with self-poisoning (Gibbons, Butler, Urwin, & Gibbons, 1978). Townsend et al. (2001) conducted a meta-analysis of research available on problem-solving therapy, deliberate self-harm, and the experience of depression, hopelessness, and improvement of problems. The authors reported that this form of treatment is more successful at improving the issues associated with deliberate self-harm and thus a useful treatment for this issue. However,

the authors could not determine whether a decrease in deliberate self-harm actually occurred based on the research reviewed. An additional concern in looking at this meta-analysis is that the studies used included small sample sizes. A larger study with more participants and randomized treatment groups using problem-solving therapy was noted by the authors as being needed to determine the true success of this treatment with self-injury.

Research has recently suggested that a more thorough cognitive-behavioral approach to treating self-injurious behaviors might be effective. Evans et al. (1999) and Tyrer et al. (2003) used a brief cognitive therapy, problem-solving, and Dialectical Behavior Therapy approach to treat self-injurious behaviors. The authors found long-term benefits of this treatment at reducing the occurrence of self-injury as opposed to participants who received treatment as usual which included strictly problem-solving approaches, psychodynamic therapy, group therapy, or brief therapy.

Crowe and Bunclark (2000) wrote on a “multidisciplinary” approach to working with individuals who self-injure. The therapy includes problem-solving interventions, cognitive restructuring, relationship skills, coping skills, medication management, group therapy, and family therapy. Over a four-year period, fifty-eight individuals were treated. Thirty-two of these participants were reported to have “significantly reduced frequency” of self-injury by their date of discharge. Twenty-three participants saw “no change” and three participants “increased frequency” of self-harm by their date of discharge. This specific study has a relatively small sample size particularly considering the time duration of the research gathered. Additional limitations to this research include minimal demographic data influencing the external validity of the study as well as the lack of a

randomized control group which impedes the internal validity or degree to which one can determine a causal relationship between the treatment and its effects on the sample.

Psychodynamic therapy. According to research reviewed by Klonsky and Meuhlenkamp (2007), Psychodynamic Therapy has shown to be effective in treating self-injurious behavior, although often as a characteristic feature of Borderline Personality Disorder. Using a psychoanalytic therapeutic approach within a partial hospitalization program, the researchers found that subjects with a diagnosis of Borderline Personality Disorder involved in the experimental treatment group had significantly less reported self-injurious behaviors than their control group counterparts. This was noted after six months, 24 months, 30 months, and 36 months.

Klonsky and Muehlenkamp (2007) identified three common therapeutic themes that presented among the research on Psychodynamic Therapy and treating self-injurious behaviors. “Processing past relationships and building new, positive interpersonal relationships; increasing awareness and expression of affect; and focusing upon the development of a client’s self-image” (p. 1052) were discussed as dominant aspects of this therapeutic approach. Klonsky and Meuhlenkamp (2007) further noted that no research has been conducted “to identify the core mechanisms of therapeutic change” (p. 1052) when utilizing Psychodynamic Therapy in treating self-injurious behaviors.

Pharmacotherapy. Medications are often used as a means of managing the symptoms and features of specific psychiatric disorders or other presenting mental health issues including depression, anxiety, impulsivity, or mood instability. As noted previously, self-injurious behaviors are often associated with these experiences. There is

currently no medication identified that specifically targets the occurrence of self-injurious behaviors among clinical and non-clinical populations (Klonsky & Muehlenkamp, 2007). The majority of research noting the use of psychiatric medications and their efficacy with self-injurious behaviors has focused on individuals with developmental disabilities such as mental retardation (Aman, 1993; Baumeister, Todd, & Sevin, 1993; Mace, Blum, Sierp, Delaney, & Mauk, 2001). More clinical research is needed in this area with a focus on the use of medication alone as well as medication in conjunction with some form of psychotherapy.

Family Therapy. There is no found empirically supported research for the use of family therapy alone in the treatment of self-injurious behaviors. There have been studies that look at the use of family therapy with individuals who have a substance abuse or eating disorders which could be classified as self-injurious behavior depending on the definition used (Fishman & Rosman, 1981). However, family therapy is often used in conjunction with or as a means to disseminate the tenets of another therapy modality.

Walsh and Rosen (1988) wrote on the importance of therapists working with the family to identify the signs of self-injurious behaviors, identifying the purposes of the self-injury including family responses, and identifying alternative less-reinforcing ways to respond. Hawton et al. (2006) note that family therapy among this population deals with increasing positive communication and problem-solving skills within the family unit. Additionally, the authors report that family therapy helps to get the adolescent to learn how to cope with issues in the family without self-injuring. Family therapy also seeks to recreate stability as self-injurious behaviors can influence the homeostasis of the family.

In utilizing DBT with adolescents, Miller et al. (2007) discussed involving families in treatment to provide an opportunity for the family to interact in front of a therapist and receive “coaching” on appropriate problem-solving. Additionally, the authors noted providing the family with DBT skills training so that they can interact with and endorse their positive use within the family environment. This family therapy is provided in addition to the individual and group therapy that the family’s identified patient receives.

The treatment of self-injurious behaviors is often connected to a specific mental health disorder. Cognitive Behavioral Therapy particularly Dialectical Behavior Therapy, Problem-solving Therapy, and a multimodal approach have shown positive results at decreasing self-injurious behaviors. Although not as thoroughly researched, Psychodynamic Therapy has also shown effective at reducing self-injury. Pharmacotherapy has yet to treat self-injurious behavior itself and is instead used to treat other issues often connected to self-injury such as depression or anxiety (Klonsky & Muehlenkamp, 2007). Finally, there is minimal empirical evidence on the use of family therapy and self-injurious behaviors. It has been discussed in the literature that involvement of family members in treatment can be useful in the treatment of self-injurious behaviors (Hawton et al., 2006; Miller et al., 2007; Walsh & Rosen, 1988).

Summary of Self-Injurious Behavior. Self-injurious behavior is a multifaceted issue that involves numerous considerations which have been discussed in the above sections. The specific definition used to study and understand self-injury needs to always be considered when reviewing the available research and literature. However, self-injury is always the intentional damaging of one’s own body. Individuals who participate in

self-injurious behaviors vary in age, gender, ethnicity, psychiatric diagnosis, and psychological characteristics. Research has pointed to some common trends in these features although continued study is necessary due to divergent findings in many areas. Self-injury serves numerous functions for an individual. These motivations are important to consider when trying to gain a more thorough understanding of the person as well as to develop positive treatment approaches for which several models have been shown to decrease the occurrence of these behaviors. Finally, adolescence, a time of confusion and stress, often compounds certain predispositions or characteristics that individuals who self-injure have. Thus, the occurrence and increase of these behaviors during this developmental stage is understandable. Overall, self-injurious behavior is an issue that warrants continued research and study as it affects the lives of many people.

Systems Theory

Although there are many perspectives of viewing and interpreting family units (e.g. strategic, structural, experiential, etc...), the basics of these therapies fall under the scope of general systems theory and cybernetic epistemology. The main focus of this framework as understood within the context of a family is to look at individuals in interaction and relationship, not independently (Becvar & Becvar, 1982; Goldenberg & Goldenberg, 2000, 2005). Additionally, systems theory emphasizes that individual persons together make up a unified whole. This functioning whole is greater than each individual person in isolation (Goldenberg & Goldenberg, 2000, 2005). Cybernetics focuses on feedback processes that are used within families to control and stabilize the unit (Goldenberg & Goldenberg, 2000, 2005).

Systems theory holds four basic assumptions (Klein & White, 1996). First, all individuals within the system are related and in connection with each other. Second, to gain full comprehension of an individual and his or her issues, one must understand the system in which that individual is part. Problems are not viewed with simplistic cause-effect relationships but instead within the context and influence of the whole system. Third, just as the system influences the individual, the individual affects the system. No person or action is in isolation; everything is conducted within the system and, in turn, affects the system. Lastly, Klein and White (1996) noted as a final assumption that systems theory has been accepted as “a way of knowing” and not an actual state of affairs. Terming a family as a system is to be used as a “metaphor” to organize an understanding of a family unit.

Circular causality is an important element of family systems thinking and is closely related to the assumptions identified by Klein and White (1996). In contrast to linear causality in which a cause-effect relationship is established, circular causality views issues as being influenced by numerous and continuous processes and interactions. Additionally, as noted earlier, the actions of one individual affect the whole system just as the system influences the individual (Goldenberg & Goldenberg, 2000, 2005). Within this perspective, individuals are most thoroughly understood in relationship to the people and contexts surrounding them (Becvar & Becvar, 1982). Further, problems are viewed as systemic issues and not the sole responsibility of the individual or identified patient.

Positive and negative feedback loops, key cybernetic concepts, are additional concepts of systems theory within a family context. Feedback is a means of keeping a system together and increases the likelihood of the system continuing to function.

Feedback is a form of communication that is aligned with one's beliefs about the world. It is a way "to promote increases and decreases in behavior valued by the family system within a tolerable range of variation" (Becvar & Becvar, 1982, p. 19). Positive feedback in a family systems context means that a change has taken place. This change might create initial stress, but eventually has been handled and reconciled by the family unit. Negative feedback, in contrast, seeks to continue family functioning as is with no changes (Becvar & Becvar, 1982, 1993; Foley, 1974; Goldenberg & Goldenberg, 2000).

Family homeostasis is a family's tendency to attain stability between constancy and variability. This concept closely relates to negative feedback loops. When in the face of change, family systems will seek to restore a balanced unit. Behaviors, thoughts, and emotions within the family are deemed appropriate only within certain limits and will quickly be redirected if close to the extremes of these limits. Homeostasis is often determined by the rules that regulate the family's relationships. It has been noted that in a dysfunctional family unit even the slightest changes elicit rigid standards to conform all members of the family to the established rules and interactions of the system. Any deviation from this family norm is not tolerated within this type of family system. Symptomology that occurs within a family is often viewed as a lack in flexibility and an ongoing need for homeostasis within the system at all times (Goldenberg & Goldenberg, 2000).

Boundaries are unseen limits between members of a family system and between the system itself and the outside world. They are a critical aspect of systems theory. Boundaries affect a family's stability and function. They can vary in their strength between being overly rigid with minimal contact between members and other systems to

overly dispersed with confused roles and over-involved relationships. The intensity of, or lack of, boundaries within a system can determine whether a family is disengaged from one another or enmeshed (Goldenberg & Goldenberg, 2000, 2005).

Open and closed family systems are also elements of understanding this theoretical perspective. Simply stated, how open or closed a particular system or relationship is depends on the developed relationship boundaries between the family and the outside world. An open system is one in which communication is freely shared, new situations are encouraged, and flexibility and change is used when things are not working. A closed system is one in which the family is not open to experience and change. This family is closed off to outside interactions and influences (Goldenberg & Goldenberg, 2000, 2005). A family unit is not totally open or closed. If a family was completely open, it would not be considered a separate system from the outside world. If a family was completely closed, it would have no interactions with the outside world and cause a family system to be eliminated. All family systems have a certain threshold of boundary adaptability and rigidity. Although this is true, certain families may be more open or more closed than others. If a family is more open, there is a strong chance of success in that this system is willing to involve outside influences and make appropriate changes depending on the circumstance. The more closed a family system is, the more difficult it is for the members to tolerate stress and change. This family is closed off to the world which prohibits the influence of interventions and influences that may assist in positively coping with the experienced stress and dysfunction (Goldenberg & Goldenberg, 2000).

Family rules are a set of “organized, established patterns” in which all members of the family are expected to follow (Goldenberg & Goldenberg, 2000, 2005). These rules are not always verbally relayed to family members, but they are comprehended by the entire family system. Rules assist in maintaining boundaries and providing stability within the family unit. In healthy family systems, rules are “consistent and clearly communicated” (Goldenberg & Goldenberg, 2000, p. 64). Additionally, rules help to organize the family, but are open to change based on the situation. Among dysfunctional families, rules are often fixed, prohibit emotional expression, and stunt growth and development (Goldenberg & Goldenberg, 2000).

Family systems theory discusses the element of an identified patient. This individual within a family system holds the problems of the unit. Within this framework, the presence of an identified patient notes the presence of family instability and dysfunction. The function of having a symptomatic family member is to help provide the system with stress relief and homeostasis (Goldenberg & Goldenberg, 2000, 2005).

Family systems theory seeks to understand an individual within the context of his or her family environment. The concept of circular causality with the individual influencing the family unit and the family unit influencing the individual is a crucial element. The family system seeks to balance homeostasis and the need to change through various feedback loops, boundaries, and rules. These aspects of the family ultimately determine how open or closed the system is. Within this framework, individual crises and problems are viewed as a family dynamic and not an issue in isolation.

Systems theory and self-injurious behaviors. Although there is no literature or research available utilizing a family systems perspective in understanding self-injurious behavior, there are numerous aspects of family relationships and functions that need to be considered when looking at features and functions of self-injury. First of all, the individual who participates in self-injurious behaviors might be viewed as the family's identified patient. This symbolizes that there is stress within the family and there has been a struggle in the system to appropriately cope and reconcile this impeding change. By viewing the behavior with circular causality, self-injurious behavior, although by definition is inflicting injury to one's own body, is an action that influences the entire family including all of the relationships and interactions within the system. Additionally, what is happening within the family environment affects the individual who participates in self-injurious behaviors.

Positive and negative feedback loops would be noted particularly in how the family handles the knowledge of having a family member who self-injures. Positive feedback would encourage more appropriate handling of these behaviors in that interventions for change would be sought out and utilized. Negative feedback might elicit ignoring the issue or dealing with the self-injurious behaviors punitively in an attempt to prevent change from occurring with the system. Inevitably, the occurrence of self-injurious behaviors changes a system; thus, homeostasis is threatened.

When self-injury occurs, there is evidence that the boundaries within the family system are ineffective. Research has shown that a negative emotional family environment is often noted among individuals who self-injure. Additionally, being emotionally intrusive or emotionally rigid are often described as common family dynamics that are

experienced (Conterio & Lader, 1998; Crowell et al., 2008; Crowell et al., 2008; Favazza, 1996; Hawton et al., 2006; Levenkron, 1998; Ng, 1998; Sim et al. 2009; Strong, 1998; Walsh & Rosen, 1988; Wedig & Nock, 2007; Yates et al., 2008; Yip et al., 2003). These emotional climates are consistent with boundaries that are found at the extremes. There are overly rigid boundaries and therefore disengaged relationships in place or overly diffuse boundaries and enmeshed relationships. Regardless of which dynamic is in place, these boundaries endorse a negative family environment and influence the occurrence of self-injurious behaviors.

If a family is to successfully navigate through this experience, an open system needs to be accepted as often outside professional help and interventions are needed to treat self-injurious behaviors. If the family is a closed system, the occurrence of self-injury already emphasizes that there is stress within the family system and an inability to cope appropriately with this stress. This action might produce more stress and increase the dysfunction that is experienced within the family unit with continued resistance to opening the boundaries of the system to outside help.

Finally, the established family rules might produce concern. These rules could be inconsistent or too rigid. The rules would most likely prohibit the expression of emotions and inhibit the healthy development of the individual which are features commonly found among individuals who participate in self-injurious behaviors.

Summary of systems theory. Systems theory and cybernetic thinking are ways to understand the dynamics and processes of self-injurious behaviors and how it is conducted with a certain context. The focus is on the entire family unit and the influence

of each individuals' actions on the unified whole. The occurrence of self-injury will inevitably affect a family system just as the aspects of the system have influenced the occurrence of the self-injury. Using these ideas and concepts as an initial and basic foundation, it is now important to look at the research and literature available on family and self-injurious behaviors.

Family and Self-Injurious Behaviors

Although individuals who self-injure attempt to remain secretive or private, their actions influence their surrounding environments. Additionally, the environment influences the individual who self-injures. Although a developing area of study, research has looked at some common characteristics among families who have a member that self-injures. Research has also looked into genetic, biological factors that might contribute to an individual participating in these actions as well as responses to environmental factors that might influence its occurrence. Information from clinical practice and minimal research has explored what family members think, feel, and do in response to the knowledge of this issue among a loved one. These aspects of this important issue will be explored in the following sections.

The emotional climate of the family. A negative family emotional climate is frequently noted among individuals who participate in self-injurious behaviors (Conterio & Lader, 1998; Crowell, Beauchaine, & Lenzenweger, 2008; Crowell et al., 2008; Favazza, 1996; Hawton et al., 2006; Levenkron, 1998; Ng, 1998; Sim et al. 2009; Strong, 1998; Walsh & Rosen, 1988; Wedig & Nock, 2007; Yates et al., 2008; Yip et al., 2003). Conterio and Lader (1998) discussed the many features that this familial environment can portray. Emotionally intrusive caregivers provide a context in which a child cannot

develop independence and the freedom to think and feel for him- or herself. The parent, in essence, “smothers” the child. In contrast, emotionally absent parents where affection and attachment are non-existent teach a child that they are unimportant and not much will result from life. Conterio and Lader (1998) discussed how often their patients who self-injure relate to a missing bond between themselves and their caregivers. Strong (1998) expanded on this parent-type by noting the self-injury is a coping mechanism as well as an attempt to attend to one’s self in the absence of a parental figure. Both of these styles of parental emotional expression will, in turn, stunt the development of the individual’s sense of self.

Rigid standards and expectations are often expressed by both forms of emotionally dysfunctional caregiver styles. Religious conviction is a common element of this rigid parental thinking. Parents have little tolerance for exceptions to their own established rules or “their interpretations of what God would want” (Conterio & Lader, 1998, p. 76). This strict enforcement of parental controls often hinders and punishes the healthy expression of emotions among the individuals that are developing within this environment (Conterio & Lader, 1998).

In a study conducted by Wedig and Nock (2007), the researchers found that parental criticism was strongly correlated with self-injurious thoughts and behaviors as well as a diagnosis of a mental disorder when looking at 36 parent-adolescent relationships. In contrast, the results showed that this correlation was not found between parental emotional over-involvement and self-injurious thoughts and behaviors and parental emotional over-involvement and the diagnosis of a mental disorder. The study’s authors do warn about the reliability and validity of many of the concepts within this

research which were assessed based on the adolescents' responses to only one question. Additionally, a small sample size was used within a laboratory setting. A larger sample would prove useful as well as research conducted in a more naturalistic setting in order to add to the external validity of the findings.

Parental criticism was also found to be associated with self-injurious behaviors in "privileged" adolescents in research conducted by Yates et al. (2008). The researchers took a cross-sectional sample of 1,036 West Coast high school students and a longitudinal sample of 245 East Coast high school students. Among both sample sets, perceived parental criticism as explained with a heightened sense of parent alienation was found to predict an adolescent's participation in self-injurious behaviors. The researchers discussed the limitation of generalizing these findings outside of middle to upper class, rural families.

The family context of adolescents who participate in self-injurious behaviors is frequently marked with anxiety, dysfunction, and trauma (Conterio & Lader, 1998). Losses, sickness, and instability (e.g. financial difficulties, frequent moves, divorce, frequent fights with and between parents (Hawton et al., 2006), and parental substance abuse (Ng, 1998)) within the home environment are common. Abuse, neglect, or maltreatment within the family system are also noted among a large majority of individuals who self-injure (Briere & Gil, 1998; Conterio & Lader, 1998; Deiter et al., 2000; Favazza, 1996; Gratz, 2006). There is often a reversal or confusion of family member roles with children taking on more parental or adult roles "prematurely and inappropriately" (Conterio & Lader, 1998). These situations in addition to a negative parental emotional presence influences an individual feeling "endangered" and

“vulnerable” and ultimately looking for a way to cope with the vastness of their emotions and stress (Conterio & Lader, 1998).

Fogarty (1976) discussed numerous characteristics of a “functioning family”. First, the family unit is secure in the sense that it is flexible and willing to accept change. This would include being tolerant of diversity among the members of the family. Second, emotions are viewed as a part of the family system not as an issue for only one member of the family. “The preservation of a positive emotional climate takes precedent over doing what ‘should’ be done and what is ‘right’” (p. 149). Third, interrelation among all individuals in the family is emphasized and encouraged. Fourth, enmeshment is not prevalent and members do not run from conflict. Fifth, triangulation is dissuaded. Sixth, every individual in the family has a personal awareness of his or her interactions with other members as well as the strengths and weakness of his- or herself and the surrounding family members. Finally, all members will claim that family life was acceptable over a lifetime and will use one another for support and growth.

Ackerman (1984) further discussed features of a healthy family unit. First, all family interactions are stable in regards to accountability and trustworthiness. Members relate so that their connections are beneficial for everyone involved. The needs of all individuals are met by various “give-and-take” interactions; ultimately, “there is no blaming, only a mutual willingness to make it work” (p. 35). The second identified characteristic of healthy families was in regards to the investments of time and energy given to each family relationship. These investments need to average out among all members so that overall everyone is devoting an equal amount of attention to each relationship.

In noting these considerations for a healthy family and the characteristics found in the families who have members that self-injure, it could be assumed that the family system of individuals who participate in self-injurious behaviors is not functional. Many of these families have difficulty with flexibility, change, and being tolerant of differences. The emotional climate of these families is negative overall and there are noted problems with the relationship roles established among family members. These family systems lack trust, emotional awareness, personal awareness, mutual respect, and mutual accountability.

Interplay of biology and family environment. Some research has suggested that there are biological factors that influence an individual's participation in self-injurious behaviors particularly when combined with dysfunctional environmental situations (Crowell, Beauchaine, & Lenzenweger, 2008; Crowell et al., 2008). In discussing a comprehensive developmental model of Borderline Personality Disorder and self-injurious behaviors, Crowell, Beauchaine, and Lenzenweger (2008) reported that biological risk factors to suicidality include "genetic influences" pertaining to serotonin and dopamine systems, "abnormalities in brain systems" including serotonin, dopamine, and hypothalamic-pituitary-adrenal responses, and "fronto-limbic dysfunction". These biological factors influence an individual's behavioral and emotional responses, impulse control, and defiance. When these characteristics interact within a dysfunctional and high stress family system where emotional dysfunction and dysregulation are present, then there is an increased likelihood that self-injury will be contemplated, attempted, and continued as a coping mechanism.

Crowell et al. (2008) looked at 20 adolescents who have participated in some form of self-injurious behavior more than five times over their lifetime or more than three times in the past six months. These participants were compared against a control group. Studied were the relationships between peripheral serotonin levels, parent-child communication patterns, and the presence of self-injurious behaviors. The results showed the peripheral serotonin levels were lower among the participants who self-injured. Additionally, negative affect communication patterns and less cohesive relationships were notable among this group as well. The authors concluded by urging the consideration of biological and environmental factors in comprehending and working with individuals who self-injure.

With this research in mind, it is necessary for future research to explore more biological factors associated with self-injurious behaviors. More specifically, research needs to look at these elements as they relate to adolescent self-injury. Further, the combination of biological factors with the environment is another aspect of this topic that also needs to be studied.

Self-injurious behavior as a response to the family environment. Adolescents who grow up in the previously described family contexts and participate in self-injurious behaviors may do so for a variety of reasons in response to the family environment. Conterio and Lader (1998) in working with patients who self-injure discussed how many of the individuals who grew up in family environments that maintained poor boundaries, whether through some form of abuse or by “smothering child-rearing” practices, described their self-injury as a means to distinguish themselves from the people around them. Further, Conterio and Lader (1998) discussed how the self-injury may serve as a

way to get back at certain people and the individual believes the self-injury harms not only him- or herself, but the family as well.

Strong (1998) also supported this claim by noting individuals who self-injury and experience this family environment “blame themselves for being abused or mistreated” (p. 47). The urge to self-injure is enacted upon, not as a means to self-punish which is an identified function of the behavior, but is a means to punish the “rejecting” family. This assessment corresponds to the trauma reenactment function of self-injurious behaviors that has been discussed in the research (Alderman, 1997; Clarke, 1998; Ng, 1998).

Conterio and Lader (1998) additionally noted that individuals who participate in self-injurious behaviors and grow up in dysfunctional family environments may use the action as a cry for help. This supports the social positive reinforcement function of attention and affection seeking. The authors noted within a chaotic family system “anything less than a dramatic gesture goes ignored” (p. 78). The concept that even negative attention is more ideal than no attention at all is critically in place here.

Family reactions to self-injurious behaviors. The knowledge that one’s adolescent child has or is participating in self-injurious behaviors can evoke a flood of emotions and reactions in caregivers. Worry, shock, denial, anger, frustration, sympathy, guilt, and fear have all been feelings used within the literature to describe the emotional reactions of parents when they find out about their child’s self-injurious behaviors (Alderman, 1997; Conterio & Lader, 1998; Levenkron, 1998; Plante, 2006; Walsh & Rosen, 1988). There is often a mix of emotions that occur all at once in response to this realization. Although not specific to self-injurious behaviors, Wagner, Aiken, Mullaley,

and Tobin (2000) looked at parental reactions in response to adolescents' suicide attempts. Their findings suggested that fathers and mothers showed "positive concern" after an adolescent's suicide attempt. This emotional reaction included feeling "sad, caring, and anxious" (p. 433). It should be noted that feelings of hostility were also noted, but were not expressed as openly as before the suicide attempt among parent participants.

Alderman (1997) wrote on thoughts that are often associated with the noted emotional reactions among family members who have an adolescent who participates in self-injurious behaviors. "It's all my fault", "I can fix this", "You're nuts", "This changes our whole relationship", "You're not who I thought you were", and "You're doing this to manipulate me" (p. 174) are all common statements that are made. Levenkron (1998) noted that parents will often assume their adolescent will "outgrow" the behavior and that it is "just a phase". Particularly within the family environment discussed previously, some caregivers respond "narcissistically" and focus the behavior back onto their own personal experience. These parents view the self-injurious behavior as a means to sabotage the parent's life (Levenkron, 1998).

Alderman (1997) provided information to family members on what to do and what not to do when faced with an adolescent who participates in self-injurious behaviors. She noted that it is important for caregivers to be open to communicating about the self-injury. Additionally, she discussed how even if the family denies the self-injury is occurring it does not mean that it is not happening or will go away. Parents need to reverse the "shame and secrecy" that frequently surrounds the adolescent who participates in the self-injury and the act itself. Caregivers need to identify with the call for help that the self-injury suggests. Additionally, caregivers need to be supportive. This

is done by keeping negative responses to one's self and being available to spend quality time with the adolescent. Finally, Alderman (1997) noted that parents should not discourage self-injury as this gesture is "aversive and condescending". This response breaks down communication about the action and minimizes the fact that "most people would choose not to hurt themselves if they could...although SIV [self-inflicted violence] produces feelings of shame, secrecy, guilt, and isolation, it continues to be used for coping" (p. 179). Although all of these recommendations would prove useful in the treatment on self-injurious behaviors, when considering the family characteristics discussed above, these suggestions might be easier said than done.

Yip et al. (2003) interviewed three adolescents who participated in self-injurious cutting, their parents, and their peers to identify the influence that the parents had on the adolescents' self-injury, the responses that parents had to the self-injury, and the affects of the self-injury on the parent-child relationship. The results showed that the parents found out about the self-injury unintentionally. They all felt "frustration, awful, puzzled, and worried" (p. 411) in response to the revelation. The parents noted difficulty managing their personal responses to their adolescent while trying to remain supportive to the feelings of their child following the self-injurious action. The behavioral responses discussed by the parents varied and included providing material reinforcements to resolve the negative feelings that led to the self-injury, giving the adolescent whatever she wanted, and facilitating communication on the reasons behind the self-injury. The researchers concluded that parents have "a very significant effect on adolescents' self-cutting" (p. 413). Further, parents appear to have a variety of responses to their

adolescent's self-injury, both positive and negative. These reactions, in turn, influence the adolescent's future self-injurious behaviors and whether they minimize or persist.

Some considerations need to be noted when reviewing the research of Yip et al. (2003). First of all, this study provided valuable qualitative information in regards to self-injurious behaviors and the influence and response of family members. The researchers themselves noted that most of the research available on this topic is quantitative in nature. Additionally, published research on family and self-injurious behaviors is not extensive and is relatively recent. The majority of information available is reported from clinical experiences and thus, more research in the area of family and self-injurious behaviors needs to be conducted with this study adding to the limited knowledge that is available. Second, the study was conducted in Hong Kong. Cultural dynamics and the role of family within this environmental context might differ from the United States. Therefore, it would be useful to pursue this research within the United States to increase the transferability of the findings as well as to increase the depth of understanding within this subject area. Thirdly, an increased sample size would also be beneficial in reporting the transferability of the findings among this identified population.

Similar to the work of Yip et al. (2003), Rissanen et al. (2008) interviewed four parents of adolescents who self-injured. The main focus of the interviews was to gather information regarding the parents' understandings and thoughts about their adolescent's self-injurious behaviors. In completing an inductive content analysis, four categories emerged including "the phenomenon of self-mutilation", "factors contributing to self-mutilation", "the purposes of self-mutilation", and "the sequels of self-mutilation". Parents discussed how the self-injurious action created negative emotions, it was viewed

as a common behavior among adolescents particularly females, and it required intervention. “Factors contributing to self-mutilation” related to the adolescent (e.g. puberty, peer relations, being different, loneliness, etc...) and to the family particularly the mother (e.g. differences in upbringing between siblings, mother’s perception of things being okay or not okay, lack of motherly nurture). “The purposes of self-mutilation” again related to the adolescent (e.g. help self to relieve negative feelings) and to others (e.g. attention seeking, protesting family, being dramatic). Finally, “the sequels of self-mutilation” was broken down to pertain to the adolescent (e.g. addiction, scars, ridding self of bad feelings) and to the parent (e.g. oblivious to acts, negative).

The research of Rissanen et al. (2008) adds to the limited experimental and qualitative information available on the response of parents to self-injurious behaviors. It should again be noted that the interviews were conducted with Finnish parents and there were only four interview subjects used. These factors would influence the transferability of the results and it would be useful for the study to be replicated in different cultures as well as with a larger sample set.

Summary of family and self-injurious behaviors. Self-injurious behaviors do not occur in isolation. The individual who self-injures is both influenced by the family and influences the family him- or herself. Research has shown that individuals who participate in self-injurious behaviors share some common family characteristics including a negative emotional climate and rigid standards and expectations. Additionally, research has shown that genetic and biological predispositions inherited through family lineage can influence the occurrence of self-injury particularly when combined with a dysfunctional family environment. Self-injurious behaviors are

sometimes done in response to the family environment. In turn, family members have various emotions, thoughts, and behavioral reactions. Overall, research is limited in the area of family and self-injurious behaviors particularly when focusing on adolescents. More study is needed to explore this problem and its influences.

Conclusion and Summary

Self-injurious behavior is an important issue that affects the lives of numerous individuals. The person who self-injures has various characteristics and is reinforced by this behavior for different reasons. In specifically looking at adolescence, this developmental stage and its challenges lead to distress and impulsivity among most adolescents and even more so to those persons who have personal features such as emotional reactivity and impulse control issues. Treatments often focus on developing appropriate coping strategies, communication skills, personal awareness, and better relationships.

In looking at the caregiver response to an adolescent's self-injury, it is necessary to understand the dynamic of a family system and the available research on the families of individuals who self-injure. Systems theory focuses on the continual influence of all individuals within the system. Through feedback loops, the development of open or closed systems, family rules, and a family's desire for homeostasis, families deal with issues as they are presented. Self-injurious behaviors present unique challenges for family units and are dealt with a variety of ways.

Much of the literature on family and self-injury is written using clinical experience as a guide. Research on this topic is limited. Aspects of the family

environment have been studied and include a negative emotional climate and rigid rules and expectations. Biological factors that might predispose an individual to participate in self-injury have also been minimally researched. Family reactions have been discussed, but this information has been based on clinical experiences more than scholarly research. However, Yip et al. (2003) as well as Rissanen et al. (2008) have introduced looking qualitatively at the responses of parents to the knowledge of their adolescent's self-injury.

It is in response to the lack of research on family responses and adolescent self-injury that this study will be conducted. The studies of Yip et al. (2003) as well as Rissanen et al. (2008) will serve as guides for the proposed research. An in-depth qualitative understanding of this topic will be sought and will be conducted in the manner discussed within the following chapter.

Chapter Three: Methods

A qualitative, collective case study design was utilized for this research study. This approach allowed for an in-depth exploration of parents' responses to their adolescent's self-injurious behaviors. Various aspects of this study's methodology enhanced the trustworthiness and verification of the findings. *A posteriori* themes were explored as the data were analyzed using inductive content analysis.

Description of Sample

The sample for this study was parents of adolescents who had been admitted to an inpatient psychiatric residential treatment facility with a presenting problem of self-injurious behaviors. The definition of a parent is a biological mother, biological father, adoptive mother, or adoptive father of a child (Department of Children & Families, 2010). The parents identified for participation in this study were the custodial parent and had legal custody of their adolescent child.

The definition of an adolescent was an individual between the ages of 10 to 22. To limit the scope of possible participants and focus on the time period of middle adolescence, only parents whose child was between the ages of 13 and 17 were interviewed. Research has identified that this timeframe is the typical age of the first occurrence as well as the age when self-injury increases in frequency and severity (Alderman, 1997; Favazza & Conterio, 1989; Klonsky & Muehlenkamp, 2007; Whitlock et al., 2006; Yip, 2005).

The definition of self-injurious behaviors used to identify parents with an adolescent who has participated in these actions to the extent that it is a presenting problem was “the intentional destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (Klonsky, 2007a, p. 1039). The parents of adolescents who had a primary substance abuse, substance dependence, or eating disorder diagnosis with no additional diagnoses were not included in this study due to the utilization of this definition. Substance use and disordered eating were not within the identified scope of self-injurious behavior for this study.

It should be noted that self-injurious behavior might be one of many presenting problems of the identified adolescents and additionally there may be several different psychiatric diagnoses that were noted. This is supported by the research that shows the occurrence of diverse mental health issues including personality disorders, mood disorders, and posttraumatic stress among individuals who participate in these actions (Alderman, 1997; Benhum, 1983; Briere & Gil, 1998; Conterio & Lader, 1998; Favazza, 1996; Favazza & Conterio, 1989; Favazza et al., 1989; Gratz, 2006; Haw et al., 2001; Klonsky & Muehlenkamp, 2007; Klonsky et al., 2003; Muehlenkamp, 2005; Nock et al., 2006; Olfson et al., 2005; Sansone & Levitt, 2004; Trepal & Wester, 2007). Although individuals who have been diagnosed with developmental disabilities often exhibit self-injurious behaviors, the parents of these adolescents were excluded from this study (Pomeroy et al., 2002; Williams & Wallace, 2006).

With these items noted, the selection-eligibility characteristics included the following:

1. The individual must be the biological or adoptive parent of an adolescent who was between the ages of 13 and 17.
2. The individual must be the custodial parent of the adolescent.
3. The adolescent child must have been admitted to an inpatient psychiatric residential facility with self-injurious behaviors noted as a presenting problem on admissions paperwork.
4. The adolescent must not have a primary diagnosis of substance abuse, substance dependence, an eating disorder, or a developmental disability.
5. The parent must be willing to discuss their adolescent's self-injurious behaviors including their personal responses.
6. The parent must be willing to sign for consent to participate in the present research study.
7. The parent must be willing to sign for consent to release their adolescent child's current medical records.
8. The parent must be willing to travel to their adolescent's present inpatient psychiatric residential facility placement to complete interview questions.
9. The parent must be willing to be contacted following the interview for member checks.
10. The adolescent child must be willing to assent to participate in the research study in order to view his or her current medical records.

Sample Scheme

A purposive, non-random sampling scheme was utilized to build an in-depth understanding of parental response to adolescent self-injury. A criterion sample set was

used. All participants met the noted criteria to allow for their participation in this study (Onwuegbuzie & Collins, 2007; Stake, 2005).

More specifically, eight parents who had an adolescent that had been admitted to an inpatient psychiatric residential treatment facility with a presenting problem of self-injury were interviewed. These parents were referred to this study by the facility's administration or therapists who were working with the family. It should be noted that I have worked on a full-time and part-time basis within this facility; thus, contributing to the accessibility and convenience of the sample used.

Instruments

Pre-interview screening tool. Upon receiving referral information from the inpatient psychiatric residential treatment facility, I contacted the potential participants via phone. To determine that the referred parents met the desired criteria, a pre-interview screening tool was developed. This initial assessment also ascertained whether the identified parents were amenable to consenting to their participation and the release of their adolescent's medical records from the current inpatient psychiatric residential facility placement. It was additionally determined if they were able to come to the facility to complete the interview questions, participate in a 1-2 hour interview, and were able to be contacted at a later date to member check. An example of this screening tool can be found in Appendix A.

Pilot study. Two participants who met the designated criteria were used for an initial pilot study of the interview questions and procedures. Their feedback was used in combination with observations made by me to revise the interview script in order to

enhance ease of understanding the question content and study focus. The participants were asked for their permission to provide feedback for this pilot study based on the consent form found in Appendix B. The pilot study script which was used before the interview script with these two participants can be found in Appendix E.

Consent form and assent form. After completing the pre-interview screening tool and meeting the designated criteria, identified participants made an appointment to meet with me at the adolescent's current inpatient psychiatric residential treatment facility. Before any interview questions were posed, the participants signed a form for consent to participate in the research study. It was at this time that the participants also provided me with a pseudonym name to be attached to all of their data in order to uphold confidentiality. Additionally, an assent form was signed by each participant's adolescent to obtain permission to review his or her current medical records. The consent to participate and assent to participate forms can be found in Appendix B.

Interview script. Upon signing the consent to participate in this research study and the assent to release the adolescent's medical records, an interview script was followed to gather the desired information. To gain further depth or clarification of the information given, probing questions outside of the interview script were asked as deemed appropriate. The interview script can be found in Appendix C. Major questions that were posed to each parent to guide the interview inquiries were:

1. How would you define self-injurious behavior?
2. How did you find out about your adolescent's self-injury?

3. What do you think are the reasons your child participates in self-injurious behaviors?
4. What thoughts did you have when you found out about your adolescent's self-injury?
5. What feelings did you have when you found out about your adolescent's self-injury?
6. What actions did you take when you found out about your adolescent's self-injury?
7. How would you describe your relationship with your adolescent child?
8. How do you think that your parent-child relationship influenced your adolescent's participation in self-injurious behaviors?
9. How do you think other members of your family have influenced your adolescent's participation in self-injurious behaviors?

Phone debriefing. The information shared by the identified parents for this research study was personal and highly sensitive. In addition to upholding professional research practices including confidentiality, a debriefing was conducted by me with study participants. This brief phone interview was used to process the participants' reactions to the research interview and allowed for further resources to be given to the participants if needed. The script used for the debriefing session can be found in Appendix D.

Interview

A semi-structured interview was conducted with each participant in this research study. The focus of these interviews was to gain an understanding of the parent perspective of their adolescent's self-injurious behavior (Fontana & Frey, 2005). A set of

predetermined questions was developed based on the research focus of this study and based on questions posed to participants in Yip et al.'s (2003) research on parental influence and response to adolescent self-injury in Hong Kong. This interview script can be found in Appendix C.

The interview followed a general outline of questioning. The interview script served as the primary guide for each session. Due to the semi-structured interview format and depending on the responses given by the study's participants, follow-up questions and simple clarification questions were used to gain a more in-depth comprehension of the participant's perspective (Janesick, 2004).

Each interview lasted approximately one hour and began with a general description of the conditions necessary to participate in the research study. Aspects such as the need to audio record each session, the assertion that anonymity would be upheld, and the option for the session to be terminated or briefly interrupted for a break were discussed. This led to the participant being given a consent form to carefully read and sign. A pseudonym name was identified to be attached to all of the gathered data. The first portion of the interview process took between 5-10 minutes. No interview questions were posed until the consent form was signed by the participant.

Following the participant giving informed consent, the remaining time included a series of questions to gather basic demographic data to encourage rapport building between the participant and me and to orient to the subject matter. These inquiries also sought to slowly ease the participant into answering more difficult questions later on in the interview session (Fontana & Frey, 2005). After the background information was

received, the interview script began to ask questions more directly related to the parent's response to the knowledge of his or her adolescent's self-injury. Within 48 hours of completing the interview session, each participant was debriefed by phone.

Additional data were used in conjunction with the interview discussion to add to the depth of information collected. Transcripts of each interview were typed and given to each participant for her careful review. I contacted each participant via phone or email following the receipt of her interview transcript. Any feedback she added to the collected information was discussed face-to-face or via email. This was in addition to any information the participants added within one week of the completed interview. Field notes were created during each session to enhance more detailed descriptions of each parent's perspective and experience. A specific focus was placed on the chronemic (e.g., speed of speech), kinesic (e.g., body gestures), and paralinguistic (e.g., volume of voice) modes of communication that each participant portrayed (Fontana & Frey, 2005). An example of the form used to gather field notes can be found in Appendix F. Additionally, consent and assent for the release of the current medical records of the adolescent child were received. This provided information pertaining to past treatment history, presenting problems, current treatment goals and progress including family therapy and involvement. An example of the form used to gather medical record information can be found in Appendix G. The goal of including this additional data was to create rich and elaborate depictions of each parent's responses.

A total of eight individuals were interviewed for this research study. The first two parents referred to this study that meet the designated criteria were used for a pilot study. Based on recommendations from Janesick (2004), two pilot interviews were conducted to

determine participant understanding of the questions posed as well as to consider further study logistics if necessary. Four parents referred to this study that met the designated criteria were used for the interviews and the information gathered was analyzed. Two parents referred to this study that meet the designated criteria participated in the interview sessions; however, their information was not used due to their failure to complete the entire study process.

The interview setting was an additional component for consideration. Each participant was interviewed at the inpatient psychiatric residential treatment facility where their adolescent was currently placed. An intake room with table and chairs was used to complete each interview. The room was reserved to ensure there were no interruptions or distractions from outside individuals. Two digital recorders and field note forms were brought into the room for study purposes.

Data Collection Procedures

Pilot test. Two participants who meet the designated criteria for participation in this research study were used for a pilot test of the interview process and questions. They were made aware that their interviews would be voice recorded and field notes would be taken. The information obtained from their interviews was not analyzed. Instead, these participants were used to assess effectiveness of the interview questions and the procedures used to meet the desired focus of this study.

The two participants involved in this pilot study answered questions posed in the interview script and provided a verbal assessment as to their understanding of these inquiries. They also discussed whether they believed these questions assisted in

developing a detailed perspective of parental response to adolescent self-injurious behaviors. I also assessed these questions and the verbal and nonverbal responses given by these participants to determine if the participants had difficulty understanding or responding to certain interview inquiries.

The pilot interviews were conducted before any of the other interviews that were used to analyze the collected data. The feedback received from the participants' responses and from my overall impressions was used to revise interview questions. A script to introduce the participants to the pilot interview process can be found in Appendix E. This script was read to the participants before the interview script began.

Interview procedures. Before any research with participants was conducted, there were a number of events that took place. This study was approved by the Institutional Review Board at the University of South Florida. Additionally, all participants provided their informed consent and assent and were made aware of their right to privacy and protection from harm (Fontana & Frey, 2005).

Data from the interviews were collected by a combination of methods. Two digital recorders were used with the signed consent of each participant to capture the discussion of each session. These audio recordings were transcribed verbatim and then given to each participant for member checking. Field notes were created during the interview process. The medical records of the identified parents' adolescents were obtained to diversify the information obtained to create in-depth descriptions.

The participants were interviewed and the data were collected over an approximately four month time period. This length of time allowed for participation in

the interview sessions, the transcriptions to be made, member checking to be conducted, and analysis of themes in the data to be found. Additionally, it allowed for a more accurate portrayal of the participants' perspective and experience as participants had several opportunities to add to their responses and accounts (Onwuegbuzie & Leech, 2007).

About the Researcher

I am a doctoral student at the University of South Florida. My program of study is in Counselor Education with a focus on self-injurious behaviors, children's mental health, and school counseling. It is with this education that I have received doctoral training in Qualitative Research Design and Data Collection, Children's Mental Health Services, and Adolescent Development.

I am also a Licensed Mental Health Counselor in the state of Florida. I have provided counseling services in a variety of settings including private practice, community mental health agencies, a crisis stabilization unit, the school system, and in an inpatient psychiatric residential treatment program. I have worked with a broad range of ages; however, the focus and interest of my work lies in working with children, adolescents, and their families. Additionally, self-injurious behavior has developed as one of my clinical specialties and I have received continuing education in this area of practice.

Research Design and Verification Procedures

A qualitative, collective case study was conducted for this research study. There were a number of aspects to this study that enhanced the verification and trustworthiness

of the findings. Lincoln and Guba (1985) specifically noted credibility, transferability, dependability, and confirmability as being key features in qualitative research.

To encourage the credibility of this study, data triangulation and member checking were utilized. With the use of the different methods for gathering information including voice taping interviews, field notes, and medical records, data triangulation was utilized. This helped to create more detailed, thick, and rich descriptions of the participants and it helped to support assembled data. Finally, member checking was a necessary component of participation in this research study. This ensured the accuracy of the information analyzed (Creswell, 1998; Lincoln & Guba, 1985).

The transferability of findings in this study was emphasized with thick descriptions of the identified participants and their situation. I provided detailed information regarding each participant's case based on evaluation of all the gathered data. With these in-depth portrayals, the information was used to determine level of transfer that the findings might have between situations (Creswell, 1998; Lincoln & Guba, 1985).

An external audit and audit trail was utilized to increase the dependability and confirmability of the study. An external auditor with no relationship to this study who has doctoral level training in qualitative research design and methods was used to review the information and presented themes. This external auditor helped to determine whether the findings were supported by the data. An audit trail accumulated in the form of raw data (e.g., digital tapes, field notes, member checking notes), data summaries and write ups, data analyses, and materials pertaining to the development and progression of the study (Creswell, 1998; Lincoln & Guba, 1985; Onwuegbuzie & Leech, 2007).

A final item for considering the verification and trustworthiness of this study was researcher bias. I am a Licensed Mental Health Counselor with experience working with adolescents who self-injure and their families. The effect of this experience may have resulted in certain assumptions and interpretations being predetermined which might have influenced data collection and analysis. Additionally, I have worked in the inpatient psychiatric residential treatment facility where the participants are being recruited on a full-time and part-time basis. This might have influenced the effect of me on the participants and the effect of the participants on me. Parents might have felt more or less comfortable speaking to me based on this factor. Participants had the opportunity to provide email feedback regarding their responses and thoughts from the interview which assisted this aspect. If they were uncomfortable or nervous during the face-to-face interview, email contact allowed for another mode of communication between the participants and me. Also, the inclusion of an external auditor protected against this bias potentially affecting the data collection and analysis (Creswell, 1998; Onwuegbuzie & Leech, 2007).

Data Analysis

A within-case analysis and cross-case analysis was conducted utilizing data gathered from each of the four identified parents who had an adolescent that has self-injured. From the within-case analysis, a detailed description was provided for each participant using interview transcripts, field notes, member checking reports, and medical records. Themes that emerged within each case were discussed. Then, a cross-case analysis was conducted where the themes across all of the individual participants were explored and compared to one another.

To determine themes a posteriori, an inductive content analysis was conducted as exemplified in the research conducted by Rissanen et al. (2008) when they looked at Finnish parents' conceptions of adolescent self-injury. I first read the transcriptions of the interview sessions numerous times to obtain an overall understanding of what the participants spoke about in regards to their responses to their adolescent's self-injurious behaviors. I then created "frames of analysis" based on the statements made in response to each interview question. This was done to break down the information into more manageable sections for analysis. More specifically, the primary interview questions were used as a tool for organizing relationships among data and "frames of analysis" were identified specific to these inquiries. Thematic "domains" within each identified "frame of analysis" were explored based on found relationships in the data gathered. The data were further analyzed by identifying "terms" that described the gathered information within each "domain". Data continued to be categorized according to thematic categories that emerged based on a thorough and continued review of the information. This abstraction process of breaking down the information was continued until there was insufficient data to support further "domains" or "terms". When all the data were analyzed, the "domains" and "terms" were given content-characteristic names based on the compilation of subcategories within its scope (Elo & Kyngash, 2008; Hatch, 2002).

Based on recommendations provided by Hatch (2002), after "domains" were identified and explored, the data were again read. The reading of the information at this time was done to ensure that the data supported the identified "domains" and categories. Page numbers that have examples of specific "domains" were noted. In further

examination of the data, information that was counter to the identified “domains” and categories were considered.

Finally, “themes across domains” were identified. Relationships among the discussed thematic “domains” were explored. Hatch (2002) noted that the questions posed during this step in the process were “what does all this mean?” and “how does all this fit together?” (p. 173). This step was particularly noteworthy when using the data from each within-case analysis to form a cross-case analysis.

Chapter Four: Results

This chapter focuses on a with-in case analysis and cross-case analysis of four parent interviews. A review of field notes, medical record reviews, and member checking was also conducted to identify additional themes. The concentration was on parent responses to their adolescent child's self-injurious behavior which addressed the following research questions:

1. What are parents' understandings of the dynamics of self-injurious behavior?
2. How do parents respond cognitively, emotionally, and behaviorally to an adolescent's self-injurious behavior?
3. How do parents perceive the impact of the caregiver-child relationship on adolescent self-injurious behavior?

Additionally, two assumptions were made at the beginning of the research study. First, it was assumed that parents would have a variety of responses when they found out about their child's self-injurious behavior. Second, parents will believe that the parent-child relationship has affected their adolescent's participation in self-injury. It was noted that the perceived extent of this influence among parents would differ.

It is important to consider the setting in which the participants were gathered and in which the interviews took place when looking at the themes that emerged and the discussion of issues. Participants were parents who had an adolescent child being treated for self-injurious behavior as well as other issues within an inpatient psychiatric residential facility. Table 1 provides the demographic data of all participants. This type of

treatment program is the highest level of care that a child can receive other than short-term crisis stabilization. The program is typically four to six months in length. Children who cannot be successful within the community are typically admitted to this program when all other avenues for treatment have been exhausted. Treatment involves intensive therapy as well as medical stabilization. Patients participated in daily group therapies, individual therapy once weekly, and family therapy once weekly. They receive twenty-four hour nursing and medical care while in the facility.

Table 1

Participant Demographic Data

Information	Shadow	Jazzy	Sweet T	Precious
Sex	Female	Female	Female	Female
Race	White	White	White	White
Personal Mental Health History	Anxiety Depression	PTSD Bipolar D/O Schizo-affective D/O	Depression	Unknown
Number of Children	Two	Three	Two	Three
Biological or Adoptive Children	Biological	Biological	Biological	Adoptive
Age of Child In Tx Facility	16 y.o.	15 y.o.	14 y.o.	14 y.o.
Sex of Child In Tx Facility	Female	Female	Female	Female
Child's Diagnoses	Bipolar D/O	MDD	Acute Stress D/O	ADHD

Table 1 (cont'd.)

Child's Diagnoses	PTSD	MDD PTSD	ODD
Significant History	Domestic Violence Separation	Domestic Violence Legal Charges Separation	Rape of Daughter Sexual Abuse Physical Abuse Family Murder

While reviewing the medical records following each parent interview, discrepancies were noted. Some parents failed to mention certain presenting problems. Some failed to understand the exact current diagnoses of their adolescent child as well as treatment plan goals for their child. Additionally, the medical records also sometimes showed conflicting accounts between past mental health providers, the current treating professionals, the parent, and the adolescent child. Some of these discrepancies have been noted within the discussion of each parent participant and in the themes identified.

With-in case analysis was conducted initially based on the recommendations of Hatch (2002). Data were read thoroughly several times to gain an understanding of the information and its content. Based on each interview question, critical “frames of analysis” were highlighted directly from the interview script. These “frames of analysis” were then identified by “domain”. Data were again reviewed and the designated “domains” were broken down into “terms” if possible. The data were organized based on each primary interview question posed to the parents. The identified “domains” and “terms” for each interview question have been italicized. Table 2 also identifies the thematic “domains” and “terms” noted.

Pilot Study

Before the interviews used for analysis were conducted, a pilot study was done. Two parent participants who met the designated criteria were gathered. They discussed the same questions used in the other interviews. A focus was placed on their feedback of the interview questions including if the inquiries were understood or if further questions should be used to gain a more thorough understanding of the subject area. My observations of the individuals' responses were also used to decide if the interview script was satisfactory. The pilot study was additionally used as a means to practice the methods used for the interview process.

Based on the feedback gathered from these two participants, the interview script remained the same. I observed each participant having no difficulties understanding the questions or wanting to add more information than was already gathered within the interview session. Thus, no additions or revisions were made to the original interview script and process.

Participant One: Shadow

Medical record review. Shadow was a white female and single mother of two children. One daughter was sixteen years old and lives with her in her home. This daughter was a patient at an inpatient psychiatric residential facility for several presenting problems including self-injurious behaviors. The other daughter was twenty-five years old and lived in a nearby town.

When Shadow's youngest daughter was born, Shadow was married to a man who was both physically and emotionally abusive toward her. While in this marriage, her

youngest daughter witnessed this abuse; however, the daughter herself was never physically assaulted. Shadow remained in this marriage until her youngest daughter was six years old when she separated from her then husband. They divorced several years later. Since that time, Shadow's ex-husband lived in a distant state, paid child support, and had no contact with Shadow or her daughter. Shadow struggled with anxiety and depression since that time.

Before placement in the inpatient psychiatric residential facility, Shadow and her daughter participated in a couple of different therapies and interventions. Shadow's daughter first utilized a psychiatrist approximately one to two years ago based on the medical record. Her daughter had two crisis stabilization stays. The medical record noted that just before her admission to the inpatient psychiatric residential facility Shadow's daughter had "no recent" counseling.

Shadow's daughter was admitted to the inpatient psychiatric residential facility for a variety of reasons. Self-injurious behavior, family problems including aggression and homicidal thinking, suicidal thoughts, impulsivity, substance abuse, anxiety including panic attacks, racing thoughts, and insomnia, legal troubles, and trauma issues were all issues identified as presenting problems. Shadow's daughter had an Axis I diagnosis of Bipolar Disorder, NOS. It was noted that there was no primary substance abuse or dependence diagnosis given despite the history of substance use. The treatment goals for Shadow's adolescent daughter were to avoid self-harm for a minimum of fourteen days, to have no aggression for a minimum of fourteen days, to reestablish a sense of hope for the future, to resolve her trauma issues, and to use family therapy to improve communication and interactions with her mother.

First impression. Shadow presented casually dressed with coffee in her hand for our interview. When she was met at the door, she smiled and apologized for bringing her breakfast. While in the interview, Shadow maintained eye contact while being asked questions. When composing her answers in her head, she would look off, but would reconnect when verbally responding to a question. Shadow appeared somewhat nervous and emotional throughout the interview. This was noted by observations of her often playing with her coffee cup or folding and refolding her hands while speaking. On several occasions, particularly when speaking about her daughter's self-injurious behaviors and the family influence on these behaviors, Shadow became tearful, quiet, leaned back in her chair, and tried to recompose herself. The volume of her voice became quieter as she spoke about her own influence on her daughter's self-injurious behaviors. Shadow responded to all the questions openly despite the difficulty she sometimes had with speaking of certain issues. She appeared very interested in learning more about self-injury as was evident throughout her responses during our interview and in her desire for resources to gain a better understanding on this issue.

Presenting problems and diagnoses. Shadow reported four different presenting problems and two diagnoses for her daughter's treatment in the inpatient psychiatric residential facility. She noted anger, running away, substance abuse, and "threatening to kill herself, kill me, burn the house down" as issues bringing her child to treatment. When asked about current diagnoses, Shadow reported "bipolar...mood swings" and "alcohol and drugs...substance issues."

Based on these responses, a couple of items were noted. Shadow did not identify self-injurious behavior as a presenting problem despite it being a primary treatment issue

as well as the focus of the interview being her adolescent's self-injurious behaviors. Additionally, Shadow did not appear to have a clear and concise understanding of her daughter's current mental health diagnoses. This suggested an overall theme of a *lack of knowledge* regarding the mental health concerns and issues present in her daughter as well as a *minimization of the self-injurious behavior* itself.

Definition of self-injurious behavior. Shadow clearly understood that self-injurious behavior is “*more than just cutting*” itself.” She spoke of it being “very deep internally...very emotional and psychological.” Shadow did acknowledge that she lacks a full understanding of this issue and that she is seeking knowledge through learning.

Shadow’s response to this question was relatively brief. She did depict the *psychological aspect of self-injurious behavior*, but failed to explore this point. The brevity of her response could be correlated to her stated *lack of knowledge* on the issue of self-injury.

Finding out about the self-injurious behavior. Shadow found out about her daughter’s self-injury from her daughter herself. She discussed how her daughter was involved in individual and family therapy at the time and she believed it was part of the therapy process for her daughter to tell her about the behavior. “She had said to me...let’s go to the beach ‘cause I wanna talk about something.” Shadow noted, “I think it was bothering her.” After her daughter told her, Shadow described, “I was pretty much in shock...probably every emotion came over me...I had no clue what to do.” Shadow stated, “I had no clue it was happening. I was completely oblivious.” Shadow said, “I never knew about this...it never dawned on me that that would happen.” Although she

later reported, “I found it a little odd that she was wearing sweatshirts, but for some reason it never clicked in my mind.” Again, Shadow responded, “I’m still learning.”

There were several important considerations for Shadow’s finding out about her daughter’s self-injurious behavior. First, it was by *adolescent disclosure* that Shadow found out about her daughter’s self-injurious behavior. This was potentially a response to therapy work done on an individual and family basis. Second, there was a noteworthy *emotional reaction* from both Shadow and her daughter. Shadow spoke of having “every emotion” and being in “shock.” She believed that the action was “bothering” her daughter. Third, there continued to be a *minimization of the self-injurious behavior* as a potential issue with Shadow stating, “It never dawned on me that would happen.” Finally, a *lack of knowledge* was present as Shadow did not know what to do and did not alert to potential signs that the self-injury was occurring.

Reasons for self-injurious behavior. The reasons Shadow identified for her adolescent’s self-injurious behavior centered around *trauma* and *parenting*. Shadow discussed the relationship she had with her daughter’s father. “She definitely saw physical and verbal abuse.” In a later portion of the interview, Shadow discussed the sexual molestation of her oldest daughter by her daughter’s paternal grandfather. She noted that the family had a *lack of communication* about this topic. She discussed how she personally did not know how to approach the issue. Additionally, if Shadow did approach a topic of importance with her youngest daughter, her daughter would say, “She doesn’t wanna talk about it...so nothing gets dealt with.”

Shadow described how leaving her husband, her daughter’s father, was influential. *Single parenting* as it affected their lifestyle and finances was a reason

identified by Shadow for her daughter's self-injurious behavior. She additionally noted the way that she parented as a factor in her daughter's self-injury. "I've made mistakes. I've not known the answers to things at times, and not known what to do in dealing with my own fears, anxieties." From these comments, Shadow reserved *guilt* and *personal responsibility* for her daughter's self-injurious behaviors.

First thoughts when found out about self-injurious behavior. Shadow reported shutting down when first learning about her daughter's self-injurious behavior. She noted, "I didn't know what to think...I didn't know how to handle it." This again stressed the *lack of knowledge* in how to cope, think, and respond when learning about these behaviors. Shadow discussed more *emotional reactions* from herself and her daughter in response to this question. She stated, "I was a little numb" and her daughter felt "better." In fact, she reported it was "a release for her to tell me."

First feelings when found out about self-injurious behavior. When discussing what feelings overcame her when first learning about her daughter's self-injury, Shadow noted feeling "every emotion." In breaking down her responses throughout the interview and in response to this specific question, Shadow often stated feeling "*guilt*." She felt responsible for her daughter's behaviors as they related to her past exposure to abuse and her parenting interactions. She focused a great deal on her own "mistakes." "I feel bad...I carry a lot of that because she's my baby." Other feelings noted were being "numb" and "frustrated"; however, these were explored with less detail and frequency than Shadow's "*guilt*."

First actions when found out about self-injurious behavior. Three themes emerged from Shadow's actions to first learning about her daughter's self-injurious

behaviors. Shadow initially shared about her *immediate behavioral response*. She stated that she “cried” and “we hugged each other” when her daughter first disclosed her self-injurious behavior.

She then reported *seeking professional help*. Shadow noted that she talked to her daughter’s therapist so that he would “know what took place.” The expectation from her was that this therapist would help give her information on “what I needed to do.” He would also work with her daughter in therapy on the issue or continue to work with her on the issue if he already knew about it.

The third theme that became evident was Shadow’s personal desire for *learning* due to her *lack of knowledge*. Shadow reported going on the internet and reading on self-injurious behaviors. She continued to reiterate, “I don’t really know enough...I need to know more. I need to know more so I can know how to interact properly with her in a healthy way.”

Description of the parent-child relationship. Shadow’s description of the parent-child relationship she shared with her daughter depicted *stress*, *distance*, and *occasionally good* aspects. Shadow discussed having “constant turmoil” in the relationship, “unspoken anxiety” between the two of them, and feeling as though “I walk on eggshells” when being around her daughter. She noted that her own personal anger “has become more prevalent” as well as her anxiety. Shadow spoke of having breathing problems which were exacerbated by *stress*, so she sometimes had “to back off” for her own health. Shadow also stated, at times “I just wanted to scream the word help” when dealing with her daughter. She reported that she believed her daughter was “scared and anxious and angry and sad.” Shadow summed up the continued *stress* in their relationship

by stating “I have felt like we’re not getting anywhere...like two people at odds all the time and we’re not getting relief, and we’re not getting, having progression.”

In discussing the *distance* between herself and her daughter, Shadow mentioned how she felt that as her daughter had gotten older she was holding onto several emotions inside of her. She believed that “walls” have been built up. “She was standoffish” were her words to describe her daughter’s interactions with her previously. She further discussed how her daughter was “not a crier” and she “does not like or is not comfortable...being in touch with her feelings.” Additionally and as noted previously, Shadow also mentioned her own retreat away from her daughter due to her health issues that impacted the tension between the two of them.

Although their relationship held significant stress and distance, Shadow was sure to note that the relationship was *occasionally good* as “we get along and things are good” at times. She noted, “I wanna talk and I wanna work it out.” Shadow also stated, “I think she knows I love her.” Again, she reported her continued learning about self-injurious behaviors in order to improve their interactions and relationship.

How the parent-child relationship influenced the self-injurious behavior. In discussing how her parent-child relationship might have influenced her daughter’s self-injurious behavior, three themes were noted in Shadow’s responses. She specifically spoke about how the *family unit* including the “relationships” and “dynamics” influenced her daughter’s self-injury. Shadow spoke about the exposure her daughter had to physical and verbal abuse. She also addressed the years of being without a father and having to act as a single parent. Shadow spoke about her daughter having “insecurities of not having

that family unit” with a father and mother present. Again, she referred to her “mistakes of parenting.”

The *family role* her daughter had was also a theme that emerged in Shadow’s discussion of the influence of the parent-child relationship on the self-injurious behaviors. Shadow reported that her daughter was “very babied” and “very loved.” She admitted to her daughter being “overly mothered in an unhealthy way.” This was expanded upon with Shadow by saying she did not allow her daughter to “experience and grow.” Instead, Shadow did “everything for her.”

The final theme evident in Shadow’s discussion was the *lack of communication* between the members of the family. She noted her daughter often saying to her, “Mother, you don’t listen to me.” Shadow spoke about feeling hurt by these statements because she thought she was listening. Shadow processed how “it wasn’t about me” instead she needed to focus on her daughter which was what she was learning to do. She reported that these statements should have served as a “red flag” for her, but instead she was too focused on her own feelings. Also, as previously noted, Shadow admitted to not knowing how to talk about certain important and impactful issues with her daughter. This was in addition to her daughter not wanting to discuss these issues as well.

Other family members’ influence on the self-injurious behavior. Shadow definitely spoke about the *family influence* in her daughter’s self-injurious behaviors. She initially returned to the discussion about her daughter’s exposure to verbal and physical abuse between herself and her ex-husband. She prefaced this with “her father, her father and myself, I think are at the top” of influence from family members.

Shadow again reported on her own parenting and its impact as another aspect of the *family influence* on her daughter's self-injurious behaviors. She talked about "compensating" for her own personal guilt by babying her daughter. She spoke about doing anything to make sure her daughter was happy and loved even if it was to her daughter's detriment at times.

Shadow also identified a lack of relationship with her daughter's grandparents that might have been an additional *family influence* on her daughter's participation in self-injurious behaviors. She reported that her daughter's paternal grandmother had died and her paternal grandfather molested her other daughter so there is no relationship with him. Her daughter's maternal grandfather lived out of state and her maternal grandmother was "critical and judgmental."

Current thoughts about self-injurious behavior. Shadow's discussion of her current thoughts about her daughter's self-injurious behaviors produced a theme of *increased understanding*. She spoke about having a greater awareness *regarding her daughter*. "I think she's broken...she has been feeling insecurity and loneliness, and like nobody is there for her." Shadow spoke about an *increased understanding* between herself and her adolescent in regards to her role as a parent. "I think she's learning that I'm a human being and I've made mistakes and I'm not perfect."

Additionally, there appeared to be a slight *increased understanding of the act of self-injurious behavior*. "It is for me somewhat complex...it seems to touch everything in one's life...I think it's just so deep emotionally and psychologically...how we live, and how we interact, and what we say, and what we do, and how we are affects our emotions and our being." She concluded by admitting, "I never realized any of this stuff."

Current feelings about self-injurious behavior. When asked about how she currently felt about her daughter's self-injurious behavior, Shadow reported *concern*, *anxiety*, and *responsibility*. Shadow noted being *concerned* about her own "lack of confidence in me 'cause I don't feel that I am comfortable that I know enough." She expressed being "apprehensive" and "a little *anxious*" in regards to her daughter returning to live at home and being able to have her remain healthy.

Current actions about self-injurious behavior. Shadow's current actions in regards to her daughter's self-injurious behaviors centered around *learning* and having an *increased understanding*. Shadow spoke about several action steps that she was actively pursuing to *learn* and improve her insight into self-injury. Shadow discussed participation in her own personal individual therapy. She also noted having family therapy with her daughter while in the inpatient psychiatric residential treatment facility. Shadow mentioned attending various support groups such as Al-Anon and NAMI meetings in her area. Finally, Shadow stated, "I'm *learning*."

How the parent-child relationship has changed. Shadow addressed the change in her relationship with her daughter by highlighting three thematic areas, *learning*, *increased understanding*, and building a *more positive relationship*. Shadow stated her *increased understanding* involved being "more aware of her, of who she is inside, of what's going on a little bit, a little insight of what's happening." Also, "It made me more aware of how real this is, and how delicate and how important her emotions are and how she thinks and how she feels."

In building a *more positive relationship*, Shadow acknowledged, "We do need to stop and we need to take the time and listen and learn and grow together." She reported,

“*Learning* how to interact...without falling down.” “*Learning* is a very part, a very important thing.”

Post-interview thoughts. Following completion of the interview questions, Shadow was interested in receiving additional resources to add to her learning on this subject area. I recommended a couple of different books for her to review. She voiced continued concern for wanting her daughter to know that she was there for her and supported her. These responses were congruent with her voiced desire to learn and improve her understanding as well as her feeling of guilt and responsibility toward her daughter and her actions.

Phone debriefing. Shadow was contacted for a telephone debriefing following our interview. She reported that she had no questions from our interview and that she was feeling no distress from our conversation. Shadow did report that she planned to go to the library to check out the books that were recommended for her future learning.

Member checking. Shadow presented in person to member check her verbatim interview transcripts. She again presented with casual dress and a cup of coffee. She smiled when she was retrieved from the waiting room and presented more relaxed when entering the interview room as she sat back in her chair and small talked about the traffic.

Shadow had no major changes or additions to make to our original interview. Instead, Shadow stressed her personal responsibility in her daughter’s actions. She stated, “I felt sorry for myself” and therefore did not invest emotionally in what her daughter needed. She reported, “The responsibility for our broken daughter is mine and her father’s, we failed” her. Shadow also noted wanting her mother, her daughter’s maternal

grandmother, to see the “broken little girl” that her daughter was in order to decrease her mother’s criticism and judgment.

Participant Two: Jazzy

Medical record review. Jazzy was a white female, single mother of three children. The oldest daughter was fifteen years old and lived in the home that Jazzy shared with her own parents. This daughter was a patient at an inpatient psychiatric residential facility. The other two younger daughters resided with their father in a different state. Jazzy had a history of diagnoses including Bipolar Disorder, Schizoaffective Disorder, and Posttraumatic Stress Disorder.

Per the medical record, Jazzy was never married to her oldest daughter’s father. This was in contrast to the information she shared during our interview session. She did marry a man who she then had two other daughters with. This man adopted her oldest daughter as his own. Approximately three years ago, Jazzy separated from this man due to severe physical abuse. All of her children were witnesses to this abuse; however, physical abuse toward the children was not documented. Jazzy moved to another state at that time to live with her own parents. She left her three daughters behind to continue living with their father. Approximately a year and a half ago, the oldest daughter moved in with Jazzy and her parents due to “begging” to be with her mother. Since moving in with Jazzy, her oldest daughter had minimal contact with her adoptive father and had brief contact with her biological father.

Before placement in the inpatient psychiatric residential facility, Jazzy’s daughter participated in several different therapies. She had seen several different psychiatrists. She attended outpatient counseling at her community mental health agency for

approximately seven months. She had one crisis stabilization admission and she attended an outpatient program for self-injury before living with her mother.

Jazzy's oldest daughter was admitted to the inpatient psychiatric residential facility for several reasons. Mood instability, defiant behaviors, posttraumatic stress, running away, self-injurious behavior, family relationship problems, and an involuntary admission to a crisis stabilization unit were all noted as presenting problems. The medical record reports that her daughter was a "happy child" until her adoptive father began abusing her mother. It also stated that when Jazzy moved away her daughter became "withdrawn" and began to self-injure at this time. This ultimately resulted in her daughter being in an earlier program for self-injurious behavior while still living with her adoptive father. Jazzy's daughter had Axis I diagnoses of Major Depressive Disorder and Posttraumatic Stress Disorder.

The treatment goals for Jazzy's daughter were to stabilize her mood and to demonstrate the ability to function in school and with her peers by getting passing grades and moving up the facility's level system. Additionally, her daughter was to control her urges to be aggressive, self-harm, have suicidal thoughts, and run away. She will also be able to verbalize physical and emotional boundaries for herself and others.

First impression. Jazzy initially forgot about our first scheduled meeting. When called to reschedule, she apologized and offered to come in later that same day. When Jazzy was retrieved for our meeting, she presented with casual clothes and greeted me with a smile and a handshake. She presented uneasy for our session as she sat straight in her chair and made frequent hand gestures as she spoke. Throughout the interview, she

appeared open in her conversation. She did have a difficult time recalling certain events. She attributed this to her own trauma experience.

Presenting problems and diagnoses. When asked about what problems her daughter presented with to the inpatient residential psychiatric facility and what her current diagnoses were, Jazzy provided several responses that suggested a *lack of knowledge* and *minimization of the self-injurious behavior*. Jazzy identified defiance, school problems including suspensions and cutting classes, risky behaviors like running away and stealing, cigarette use, strange behaviors such as staring at her mirror for hours, the trauma of her exposure to domestic violence and the separation between herself and her daughter as issues important to her daughter's present treatment. Jazzy could not identify specific diagnoses for her daughter instead she reiterated her presenting problems by reporting "disobedience", a "little trauma", a "hiking problem", "a lack of respect for authority", and "schizoaffective" as supposed diagnoses that her daughter had.

Jazzy did not identify self-injurious behavior as a presenting problem despite it being a primary treatment issue as well as the focus of our interview being her adolescent's self-injurious behaviors. Additionally, Jazzy did not appear to have an understanding of her daughter's current mental health diagnoses. This supported the themes of *lack of knowledge* and *minimization of the self-injurious behavior*.

Definition of self-injurious behavior. Jazzy's initial response to how she would define self-injurious behavior was "I don't know." This suggested a continued *lack of knowledge* on the subject. When allowed more time, she began to talk about her daughter's depression which suggested she understood there is a *psychological aspect to self-injurious behavior*. Jazzy also reported on the *behavioral act of self-injurious*

behavior as she noted “hurting herself”, “running away at nights”, and “a lot of odd behavior” as examples of what she considered self-injurious in regards to her own daughter.

Finding out about the self-injurious behavior. Jazzy had considerable difficulty recollecting exactly how she found out initially about her daughter’s self-injurious behavior. She blamed this difficulty on her own Posttraumatic Stress Disorder. Through continued conversation, Jazzy was able to surmise that she found out about her daughter’s self-injury from her daughter’s adoptive father. He relayed the news to her when he placed their daughter in an outpatient day program for self-injury. He also reported that their daughter wanted to move down south with her. Jazzy reported that when her daughter did move down, she was unpacking her belongings and found medications. She noted that her daughter and her ex-husband had not told her about these medications and it was with this discovery that she “found out about everything” via phone from her ex-husband after calling him to question him about the medications. With this information, an identified theme was finding out about the self-injurious behavior from *someone other than the adolescent*. In Jazzy’s case, this was directly *in response to medical interventions* with both the day program her daughter attended and the finding of her psychotropic medications.

Reasons for self-injurious behavior. Again, Jazzy responded “I don’t know” in regards to the reasons her daughter might participate in self-injurious behavior. This emphasized the *lack of knowledge* she had in this subject area. With time to ponder the question, Jazzy noted the *trauma* experience of “seeing her mother get beat up by my husband[her oldest daughter’s father]” and the “verbal abuse” that occurred. She stated,

“she hurts” in response to witnessing and experiencing these actions. Jazzy also identified *an emotional release* as a possible reason for her daughter’s self-injury. She discussed this by saying, “she was hurting herself to get rid of the pain that she has inside.” Jazzy additionally discussed *social influence* from media. She voiced concern that her daughter reads vampire books and “they’re so dark and gritty.” She believed these books might have influenced her daughter’s actions as well.

First thoughts when found out about self-injurious behavior. Two themes emerged in Jazzy’s discussion of her first thoughts when she found out about her daughter’s self-injurious behavior. The first theme involved thoughts about *taking action in order to fix the problem* by removing her daughter from the present situation she was in with her adoptive father. Jazzy stated, “I wanted her to move back with me” and “to have her come where I know she’s...loved so much.” She reported thinking if she removed her from her adoptive father the self-injury would stop. She did note that “it stopped for a while”, but then her daughter began to “take a rubberband” and would slap her wrist enough times to leave marks.

A second theme to emerge was Jazzy’s desire to *understand ‘why’* the self-injurious behaviors had begun. Jazzy questioned not knowing if her ex-husband was treating their daughter differently because she was adopted. She reported thinking that her daughter “felt like she wasn’t even there, like no one acknowledged her” which she believed might have caused the self-injury to occur.

First feelings when found out about self-injurious behavior. Jazzy felt *protective* and *love* when she first found out about her daughter’s self-injurious

behaviors. She talked about wanting her daughter to come live with her when she found out. She also wanted her daughter to know that she is “*loved* very much.”

First actions when found out about self-injurious behavior. Jazzy’s actions to learning about her daughter’s self-injury included *removal from the situation* and *seeking professional help*. Jazzy reported that she moved her daughter to her home as soon as possible. She then reported taking her daughter to a psychiatrist and a counselor once a week consistently once she began living with her.

Description of the parent-child relationship. When asked about her relationship with her daughter, Jazzy made some conflictual statements. She first noted that their relationship was *close* by stating, “we like tell each other anything.” She also stated, “I never spanked her” nor was her daughter ever physically abused which Jazzy alleged influenced the *closeness* and positive aspects of their relationship.

Further discussion presented a more *distant* relationship between the two individuals. She discussed a recent conversation that they had about sex with her daughter telling her that she was not ready to have it. Jazzy then went on to mention that soon after this conversation she learned that her daughter had already had intercourse, a direct contradiction to telling each other everything. Jazzy also discussed how she takes her daughter shopping or to the beach; however, this time together is short because her daughter quickly wants to be with her friends. Additionally, Jazzy reported “I didn’t talk to her about it at all” in regards to the witnessing of her domestic violence. Jazzy had difficulty recollecting information regarding her daughter and attributed it to her posttraumatic stress which may also influence the potential to build a close relationship as well and may instead contribute to more *distance*.

How the parent-child relationship influenced the self-injurious behavior.

Initially, Jazzy responded that her relationship with her daughter had *no influence* on her participation in self-injurious behaviors. She discussed how she spends time doing things with her daughter. It should be noted that she then stated her daughter often asks to return early to be with her friends instead of her mother. She also voiced how she might be in “denial” over the extent her experiences with her own self-injurious behavior might have influenced her daughter.

As she continued to discuss the question, Jazzy stated, “Maybe I grounded her too much.” She also remarked, “She never did anything like this until after I left.” Jazzy expanded saying, “That’s when it really got bad” and “it probably hurt her to think mommy left”. These statements suggested a theme relating to the *family unit* involving the negative environmental dynamics that evolved from the interactions between Jazzy and her daughter which might have influenced the self-injury.

Finally, *family mental health* became a notable theme in Jazzy’s account. She specifically mentioned her own diagnosis of Posttraumatic Stress Disorder as it resulted from her domestic violence relationship. Jazzy also noted, “After my husband beat the living you know what out of me, I took a knife and I did self-harm me.” Although Jazzy reported this was the only time she participated in this behavior and that her daughter did not see it, she showed me the scar that was left from this episode, a noticeable mark a few inches in length on her inner wrist.

Other family members’ influence on the self-injurious behavior. The other family members that Jazzy identified as having *family influence* were her daughter’s adoptive father and her biological father. Jazzy noted the pain and hurt her children had

to go through when they watched their father beat her up. She also noted the lack of support from the adoptive father since her daughter moved to live with her and her parents. Jazzy also mentioned her daughter meeting her biological father for the first time recently. She reported that she and her ex-husband had never told her daughter she was adopted. Jazzy's daughter began asking questions about family pictures when she was younger, so they eventually told her the truth. Jazzy noted this was a conflictual relationship itself due to the biological father's current wife.

Current thoughts about self-injurious behavior. Jazzy discussed three dominant themes when conversing about her current thoughts regarding her daughter's self-injurious behavior. She first identified a concern for its *reoccurrence* after receiving treatment at her current level of care. She stated, "I don't know if she's gonna do it or not." Although this was Jazzy's statement, she did voice a greater *focus on other presenting problems*. She noted being "more worried" about her daughter running away or getting pregnant. Finally, Jazzy expressed a continued *lack of understanding*. "I don't know why she does it or I really can't explain it." Later she mentioned, "I don't know where she got this trauma from and that's what's so puzzling and bothering."

Current feelings about self-injurious behavior. When asked about what current feelings she had in regards to her adolescent's self-injurious behaviors, Jazzy voiced general *concern* and *hurt*. Jazzy reported, "I don't want her to do it. What I want for her is to be happy and healthy." As noted previously, she stated she was puzzled and bothered by her adolescent's participation in these types of behaviors. In regards to the hurt she feels, Jazzy noted to feeling *hurt* about having her daughter in the inpatient

residential psychiatric facility which led to their separation as well as the inability for her to lead a more normal life.

Current actions about self-injurious behavior. Jazzy noted *positive communication* when asked about her current actions in regards to her daughter's self-injury. She simply stated, "I made her promise me not to hurt herself." She also stressed, "I said, 'mommy, loves you so much'", when in discussion about her treatment issues.

How the parent-child relationship has changed. Jazzy focused on how she was building a *more positive relationship* through supporting her daughter when asked about how her parent-child relationship has changed since learning about her daughter's self-injurious behavior. She reported "I try to give her a lot of love...I'd say 'do you understand mommy loves you, I want the best for you, and I want you to be healthy and happy and not sad and not depressed'."

Post-interview thoughts. Jazzy had some difficulty recollecting her memories of her experience with her daughter's self-injurious behavior. Some of the statements she made in regards to her relationship between her and her daughter appeared conflictual upon review of the interview. She seemed open and wanting to share her experiences with me throughout the interview. She seemed eager to be part of the process and welcomed the idea of participating in member checking.

Phone debriefing. Jazzy was contacted for a telephone debriefing following our initial interview. She reported to have no uncomfortable feelings after our session. She had no additional questions and requested no additional help. She again expressed a willingness to participate in member checking.

Member checking. Jazzy reviewed the verbatim interview transcripts for member checking in person. She presented with casual clothing and appeared again uneasy as she sat upright in her chair and displayed frequent nervous hand movements. When asked about what additions or revisions she would make to the transcripts, Jazzy noted no major content areas that needed to be altered. The minor changes she pointed out were not impactful to the identified themes for each question.

Participant Three: Sweet T

Medical record review. Sweet T was a white female, single mother. She had two children, a twenty-four year old son and a fourteen year old daughter. She currently resided with her live-in boyfriend and her adolescent daughter. Her daughter was placed in an inpatient psychiatric residential facility. Her son remained in touch and lived in her near proximity.

According to documentation, there was a family history of mental health disorders. Sweet T had a history of depression and anxiety. Her daughter's biological father had been diagnosed with antisocial personality disorder.

The medical record showed that Sweet T's daughter's biological father was in prison for murder and had no contact with the family. The relationship between her daughter and her boyfriend was written as "best friends." There was a conflictual relationship shown between herself and her daughter as documented in a psychosocial assessment.

Reports indicated that both Sweet T and her daughter stated "growing up was fine." When her daughter hit puberty, this was when issues began to evolve. Approximately one year ago, Sweet T's daughter was raped. They later found out that the

individual that raped her was HIV positive. Testing has shown that her daughter has not contracted the virus. Approximately six months ago, Sweet T's daughter had sexual relations with a thirty-four year old man. A report was made to the police, but there was not documentation of follow through at the time of data collection. Sweet T's daughter had gathered charges for domestic violence and grand theft auto. She was on probation. It should be noted that there were conflicts noted in the medical record accounts between Sweet T and her daughter specifically in regards to sexual activity and drug use. Sweet T noted her daughter participating in sexual activity and drug use more frequently than her daughter's self-report.

Sweet T and her daughter had been involved in numerous therapeutic interventions and therapies. The medical record noted that her daughter had been seeing a psychiatrist since she was seven years old. There had also been individual therapy and family therapy conducted for a "significant amount of time." Her daughter had six crisis stabilization stays and she also had a 504 plan within the school system which provided support services while learning in the classroom setting based on her mental health diagnoses. It was reported that her daughter had a history of non-compliance with her medications and involvement in therapy.

Sweet T's daughter had numerous presenting problems noted in the medical record as reasons for treatment at an inpatient psychiatric residential facility. Anger, self-injurious behaviors, drug use, lying, stealing, and sexual behaviors were all identified as concerning issues. Sweet T's daughter had Axis I diagnoses of Acute Stress Disorder, Major Depressive Disorder, and Impulse Control Disorder. It should be noted that

although substance abuse was an identified problem, her daughter's use did not lead to a primary substance abuse or dependence diagnosis.

The treatment plan was specifically targeting anger management, self-destructive behaviors, and substance abuse. Treatment goals focused on no aggression or stealing for a minimum of sixty days, successful family therapy with passes that include no aggression, stealing, property destruction, or verbal abuse, and completing a substance use workbook program.

First impression. Sweet T presented neatly and casually dressed for our interview. She arrived on time and greeted me with a smile and a handshake. She entered the interview room and sat back comfortably in her chair. She was able to maintain eye contact while in discussion and would swing slightly back and forth in her chair while responding to questions. She had a soft voice so at times it was difficult to hear her. Sweet T voiced enthusiasm about helping out with this research as she noted that she was in the medical profession. She appeared open in her conversation and willing to discuss her personal experiences with her daughter's self-injury.

Presenting problems and diagnoses. When asked about the presenting problems and current diagnoses of her daughter, Sweet T identified several issues of concern. She initially discussed a variety of mental health diagnoses such as Posttraumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, depression, anxiety, and Bipolar Disorder that she wanted the psychiatrist "to wade through all those and see" what her daughter had. To further clarify, specific behaviors of concern that Sweet T noted were "sexually inappropriate behavior...poor impulse control, anger management, problems in school...compulsive

lying, stealing, personal stealing in the home...destruction of property.” Later in the interview, Sweet T also identified her daughter using marijuana, “being highly manipulative”, and her “behaviors just started going wild and out of control.”

I had to specifically question Sweet T about her daughter’s self-injurious behaviors which supported the theme of *minimization of the self-injurious behaviors*. It was following this question that Sweet T spoke about her daughter’s “jailhouse tats”, piercings, and also some cutting behaviors. Sweet T did not have a specific knowledge on the current diagnoses that her daughter had despite participation in her therapies and treatment planning. This fact lent to an identified *lack of knowledge* regarding her daughter’s present treatment focus.

Definition of self-injurious behavior. Sweet T’s response to defining self-injurious behavior focused on the *behavioral act of self-injurious behavior*, but she did identify that self-injury is *more than cutting*. She initially stated, “Well, obviously the cutting.” She then went on to discuss her view of her daughter’s self-piercings and gauging practices as “mutilating yourself”.

Finding out about the self-injurious behavior. Sweet T remembered the specific day that she learned about her daughter’s self-injurious behavior. She first spoke about her *lack of knowledge* in regards to the signs that were present before her finding out. “She had always worn long sleeves” and Sweet T assumed that this was in response to her keeping the air conditioning cool. She then discussed the events that occurred. Sweet T noted that her daughter had been suspended from school and had voiced suicidal ideations. She took her to the ER to get assessed for suicidality. While at the ER, a nurse or doctor, *someone other than her adolescent and in response to medical intervention*,

called her to look at her daughter's cuts on her forearm. She identified them as "some slashing or some cuts." Sweet T noted an *emotional reaction* of "total shock and surprise." She voiced her *behavioral reaction* which was to ask, "Why are you doing this?" However, her daughter chose not to give an explanation.

Reasons for self-injurious behavior. In responding to the reasons her daughter might have participated in self-injurious behaviors, Sweet T's answers focused on an *emotional release* and a *social influence*. "The cutting, I believe, is anger toward herself." She also stated they are "primarily acts of rage against herself" and "a way of getting out her rage."

She further discussed the *social influence* of her daughter's self-injury. She noted her daughter was experiencing stress at school and several of her peers had numerous piercings which might have affected the behavior. She also stated, the self-injurious behavior was "for her actions, for being pointed out that her actions don't follow life the status quo or what would be normal."

First thoughts when found out about self-injurious behaviors. Sweet T spoke about her *emotional reaction* and her desire to *understand 'why'* her daughter participated in these actions when asked about her first thoughts. Sweet T noted, "It frightened me" and discussed being in "total shock". She also reported "concern", but specified "it wasn't anger." Sweet T additionally noted thoughts of losing trust in her daughter and questioning whether she would do it again.

These emotional responses led her to question and try to understand, "What is going on inside of her or around her that is making her want to do this to herself?" She

also thought, “What in heck is going on in her life that I’m not aware of that is making her do this?” Another question she noted was “how long has she been doing this?”

First feelings when found out about self-injurious behavior. In response to the first feelings that she felt when Sweet T learned about her daughter’s self-injurious behaviors, she emphasized being *scared* and “frightened.” She also identified feeling *concern*, specifically being “concerned about her and concerned for her.” As noted previously and not specific to this question, but within the interview, Sweet T noted *surprise and shock* as well as feeling a *loss of trust* when learning about her daughter’s self-injury.

First actions when found out about self-injurious behavior. Two themes emerged among Sweet T’s responses to what her first actions were when she found out about her daughter’s self-injurious behavior. Sweet T discussed two separate *punitive behavioral responses* that ensued. She noted that due to the loss of trust she was no longer taking chances with her daughter. She reported that any following incident of self-injury would result in her involuntarily admitting her daughter to a crisis stabilization unit. “This is what we must do” was her rationalization for this action. Sweet T also reported on a self-injurious incident following her initial findings where she made her daughter wash out a wound with soap and water and then had her pour alcohol on it to “cause discomfort.”

In addition to a *punitive behavioral response*, Sweet T noted *seeking professional help*. She discussed bring her daughter for “doctor’s visits” in which she self-paid while waiting to fix her insurance. Once insurance came into place, Sweet T connected her

daughter with intensive therapy including visits to a psychiatrist and therapist. She noted that in therapy her daughter's cutting was discussed, but the act continued.

Description of the parent-child relationship. When discussing her parent-child relationship with her daughter, Sweet T focused on her *personal stress* in the relationship and the overall *stress in the relationship*. Sweet T reported they are in “a transition period” right now. She focused considerably on the trust issues that are between them. “Trust has to be earned and [her daughter] cried wolf so many times that, you know, I can’t always believe what [she] says.” In focusing on her *personal stress*, Sweet T noted “It’s more or less a time of R & R” having her daughter placed in the inpatient psychiatric residential facility. She voiced “getting too stressed out” and having “no recycling period from bouncing from one behavior to the next, to where I feel like I have had a major depressive episode.” She added that she was presently seeking her own therapy to address this stress.

How the parent-child relationship influenced the self-injurious behavior.

Sweet T initially stated their parent-child relationship had *no influence* on her daughter’s participation in self-injurious behavior. The only issue she believed might have influenced these actions related to the *family unit*. Sweet T stated, “Unknown to me, unless she did this as a way of if, say for instance, I denied her privileges for something, if she did that to herself because she got privileges denied for behavior.” She continued this statement by adding, “I don’t know”; thus, still emphasizing her belief that there is *no influence* from the parent-child relationship.

Other family members’ influence on the self-injurious behavior. When asked about how other family members might influence her daughter’s self-injurious behavior,

Sweet T quickly answered, “none”, an initial belief that there is *no family influence*. I attempted to explore other family members involved with her daughter and she reported that there is no contact from her daughter’s biological father. She did not address this further. She talked about her daughter’s brother and the ten year gap in age between the two. She made sure to note, “He’s not even in the home” and continued by saying, “She sees him as perfect...she sees him as a standard that she feels that she could never achieve.” Sweet T added, “But I have never compared the two.” When questioned if the perception her daughter has of her brother might have influenced her self-injury, Sweet T stated, “Possibly.” This suggested that there may be a *family influence* with a closer look into the family dynamics.

Current thoughts about self-injurious behavior. Two themes emerged among Sweet T’s responses to her current thoughts regarding self-injurious behaviors. Sweet T noted concern for *reoccurrence*. She discussed that despite the fact that her daughter “doesn’t have much opportunity to do any self-injury” in her present setting, she is “hypervigilant toward triggers” that might prevent future occurrences of self-injury.

The second theme that presented was having a general *lack of understanding* about the self-injurious behavior and her daughter’s participation in this type of behavior. Sweet T reported that following a recent self-injurious incident she talked with her daughter saying, “I thought you were like so already so over that...why the sudden regress?” Sweet T remarked, “This is totally unacceptable behavior” and that self-injury is “deemed taboo.” This response suggested a *lack of understanding* regarding the difficulty in treating and stopping self-injurious behavior. It also showed a *lack of understanding* and empathy for why self-injury occurs within her daughter’s situation.

Sweet T spoke about how if her daughter were to participate in self-injurious behaviors following her treatment at the inpatient psychiatric residential facility “I would feel that she faked all her little good stuff to get out of here, or none of it was effective.” She stated that she does not understand a recent self-injury incident and that regression back to this behavior “would be unacceptable.” These statements also suggested a more *punitive* thinking from Sweet T in regards to self-injurious behavior. This may again relate to her *lack of understanding* regarding the dynamics of self-injurious behavior.

Current feelings about self-injurious behavior. Sweet T voiced being *numb* and *concerned* when she discussed her current feelings in response to her daughter’s self-injury. She stated, “I honestly do not know” initially when asked this question. She then remarked, “I’m just burnt out.” She then discussed her concern for the effectiveness of her daughter’s present treatment if her daughter were to relapse when she returned into the community.

Current actions about self-injurious behavior. *Punitive communication* and a desire for *learning* presented as themes in Sweet T’s current actions in response to her daughter’s self-injury. She reported giving her daughter “stupid looks” in regards to a recent self-injury incident. As noted above, she communicated with a *lack of understanding* or sympathy toward her daughter during this incident as well. When discussing future self-injury, Sweet T reported she would say to her daughter, “You know the drill, here we go. And I would just Baker Act her.” She also stated, “We would have a talk, but I would probably be talking very loudly...and it’s not going to wait until the therapy session, it’s going to be told to you right now.” All of these statements suggested a negative and *punitive communication* style between Sweet T and her daughter.

Sweet T noted wanting to be more vigilant toward her daughter's triggers. This desire for *learning* about her daughter's stressors was mentioned when she discussed her current actions and preparations for her daughter coming out of treatment. This identification of triggers was also an issue that she was *learning* through the current treatment available to herself and her daughter.

How the parent-child relationship has changed. Three issues emerged when Sweet T was asked about how her parent-child relationship has changed since learning about the self-injurious behavior. Sweet T initially discussed a *more negative relationship* as it related to an increased lack of trust. She specifically noted a past self-injurious incident where her daughter used a scalpel. "What if she really got in a mode and added more pressure?" With this was also a *lack of understanding* in regards to the incidents of self-injury that her daughter has participated in. "I still cannot understand why she regressed back."

On a more positive note, Sweet T discussed a desire for *increased learning* about her daughter. She continued to state wanting to be able to identify her daughter's triggers. She also wanted to identify "better coping skills" for her daughter to prevent future regression.

Post-interview thoughts. Sweet T presented open and willing to discuss her thoughts, feelings, and actions in response to her daughter's self-injurious behaviors. It was noted that she placed the majority of responsibility for the actions on her daughter with minimal focus on the family influence. She voiced a continued concern for self-injury being "unacceptable" and "taboo."

Phone debriefing. Sweet T was contacted via phone for a debriefing following our interview. She reported having no questions from our session. She identified no unpleasant feelings or stress from our discussion and requested no additional resources or assistance.

Member checking. Sweet T presented in person for our member checking session. She was most concerned with the amount of “ums” in her verbatim interview transcripts. She made minimal grammatical corrections, none of which impacted the identified themes in her interview.

Participant Four: Precious

Medical record review. Precious was a white female and single mother to three adopted daughters. She had two fourteen year olds and an eleven year old. The two fourteen year old girls were not biologically related. The middle daughter was placed in an inpatient psychiatric residential facility. All of Precious’ daughters were Caucasian.

The medical record showed some inconsistencies. It was noted that Precious had her middle daughter since she was age four. This daughter was removed from her biological parents’ home due to sexual abuse from her biological brother as well as physical abuse in the home setting. One report stated that the daughter had minimal contact with her biological mother while another read there was a “no contact order” between the daughter and her biological parents. Approximately three years ago, the daughter’s biological father was murdered during a drug deal.

Precious’ daughter had several medical and therapeutic treatments through the years. Her daughter had been seeing a psychiatrist since she was five years old. She had several evaluations. There had been individual and family therapy on an outpatient basis

for many years. Although her daughter had never been admitted to a crisis stabilization unit, she had gone to a two week “locked facility” summer program. Her daughter, prior to her admission to the inpatient psychiatric residential program, was in a therapeutic group home placement for approximately nine months.

Precious’ daughter’s presenting problems were mood lability, self-injury, trauma history, oppositional behaviors, and substance use. Her Axis I diagnoses were Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. Treatment goals for her daughter were to have no self-injurious behavior for sixty days. She will also have successful participation in family therapy with passes that involve no stealing, verbal abuse, substance use, or elopement attempts. Her daughter will also work on the substance abuse workbook program that the facility uses.

First impression. Precious was escorted to the interview room by a facility staff. She met me at the door with a smile. She was neatly dressed in work casual clothing. She entered quietly and hesitantly sat in a chair. She initially sat upright and rigid, but as the interview progressed Precious’ body relaxed. She maintained eye contact throughout the session even when hesitating to think and respond about a question as well as when she became tearful. Precious appeared open to talking with me and appeared honest in her responses.

Presenting problems and diagnoses. When asked about the presenting problems that brought her daughter to the inpatient psychiatric residential facility and her current mental health diagnoses, Precious responded with some information congruent with the medical record. There appeared to be a *minimization of the self-injurious behavior* in comparison to other presenting problems and a slight *lack of knowledge* on her daughter’s

current diagnoses. She first identified “oppositional defiance, drugs, alcohol, running away” as presenting problems. Then she reported “self-harm” and “lack of respect for authority” suggesting a *minimization of the self-injurious behavior*.

Precious stated that her daughter’s current diagnoses were “oppositional defiance” and “alcohol and drugs.” Later in the interview, Precious remarked that her daughter also had “attachment disorder” and “bipolar.” As noted previously, based on the psychiatric evaluation and treatment plans, Precious’ daughter was diagnosed with Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. She failed to mention Attention Deficit Hyperactivity Disorder as a current mental health diagnosis and although she indicated substance abuse, attachment disorder, and bipolar as other current diagnoses, these were not noted in the medical record supporting a theme of *lack of knowledge*.

Definition of self-injurious behavior. Precious described self-injurious behavior as “anything that would purposely hurt the body, via food, drugs, alcohol, smoking. A purposeful choice to do it, even being aware of the consequences.” She focused her definition on the *behavioral act of self-injurious behavior*; however, she did note that self-injury is *more than cutting* behavior.

Finding out about the self-injurious behavior. Precious found out about her daughter’s self-injurious behaviors by *someone other than her adolescent*. She reported that she found out initially following a conversation between two of her daughters including her adolescent daughter who was residing at a therapeutic group home at the time and her youngest daughter. The youngest daughter living in her home told Precious

that her adolescent daughter tried “to kill herself because her younger sister [the one disclosing the information] made her leave home.”

With this disclosure, Precious contacted the therapeutic group home where her daughter was living to inform them of this information. The nurse “started looking and found scars.” Thus, Precious’ daughter’s participation in self-injurious behaviors was confirmed *due to a medical intervention.*

Reasons for self-injurious behavior. Precious’ responses in regards to the reasons her daughter might have participated in self-injurious behaviors focused on *trauma* issues either by *abuse* or neglect toward her daughter, *family mental health* concerns, or abandonment and *loss* issues. She noted, “She’s had a very, very rough childhood.” Precious went on to discuss how her daughter was “sexually abused by her brother.” This incident led her to be placed in foster care, but she was later placed back with her father who was on drugs. Her father’s drug use eventually led her to being placed back in foster care on and off for approximately three years. Her father was later murdered. Precious remarked that her daughter has gone through a lot of “emotional” situations in her lifetime.

A second reason Precious identified that her daughter might have participated in self-injurious behaviors was *control*. She stated, “She’s very frank that she does a lot of that because she wants to hurt me.” She further voiced, “She says it makes her know that she’s in control of her own body.”

First thoughts when found out about self-injurious behaviors. Precious’ first thoughts when she found out about her daughter’s self-injurious behavior centered on two themes, trying *to understand ‘why’* and a *lack of knowledge* on how to respond. Precious

stated, “My first thought was why wasn’t she being more supervised?” This statement showed Precious trying to *understand ‘why’* her daughter was within an environment that would allow such an action to occur. She then added, “And my second one was what can I do...to stop it?” This was in response to her *lack of knowledge* regarding how to handle her daughter’s self-injurious behavior.

First feelings when found out about self-injurious behavior. Precious identified only one feeling that she had when she first found out, “I was *scared*.” She noted she was *scared* when she first found out and “I still am to this day.” She explained this feeling by saying, “She doesn’t have a realistic view of things she does and how it could hurt her.” Precious further remarked, “I’m really more *scared* for her than anything.”

First actions when found out about self-injurious behavior. Precious had two distinct actions that she took when she first found out about her daughter’s self-injurious behaviors. She first took an *immediate behavioral response* by gathering information to phone in a report on the therapeutic group home where her daughter was staying for neglect. Her second action step was to *seek professional help*. Precious noted that she called the therapeutic group home to talk to them about the situation. She also “talked to the counselor that works with me and my other daughter.”

Description of the parent-child relationship. When asked to describe her parent-child relationship, Precious identified a theme of ongoing *change* from *closeness* to *distance* in their connection. She spoke of when her daughter being “very quiet” when she first came to her household. When Precious officially adopted her daughter, she reported getting her involved in sports and extracurricular activities which, in her words,

created “a changed girl. She was active and happy.” Precious specified, “There would be periods of time we would be very close, and she’d wanna talk and be with me and go places with me.” She went on to discuss how conflict began to emerge between the two of them about the time her daughter got her first period. She reported her daughter would say, “You can’t tell me I can’t wear one [a bra]” and she began to sniff “markers to get high.” She further discussed, “It was right around 12 that there was just a complete [change in attitude], where [her daughter would say] I don’t love you, I don’t wanna be with you, you can’t tell me, I’m old enough to make my decisions.”

How the parent-child relationship influenced the self-injurious behavior.

Precious’ response to how she felt the parent-child relationship influenced her daughter’s participation in self-injurious behavior focused on two themes, the dynamics of the *family unit* and *communication* between the two of them. Precious reported that her daughter “felt betrayed” because she was sent out of the home for more intensive therapeutic help. She further described how her daughter continued to act oppositional despite being told in therapy that her actions needed to change. “I don’t think she honestly ever thought that it would come to that place.” She voiced her daughter did not believe that she would be sent to a residential program and when this eventually occurred, “she very strongly feels I betrayed her by doing that.”

Precious further distinguished that the self-injurious behavior was a method of *communicating*. “She was so upset with me that she wanted to let me know, you know, that she was even going further.” Thus, from feeling “betrayed” and “upset” at being placed in a treatment program by her mother, Precious’ daughter communicated her discontent through her actions.

Other family members' influence on the self-injurious behavior. Precious reported a definite *family influence* to her daughter's self-injurious behaviors. Without hesitation, Precious began to discuss the relationships between her three daughters. She reported that her middle daughter (the one placed in an inpatient residential psychiatric facility) treated her oldest daughter "like her best friend" in order to manipulate her to get away with things in the home. Precious stated that as soon as the two go into public, her middle daughter ignores her older sister which creates "hurt" within this sister. This sister has hesitation on whether her younger sister can truly change and she was "very angry" with her.

Precious then discussed the relationship between her middle daughter and her youngest daughter. Her middle daughter was reportedly "very physically and verbally" abusive toward her. Precious noted that her middle daughter would tell the youngest daughter "terrible things" and then add, "Don't you dare tell mom." The youngest daughter would inevitably build up these secrets and "she would explode." The youngest daughter placed a lot of blame on herself for her middle sister's actions. The middle daughter made statements before that the youngest daughter "shouldn't have been in the family" instead "she [the middle daughter] was the last one to be adopted and she [the youngest daughter] shouldn't have been."

Current thoughts about self-injurious behavior. Two themes presented within Precious' remarks on her current thoughts of her daughter's self-injurious behavior. Precious voiced an *increased understanding* about her daughter and the relationship they share. She stated that therapy had been helping her daughter identify the long-term consequences of her actions. She discussed how "I think she knows more of why she

might be doing it.” Precious noted she still thought her daughter did not have a full realistic understanding of the things that she was doing and how they could hurt her. She also added that she was personally responding to less verbal abuse from her daughter to improve their interactions.

Precious voiced concerns for a *reoccurrence* of her self-injurious behaviors. She questioned whether stopping the self-injury was fully “resolved” in her daughter’s mind. Precious stated, “I probably don’t believe her” when she said she will never self-injure again. She further added, “In the back of my mind, I keep thinking, ‘well, the next time she gets mad that, you know, she’ll do it again’.” Later in the interview she remarked, “She’s just gonna do it again.”

Current feelings about self-injurious behavior. Precious’ responses to her present feelings about her daughter’s self-injurious behaviors focused on *concern*, *hurt*, and feeling *numb*. Precious voiced considerable concerns over her daughter’s actions. “I know I care, but part of me is like I’m not gonna care because she’s just gonna do it again.” She stated she felt “afraid” and “nervous” about the future of her daughter’s actions. She also felt *concerned* about “will I have the answers, will I know how to calm her down, will I be able to work with her effectively?”

Precious discussed feeling “*hurt*” by her daughter’s self-injurious behaviors and oppositional behaviors. She discussed the verbal abuse that she has gone through with her daughter and stated, “It’s not fair for me to hear that week after week.” She voiced her disappointment when she does not “see any responsibility” taken from her daughter.

Finally, Precious responded that “I kinda harden myself.” She spoke about the pain her daughter has caused the family. Precious discussed the problems that her

daughter has caused including possible losing her job. She discussed caring, but not wanting to care because “she’s just gonna do it again.” Essentially, Precious had made herself *numb* to the present communications and behaviors of her daughter due to the past of hurt, lack of responsibility, and lack of trust.

Current actions about self-injurious behavior. *Positive communication* was a theme to emerge among Precious’ responses to her current actions with regards to self-injurious behavior. She talked about giving her daughter every opportunity to be around the family. She also noted that despite her lack of trust she responds to her daughter with positive affirmations such as “I’m so glad you’re heading that way, you’re thinking that way, you’re realizing it.” As noted previously, Precious also talked about no longer taking verbal abuse from her daughter which additionally showed an increased use of positive communication strategies.

Protective actions were discussed by Precious as well. She stated, “There will be knives locked up...a lot more monitoring...whatever I can to keep the house safe.” She also discussed protectively about her other two daughters. “The bottom line” was her middle daughter. “My other ones are more important right now, even though she might be more ill. I can’t let her destroy the other two that’s also, you know, had a rough life.”

How the parent-child relationship has changed. When talking about how her parent-child relationship has changed, Precious focused on a *more negative relationship*. She discussed feeling “more hurt” due to the lack of responsibility that her daughter takes for her actions. She also discussed not trusting that her daughter was truly invested in stopping the self-injurious behavior. She made these comments several times throughout the interview.

Precious also remarked on how she was trying to create a *more positive relationship*. She discussed giving her daughter opportunities to be with the family including phone calls, visits, and future passes out of the facility. She remarked, “I still try to do everything for her, call her, spend time with her on the phone.” Additionally, Precious was attempting to break the cycle of verbal abuse by not accepting it and ending conversations that result in this type of communication.

Finally, Precious noted *increased learning* on how to interact more appropriately with her daughter. Her desire to no longer allow verbal abuse to occur when in conversations with her supported this improved dynamic. She also reported continued work in therapy with her daughter to work on these issues.

Post-interview thoughts. Precious provided brief, but open responses. She began the session appearing uncomfortable; however, as the session continued, her body language suggested that she began to relax as she sat back in her chair and her shoulders were more slouched instead of rigid. At conclusion of the interview, Precious asked about her daughter’s response to her participating in this research and appeared somewhat disappointed when I told her our interaction was matter-of-fact and focused on the assent form. This was suggested by a sigh and voicing a desire for her daughter to see the consequences of her behaviors.

Phone debriefing. Precious was contacted via phone for a debriefing session. She reported that she had no questions in response to our interview. She also noted no feelings of stress or discomfort resulting from our discussion. She asked for no additional resources or assistance.

Member checking. Precious participated in member checking via email correspondence. After reading the verbatim interview transcripts, she provided me with a written reply. Her email read, “This is an accurate account of our meeting. I have no changes.”

Table 2

Within-Case Analysis

Participant	Presenting Prob. & Diagnoses	Definition of SIB	First Time Learned	Reasons for SIB
Shadow	Lack of Knowledge Minimization of SIB	More than Cutting Psychological Aspect Lack of Knowledge	Adol. Disclosure Emotional Reaction Minimization of SIB Lack of Knowledge	Trauma Parenting Lack of Communication Guilt Personal Responsibility
Jazzy	Lack of Knowledge Minimization of SIB	Lack of Knowledge Psychological Aspect Behavioral Act of SIB	Someone other than Adol. Response to Med. Interv.	Lack of Knowledge Trauma Emotional Release Social Influence
Sweet T	Minimization of SIB Lack of Knowledge	Behavioral Act of SIB More than Cutting	Lack of Knowledge Someone other than Adol. Response to Med. Interv. Emotional Reaction Behavioral Reaction	Emotional Release Social Influence
Precious	Minimization of SIB	Behavioral Act of SIB	Someone other than Adol.	Trauma

Table 2 (cont.)

	Lack of Knowledge	More than Cutting	Response to Med. Interv.	-Abuse -Family Mental Health -Loss Control
<i>Within-Case Analysis</i>				
Participant	First Thoughts	First Feelings	First Actions	Describe Relationship
Shadow	Lack of Knowledge Emotional Reaction	Guilt	Immed. Beh. Response Seek Prof. Help Learning Lack of Knowledge	Stress -Relationship -Personal Distant Occasionally good
Jazzy	Take Action -To fix problem Understand 'why'	Protective Love	Removal from Situation Seek Prof. Help	Close Distant
Sweet T	Emotional Reaction Understand 'why'	Scared Surprise Shock Concern Loss of Trust	Punitive Beh. Response Seek Prof. Help	Stress -Personal -Relationship
Precious	Understand 'why'	Scared	Immed. Beh. Response	Change

Table 2 (cont.)

		Lack of Knowledge	Seek Prof. Help	Close Distant
<i>Within-Case Analysis</i>				
Participant	Rel. Influence	Other Fam. Influence	Current Thoughts	Current Feelings
Shadow	Family Unit Family Role Lack of Communication	Family Influence	Inc. Understanding -Regarding Adol. -Regarding SIB	Concern Anxiety Responsibility
Jazzy	No Influence Family Unit Family Mental Health	Family Influence	Reoccurrence Focus on Other Issues Lack of Understanding	Concern Hurt
Sweet T	No Influence Family Unit	No Fam. Influence Family Influence	Reoccurrence Lack of Understanding Punitive	Numb Concern
Precious	Family Unit Communication	Family Influence	Inc. Understanding -Regarding Adol. -Regarding Relationship Reoccurrence	Concern Hurt Numb
<i>Within-Case Analysis</i>				
Participant	Current Actions	Change in Rel.		
Shadow	Learning	Learning		

Table 2 (cont'd.)

	Inc. Understanding	Inc. Understanding More Pos. Relationship
Jazzy	Pos. Communication	More Pos. Relationship
Sweet T	Punitive Communication Lack of Understanding Learning	More Neg. Relationship Lack of Understanding Increased Learning
Precious	Pos. Communication Protective Actions	More Neg. Relationship More Pos. Relationship Increased Learning

Cross-Case Analysis

Cross-case analysis was conducted following the with-in case analysis again based on the recommendations of Hatch (2002). “Domains” and “terms” that were present across participant cases were identified and discussed. Additionally, some information that was counter to the identified dominant “domains” and categories was also noted. Table 3 summarizes these themes.

Presenting problems and diagnoses. Among the responses from all four participants regarding the presenting problems and diagnoses that their adolescent children had upon entering the inpatient psychiatric residential facility, there were some notable themes that presented. The only answer that all four participants discussed was some form of *substance use* in addition to other presenting issues and diagnoses. The type of substance used and the severity of the behavior were different between the participants. Each participant distinguished this as a presenting problem. Only two participants, Shadow and Precious, reported substance abuse being a current diagnosis despite this being contrary to the treatment plan and psychiatric evaluation within the medical record.

There were three identified problems or diagnoses that three out of the four parents reported. *Running away* was mentioned as a presenting problem in addition to the self-injurious behavior by Shadow, Jazzy, and Precious. *Bipolar*, noted by Shadow, Sweet T, and Precious, as well as *defiance*-related diagnoses, noted by Jazzy, Sweet T, and Precious, were also discussed as current mental health issues for the participants’ adolescent children.

Notably, three of the four parent participants did not identify self-injurious behavior as a presenting problem when asked initially during the interview. Precious was the only participant to note this issue without prompting from myself as the interviewer. All participants have children being treated for self-injurious behaviors in addition to other issues within an inpatient psychiatric residential facility as evidenced by the treatment plan, psychiatric evaluation, and psychosocial assessment within the medical record. This pattern presented a theme of *minimizing the self-injurious behavior* in comparison to other presenting problems and diagnoses. All participants noted several presenting problems and more than one mental health diagnoses for their adolescent child; however, these reports did not match the medical record which highlighted a *lack of knowledge* regarding important treatment information.

Despite *trauma* being noted in all four participants' children within the medical record, only two participants noted this as a presenting problem or current diagnosis. Jazzy reported a "little trauma" being a diagnosis and discussed her daughter witnessing domestic violence between her and her husband as a presenting problem. Sweet T also addressed trauma as a diagnosis, but failed to mention it in regards to a presenting problem.

Definition of self-injurious behavior. Shadow, Jazzy, Sweet T, and Precious all identified that self-injurious behaviors was *more than cutting*. There was a particular focus on the different *behaviors* that self-injury could include such as running away, gauging, and substance use.

Shadow and Jazzy spoke about the *psychological aspects of self-injurious behavior*. Shadow reported , "It's very deep internally and very emotional and

psychological.” Jazzy addressed a specific situation in which she noted her daughter’s depression and how she was told that she was hated. In her eyes, these factors led to her daughter harming herself.

Both Shadow and Jazzy also identified a *lack of knowledge*. Shadow reported that she was still learning about the issue and stressed this throughout our interview. Jazzy initially responded, “I don’t know” when asked to define self-injurious behavior. She needed to be prompted briefly in order to explore her thoughts more.

Finding out about the self-injurious behavior. Three of the four participants, Jazzy, Sweet T, and Precious, were notified about their daughters’ self-injurious behavior by *someone other than their adolescent child*. These findings were all *in response to medical treatment*. Jazzy spoke of learning about it from her ex-husband in response to her daughter’s participation in an outpatient program for self-injurious behaviors and receiving psychotropic medication. Sweet T learned from an emergency room worker after her daughter was brought there to be assessed for suicidality. Precious heard it initially from her youngest daughter, but the issue was later confirmed by staff at the group home facility where her daughter was receiving treatment at the time.

Three of the women discussed their *adolescent’s disclosure*; however, their experiences were very different. Shadow learned of her daughter’s self-injurious behavior directly from her. It was a discussion arranged possibly in response to therapy interventions. Sweet T noted that her daughter “chose” not to give an explanation for her self-injury. Precious reported that when she talked to her daughter about the self-injury, her daughter said it was “in retaliation of her being sent” away from the home for treatment.

Reasons for self-injurious behavior. Shadow, Jazzy, and Precious identified *trauma*-related issues as possible reasons for their adolescent's self-injurious behavior. Shadow referred to the domestic violence her daughter witnessed between herself and her husband. Jazzy reported her daughter experiencing verbal abuse from her adoptive father, Jazzy's ex-husband, as well as her witnessing domestic violence between herself and her ex-husband. Precious noted the sexual abuse, neglect, loss, and family mental health issues that contributed to her daughter's trauma which she, in turn, believes impacted her daughter's self-injury. It should be noted that although Sweet T identified Posttraumatic Stress Disorder as a current diagnosis for her daughter, she did not disclose trauma as a possible reason for her daughter's self-injurious behavior.

Jazzy and Sweet T spoke about the *emotional release* that self-injury provided their daughters. Jazzy stated, "She was hurting herself to get rid of the pain that she has inside of her." Sweet T noted her daughter's self-injurious behaviors were "anger toward herself." She further voiced the self-injurious behaviors were "primarily acts of rage against herself and perhaps a way of getting out her rage."

Jazzy and Sweet T also voiced the *social influence* that they believe contributed to their daughter's self-injurious behaviors. Jazzy spoke about the books her daughter reads and the movies she watches involving vampires. She termed them "dark and gritty" and questioned whether they might be part of why her daughter self-injures. Sweet T spoke about the influence of her daughter's peers. She reported that her daughter's peers have several piercings and she believed this affected her daughter wanting to participate in this type of behavior.

First thoughts when found out about self-injurious behaviors. Three of the four parents identified thoughts of *trying to gain an understanding of why* their adolescent was participating in self-injurious behavior. Sweet T was most specific with direct questions such as “why are you doing this?” and “what is going on inside of her or around her that is making her want to do this to herself?” Precious questioned the lack of supervision in the treatment facility that allowed for such behavior to occur and continue. Jazzy voiced possible answers for why she believed her daughter was self-injuring. These attempts to understand why the self-injury was occurring focused on a *desire to fix* the problem.

Two mothers, Shadow and Precious, discussed a *lack of knowing how to respond* when they learned about their daughter’s self-injurious behavior. Again, these thoughts focused on a *desire to fix* the problem. Shadow reported that she did not know how to cope or think about the information of her daughter’s self-injury. Precious asked, “What can I do to stop it?” when she found out about her daughter’s self-injurious behavior.

First feelings when found out about self-injurious behavior. The only emotion that was identified and shared by two of the four parents was being *scared*. Sweet T noted being “frightened” and “scared” when learning about her daughter’s self-injury. Precious stated, “I’m really more scared for her” in response to her daughter’s actions.

Analyzed in a different form, three of the four participants focused on feelings pertaining to *the situation* in which they learned about their child’s self-injurious behavior. Sweet T reported feeling “surprise” and “total shock.” Jazzy discussed feeling protective and wanting her daughter to come to live with her instead of in the situation

with her adoptive father that she believed influenced the self-injury. Shadow spoke of feeling “frustrated” and helpless. She voiced, “I just wanted to scream the word help.”

Sweet T and Jazzy also focused on feelings associated with *the relationship* they share with their daughters. Sweet T noted losing trust in her daughter. Jazzy spoke of loving her daughter “so much.”

Sweet T and Precious addressed their feelings regarding their *adolescent* child. Sweet T discussed “concern about and for” her daughter. She also voiced being “scared” for her daughter. Precious also noted being scared for her daughter.

An important note is that Shadow was the only participant to maintain a *parent* focus to her feelings when she first learned about her daughter’s self-injurious behaviors. Her responses spoke of personal “guilt.” She deemed herself responsible for her daughter’s actions and voiced, “I have made many mistakes.”

First actions when found out about self-injurious behavior. Two themes emerged among the responses of all four participants in regards to their first actions when they found out about their child’s self-injurious behavior. Each parent reported on their *behavioral response* to hearing this information. Positively, Shadow “cried” and “hugged” her daughter immediately within the conversation. Jazzy worked to move her daughter down to her home and Precious began to gather information to make a complaint regarding the neglect of the group home in treating her child. More punitively, Sweet T discussed placing her daughter in a crisis stabilization unit on an involuntary admission for every attempt following the initial disclosure of self-injury. She explained this based on a loss of trust and simply stated, “This is what we must do.” Sweet T also reported that at one point she made her daughter wash out her wounds with soap and

water knowing that it would “cause discomfort.” She then made her daughter rinse the wounds with alcohol.

The second theme to dominate the participants’ discussion was to *seek professional help* with therapy. All four parents discussed addressing the situation with the adolescent’s therapist and having the child work out the issues in *individual* sessions. Shadow, Sweet T, and Precious discussed participation in *family-based* counseling to also explore the issue.

Description of the parent-child relationship. Shadow, Jazzy, and Precious described their parent-child relationship as being *distant*. In focusing on their *adolescent’s influence* on the relationship, Shadow discussed her daughter as being “standoffish.” She voiced that her daughter “does not like or is not comfortable being in touch with her emotions.” Jazzy spoke of her daughter being dishonest and wanting to spend more time with her friends. Precious noted periods of time when her daughter would become defiant and “back off.” She stated her daughter would say, “I don’t love you, I don’t wanna be with you, you can’t tell me, I’m old enough to make my own decisions.” In focusing on the *parent’s influence* on the relationship, Shadow reported breathing issues that reacted to stress. To keep herself healthy, she would have to “retreat.” Jazzy discussed her own struggles with Posttraumatic Stress Disorder. She could not recall if her daughter ever opened up to her about her self-injury. She did note that she has never spoken with her daughter about her witnessing the domestic violence.

Shadow and Sweet T described the *stress* within their parent-child relationship. Shadow reported having “constant tension” and “unspoken anxiety” between herself and her daughter. Sweet T also discussed the *stress in the relationship* by describing

“conflict” and trust issues between herself and her daughter. Both participants also expressed the *stress within themselves*. Shadow reported that the anger and anxiety within her have been building as their relationship proceeds. Sweet T stated having her daughter in an inpatient psychiatric residential treatment facility is “more or less a time of R & R.” She admitted, “I was just getting too stressed out” to the point “where I feel like I have had a major depressive episode.” Sweet T described herself as being “constantly on high alert” and “an administrator and barker of orders” adding to her personal *stress*.

Jazzy and Precious identified that the relationship with their daughter has been *close* at times. Jazzy reported, “We like tell each other everything.” She also made sure to clarify that she has never abused her daughter including having never spanked her which she believed contributed to their closeness. Precious discussed how her daughter has periods of time where she will want to be close, be with her, and do things with her, but she noted that this is not a consistent state of their relationship.

How the parent-child relationship influenced the self-injurious behavior.

Issues pertinent to the *family unit* and the interacting family dynamics were noted among all four participants as potential influences for their child’s self-injurious behavior. More specifically, *abuse*, *separation*, and *response to consequences* were observed as common matters that the parents spoke of. Shadow spoke about the *abuse* her daughter witnessed and also addressed the *separation* between her daughter and her daughter’s father. She commented, “Our family relationship, our family dynamics, and with her father...the nine years without her father that I’ve parented” have influenced her daughter’s participation in self-injury. Jazzy spoke as well about her daughter witnessing the physical *abuse* between herself and her ex-husband. She also noted, “It got bad” when

she left her daughter and moved away to leave the abuse. Jazzy added that her daughter's self-injurious behavior may be *a response* to her being grounded too much. Precious spoke about her daughter being removed from the family environment to pursue treatment in a group home placement. She reported that her daughter "felt betrayed" by this *separation* and this might have possibly led to her self-injury. Sweet T spoke about her daughter participating in self-injurious behavior "as a way of, if I denied her privileges for something" in *response to consequencing her negative behaviors*.

Two parents, Shadow and Precious, spoke about how the self-injurious behavior may have been a form of *communication* within the relationship. Shadow reported that her daughter often commented to her that she was not listening. Instead of focusing on her daughter, she voiced feeling hurt by these remarks and she simply "didn't notice" what was going on with her daughter. Precious reported that her daughter was angry with her and "wanted to let me know that she was going to go even further" with her behaviors.

It should be mentioned that two parents, Jazzy and Sweet T, initially stated that the *relationship had no influence*. Jazzy spoke about the activities that she does with her daughter such as shopping and going to the beach. While addressing these activities, she noted that her daughter often wants to return home early to be with her friends. Sweet T answered "none" to this interview question. She did go on to note, as mentioned above, that her daughter's self-injurious behavior could be in response to being consequenced for her behavior.

Other family members' influence on the self-injurious behavior. Each parent discussed possible other family members that may have influenced their daughters'

participation in self-injurious behavior; although Sweet T initially responded “none” to the influence of the family and needed to be probed to discuss the situation further. The family influences discussed focused on *abuse, exposure to domestic violence, separation,* and *negative interactions.* Precious reported her middle daughter being *abusive* toward her siblings which influenced their relationships and interactions. Shadow discussed her oldest daughter being sexually molested by her grandfather and the family being unwilling to talk about it as well as their lack of involvement with this family member. Shadow and Jazzy spoke of their personal *domestic violence* situations and the fact that their daughters had to witness this abuse.

Shadow, Jazzy, and Sweet T spoke of *separation* between their daughters and certain family members. Shadow reported that one of her daughter’s grandparents lived in another state. This allowed for minimal contact and connection. Jazzy commented on the *separation* of her daughter from her adoptive father who had been minimally supportive since her move away from him. She also noted that her daughter recently met her biological father. Jazzy voiced that they never told her daughter she was adopted until recently when she began asking questions regarding her family history. Sweet T, although she did not identify a family influence, did report that her daughter had no contact with her biological father when questioned further about family involvement.

Shadow and Jazzy noted the *negative interactions* between their daughters and other family members which might contribute to the self-injury. Shadow noted a grandmother who was “critical and judgmental” toward her daughter. She noted this grandparent lived in the same town and “I know that that relationship’s affected” her daughter. Jazzy spoke about the lack of support from her daughter’s adoptive father. She

noted he did not call her daughter instead he would send “monetary” items. She specifically spoke of a recent gift in which he also included a small note. Jazzy commented on how her daughter was more interested in keeping the note safe than on using the gift given.

Current thoughts about self-injurious behavior. When asked about what current thoughts they have in regards to their child’s participation in self-injurious behavior, two themes presented. A *lack of understanding* specific to *the self-injury* was noted among three of the four parents. Shadow spoke about not realizing the extent and impact of self-injurious behavior and what it all involves. Jazzy reported that she does not understand why her daughter participates in these actions and she does not know “where she got this trauma from.” Sweet T voiced difficulty understanding why her daughter continued to participate in self-injurious behavior. She termed the action “taboo” which suggested a *lack of understanding* with regards to the reasons for self-injury as well as the difficulty her daughter had in diminishing her participation in this type of behavior.

Three parents discussed their thoughts about the *reoccurrence* of self-injurious behavior. Jazzy commented that she was unsure whether her daughter would continue this behavior after treatment. She further discussed that she was more concerned about her running away and getting pregnant. Sweet T reported that relapse would be “totally unacceptable.” She voiced her thoughts that if her daughter began to self-injure again she would believe the treatment was “faked” and “none of it was effective.” Precious discussed her concerns that her daughter was not invested in stopping. She stated that she did not believe her daughter when she said she would not self-injure again. She believed that when her daughter gets mad in the future she will start again.

Current feelings about self-injurious behavior. All four participants spoke about their feeling of *concern* regarding their adolescent's self-injurious behavior. Shadow voiced being "apprehensive" about her daughter coming home when discharged from the treatment facility. Jazzy talked about not wanting her daughter to do it again and being "puzzled" and "bothered" by her daughter's actions. Sweet T noted concerns for relapse and how if her daughter continued to self-injure the work done in treatment would have been unsuccessful. Precious stated she was "nervous" and "afraid" about the behaviors of her daughter. She discussed worrying about being able to effectively handle her daughter when she was returned home.

Two parents, Jazzy and Precious, reported being *hurt* by their child's self-injurious behavior. Jazzy spoke about her hurt in regards to her daughter being placed currently in an inpatient psychiatric residential facility instead of being at home with her. Precious noted the hurt she felt in regards to her daughter's verbal abuse toward her and her continued lack of taking responsibility for her actions.

Sweet T and Precious additionally noted being *numb*. Sweet T stated she was "burnt out" and that she was experiencing "R & R" with her daughter being in an inpatient psychiatric residential facility. Precious discussed being "hardened." She commented on how she did not believe her daughter's statements regarding her self-injury. She also discussed, "I know I care, but part of me is like I'm not gonna care because she's just gonna do it again."

Current actions about self-injurious behavior. Three parents discussed *communication* in regards to their current actions in response to their daughter's self-injurious behaviors. Two of these parents, Jazzy and Precious, noted more *positive*

communications with their child. Jazzy stated she “made her [daughter] promise not to hurt herself.” She also discussed telling her daughter, “Mommy loves you so much.” Precious spoke about providing her daughter with positive affirmations and responses to her treatment progress. She also noted giving her daughter every chance to be with the family to improve relationships and communications with increased time together.

Sweet T discussed *communication*; however, her current actions in response to her daughter’s self-injury expressed a *punitive* reaction. She noted a recent situation in which her daughter had participated in self-injury. Sweet T reported, “I just gave her, not a bad look or sad look, but just kind of like stupid looks are free...I mentioned I told her, I thought you were like so already over that...why the sudden regress?” She commented that if her daughter would self-injure again in the future she would say, “You know the drill and I would just Baker Act her.” She also voiced, “We would have a talk, but I would probably be talking very loudly.” Further, she noted the talk would not wait until therapy. “It’s going to be told to you right now” was her remark.

Shadow and Sweet T discussed *learning* as an additional current action. Shadow noted several therapeutic modalities that she was using to learn more about herself, her daughter, and her daughter’s issues. The interventions she discussed were individual therapy, family therapy, and community support groups. Sweet T spoke about learning her daughter’s triggers as well as her own daughter learning new coping skills in order to improve her daughter’s participation in self-injurious behavior.

Precious was the only parent to discuss *protective actions* that she will be taking to keep her daughter safe. She reported that she would be locking up the knives when her

daughter returns home. She also discussed increased monitoring of her daughter and doing anything “to keep the house safe.”

How the parent-child relationship has changed. In addressing the changes made to their parent-child relationship, three parents noted *increased learning* specific to *their adolescent* and *their communication*. Shadow spoke of being “more aware of her, who she is inside, of what’s going on” while referring to her daughter. She further mentioned, “I’m learning that truly [her daughter’s] a victim because I didn’t see that.” Sweet T discussed learning her adolescent’s triggers to help with future prevention.

In regards to *increased learning* through *communication*, Shadow voiced, “We do need to stop and we need to take the time and listen and learn and grow together.” She spoke about learning to interact with her daughter “without falling down.” Precious addressed the verbal abuse that she has taken from her daughter. She reported that this was no longer acceptable and she refuses to listen to these harsh words.

All four parents commented on the *relationship* between themselves and their adolescent. Shadow, Jazzy, and Precious noted *positive changes* made within the relationship. Shadow reported having more “compassion” and wanting to be closer with her daughter. She stated that she feels treatment has given their relationship “another chance.” Jazzy spoke about giving her daughter “a lot of love.” She noted telling her, “I want the best for you and I want you to be healthy and happy and not sad and not depressed.” Precious voiced, “I still try to do everything for her” including talking on the phone, visiting, and participating in therapy sessions.

Sweet T and Precious commented on *negative changes* to the *relationship*. When asked about changes in the relationship, Sweet T only noted the loss of trust between her

and her daughter. Precious spoke about the strain on the relationship with her daughter when she does not “see any responsibility” taken for her daughter’s actions.

Table 3

Cross-Case Analysis

Questions Terms	Thematic Domains	Thematic
Presenting Prob. & Diagnoses	Substance Use Running Away Bipolar Defiance Minimization of SIB Lack of Knowledge No trauma focus	
Definition of SIB	More than Cutting Psychological Aspects Lack of Knowledge	Behaviors
First Time Learned Med. Tx	Someone Other than Adol. Adolescent Disclosure	Response to
Reasons for SIB	Trauma Emotional Release Social Influence	
First Thoughts	Understand ‘why’ Lack of Knowing how to Respond	Desire to fix Desire to fix
First Feelings	Scared Feelings About the Situation Feelings About the Relationship Feelings About the Adolescent Feelings with a Parent Focus	
First Actions	Behavioral Response Seek Professional Help	Individual Family-based

Table 3 (cont.)

Describe Relationship	Distant Stress Close	Adolescent's Influence Parent's Influence In the Relationship In self
<i>Cross-Case Analysis</i>		
Questions Terms	Thematic Domains	Thematic
Relationship Influence	Family Unit Communication No Influence	Abuse Separation Response to Conseq.
Other Fam. Influence	Abuse Exposure to Domestic Violence Separation Neg. Interactions	
Current Thoughts	Lack of Understanding Reoccurrence	Regarding SIB
Current Feelings	Concern Hurt Numb	
Current Actions	Communication Learning Protective Actions	Positive Punitive
Change in Relationship	Increased Learning Relationship	About Adol. About Comm. Positive Changes Negative Changes

This chapter looked at themes that emerged through a with-in case analysis and across case analysis based on parent interviews, medical record reviews, and member checking in regards to parent experiences with their adolescent child's self-injurious behavior. Several themes were apparent among all participants including discussion of substance use as a presenting problem, trauma history noted within the medical record, identifying that self-injurious behavior is more than cutting, noting a behavioral response to first learning about their child's self-injury, seeking professional help, the parent-child relationship influencing the self-injurious behavior through issues pertaining to the family unit, identifying other family members influence on the self-injurious behavior, concern for the adolescent child, and noted changes within the parent-child relationship since learning about the self-injury. Other themes emerged and were noted; however, they were not expressed by all participants. The following chapter will review these themes within the context of current literature on the subject of self-injurious behavior.

Chapter Five: Summary and Conclusions

This chapter will review the identified themes found in the four parent interviews, medical record reviews, field notes, and member checkings within the context of current literature and research on the subject of self-injurious behavior. Clinical implications for these identified themes will be discussed. The limitations of this study as well as recommendations for the use of the present findings and for future research in this area will additionally be reviewed.

Review of Themes within the Literature

Within the responses given by the parents, the reviews of the medical records, the gathered field notes, and the member checking sessions, each interview question presented identified themes. Several themes were supported in the literature and research on parents, adolescents, and self-injurious behavior. Other responses were new contributions to this area of study and will require future research as noted.

Presenting problems and diagnoses. Parent participants discussed *substance use, running away, bipolar, and defiance* as presenting problems and diagnoses that contributed to their adolescent's admission to an inpatient psychiatric residential facility. More specifically, all four parents noted *substance use* as a presenting issue. Substance abuse and substance dependence diagnoses have been shown in the research to be common among individuals who participate in self-injurious behaviors (Haw et al., 2001; Nock et al., 2006; Olfson et al., 2005). Although the participant's adolescent did not have a primary or secondary diagnosis of a substance-related disorder in order to meet criteria

for this study, the prevalence of these issues among individuals who self-injure is supported in the research (Haw et al., 2001; Nock et al., 2006; Olfson et al., 2005). Additionally, mood disorders such as *Bipolar* Disorder have been shown to have a high occurrence in individuals who participate in self-injurious behavior (Haw et al., 2001; Nock et al., 2006; Olfson et al., 2005). *Running away* and *defiance* may fall under the scope of several mental health disorders; however, Nock et al. (2006) did note a presence of Oppositional Defiant Disorder among individuals who self-injure as well.

The present study presented a theme of *minimizing the self-injurious behavior* among the parent participants. As noted, each adolescent was admitted to the inpatient psychiatric residential facility for several presenting problems including self-injurious behavior. The *minimization of the self-injurious behavior* may be due to the severity and number of other mental health issues. Future research may serve to look at this possible connection. This will be further noted in the recommendations for future research section of this paper.

Literature suggests that individuals who self-injure sometimes come from emotionally-absent parents (Conterio & Lader, 1998). This lack of an emotional attachment may result in the parents not acknowledging the severity or importance of specific treatment issues particularly the self-injury as explored in this study. Rissanen et al. (2008) also noted that parents do not know much about the phenomenon of self-injurious behavior. Their research also showed that parents acknowledge a lack of discussion around the issue which also may contribute to a *minimization of the self-injurious behavior*. Further, Rissanen et al. (2008) noted parental “blindness” to the

actions of their child who was participating in self-injury among the participants of their study. Again, this may influence *the minimization of the self-injurious behavior*.

Definition of self-injurious behavior. Shadow, Jazzy, Sweet T, and Precious all acknowledged that self-injurious behavior is *more than cutting*. They focused on other behaviors that are included on the spectrum of self-injurious behavior. Literature and research shows that self-injurious behavior can involve a variety of different actions such as burning one's self, self-hitting, or interrupting normal bodily healing (Alderman, 1997; Conterio & Lader, 1998; Favazza & Conterio, 1989; Klonsky, 2007a; Klonsky & Muehlenkamp, 2007).

Two parents focused on the *psychological aspects of self-injurious behavior*. They noted their daughter's feeling "pain", "hurt", and "rage" which influenced their participation in self-injurious behavior. Individuals who self-injure experience heightened emotions in addition to showing deficits in several areas including emotional awareness, appropriately communicating emotions, and positive coping (Klonsky & Muehlenkamp, 2007). This suggests the "emotional and psychological" experience that is often involved in self-injurious behavior.

A final theme noted among two of the participants was a *lack of knowledge*. Literature on individuals who are involved with a family member who participates in self-injurious behavior has minimally explored the extent and type of knowledge that these individuals have in regards to the act of self-injury. Rissanen et al. (2008) noted that parents had difficulty perceiving the phenomenon of self-injury and they were unfamiliar with the issue. This may be a direction for future research in this subject area and is noted in the recommendations for future research.

Finding out about the self-injurious behavior. Three of the four parents learned about their child's self-injurious behavior from *someone other than their adolescent child*. For all three participants, this was *in response to medical treatment*. Yip et al. (2003) found that the all of the parents interviewed in their study of parental response to adolescent self-injury discovered their child's self-injury by accident. Although they were not told by other people or in response to medical treatment, the adolescents did not intend to disclose their actions to their parents.

Three of the parents in this study discussed their *adolescent's disclosure* about the self-injury. Although only one parent found out directly from her adolescent daughter, the other parents reported on how their adolescent daughters responded when approached about the act of self-injury after the parents found out about it from an alternative source. Research has not specifically reviewed this event of personal disclosure about one's self-injurious behavior. This may be an area for future qualitative inquiry and is noted in the recommendations for future research.

Reasons for self-injurious behavior. *Trauma* was identified as a theme among the responses the parents had regarding the possible reasons their child participated in self-injurious behavior. Childhood maltreatment in the form of physical, psychological, and sexual abuse has been shown to be a common factor among individuals who participate in self-injurious behavior (Briere & Gil, 1998; Favazza, 1996; Gratz, 2006). Dysfunctional family patterns involving abuse, neglect, loss, sickness, and instability are also associated with individuals who self-injure (Conterio & Lader, 1998). Additionally, trauma reenactment has been reported as a possible purpose for an individual

participating in self-injurious behavior within the literature (Alderman, 1997; Clarke, 1998; Ng, 1998).

Two parents noted the *emotional release* that self-injury may provide for their daughters. Affect regulation has been shown to be a primary reason for individuals to participate in self-injurious behavior (Alderman, 1997; Gratz, 2007; Kamphuis et al., 2007; Kleindienst et al., 2008; Klonsky & Muehlenkamp, 2007; Machoian, 2001; Nixon et al., 2002; Plante, 2007; Rodham et al., 2004). The self-injurious behavior acts as a method for relief from strong negative emotions including anger, depression, or anxiety. Parents interviewed by Rissanen et al. (2008) also shared this conception that self-injurious behavior is related to attempts to relieve negative feelings.

Jazzy and Sweet T discussed the *social influence* that may have contributed to their daughter's participation in self-injurious behavior. Research has also shown that social contagion is a factor in self-injurious behavior (Cerel et al., 2005; Clarke, 1998; Derouin & Bravender, 2004; Hawton et al., 2002; Laye-Gindhu & Schonert-Reichl, 2005; Lloyd-Richardson et al., 2007; Nixon et al., 2002; Nock & Prinstein, 2004; Plante, 2006; Ross & McKay, 1979). Although not a primary reason for participating in self-injurious behavior, being accepted in a group has been a noted function among individuals who participate in this action (Laye-Gindhu & Schonert-Reichl, 2005; Lloyd-Richardson et al., 2007; Nixon et al., 2002; Nock & Pristein, 2004). This parent perception that self-injurious behavior may be influenced by social factors was also present among parent participants interviewed by Rissanen et al. (2008). In this research, one participant characterized self-injury as "trendy" which served as a discussed factor for participation in this behavior.

First thoughts when found out about self-injurious behaviors. When asked about the first thoughts that occurred when they learned about their child's self-injury, three parents noted *trying to gain an understanding of why* the behavior had occurred. Two parents discussed a *lack of knowing how to respond*. Further, these thoughts were both with an intended *desire to fix* the problem. The literature and research available on parent responses to their adolescent's self-injurious behavior does not explore this specific area. The attempt to understand the behavior may relate to the confusion and unfamiliarity noted among parents by Rissanen et al. (2008) when discussing the phenomenon of self-injury. Future research would benefit from looking at this thought process more in-depth. This is further noted in the recommendation for future research section.

First feelings when found out about self-injurious behaviors. When addressing the first feelings that were associated with learning about their child's self-injurious behaviors, the parents focused on different aspects of the event. Feelings in response to *the situation* were noted as well as feelings about *the relationship* and *the adolescent child*. Only one parent, Shadow, maintained a *parent* focus in responding to this interview question when she spoke about her personal feelings of "guilt" and "responsibility."

Two of the four parents noted being *scared* when they learned about their child's self-injury. This emotion is supported in the literature as a common reaction of parents (Alderman, 1997; Conterio & Lader, 1998; Levenkron, 1998; Plante, 2006; Walsh & Rosen, 1988; Yip et al., 2003). The lack of a unified theme among all the participants would be expected based on the mix of emotions that the literature has shown occurs to

parents when they learn about their child's self-injurious behavior (Alderman, 1997; Conterio & Lader, 1998; Levenkron, 1998; Plante, 2006; Wagner et al., 2000; Walsh & Rosen, 1988; Yip et al., 2003).

First actions when found out about self-injurious behaviors. Two themes emerged among the actions the four parents took when they found out about their child's self-injurious behavior. Each parent voiced having a *behavioral response* as well as pursuing *professional help* through counseling *for the adolescent* and *for the family*. Yip et al. (2003) reviewed the behavioral responses of the parents they interviewed and noted they attempted to rid themselves of the complicated feelings related to their child's self-injury. Although the parents within this study did not share similar behavioral patterns, it suggests that parents will have a noted behavioral reaction to learning about their child's self-injury. It also suggests the variety of responses that individuals have which may depend on individual and family variables. This may be an interesting issue for future research and is mentioned in the recommendations for future research.

All four parents sought *professional help* after learning about their child's self-injurious behavior. Research has shown the benefit of psychotherapeutic approaches in treating self-injury (Klonsky & Muehlenkamp, 2007). Additionally, therapy including family members has been shown to be helpful (Hawton et al., 2006; Miller et al., 2007; Walsh & Rosen, 1988). The population of this study should be noted with this identified theme. All of the parents and their adolescents had been involved previously in various forms of therapy and psychiatric care, so it would be understandable that this would be an identified action. Despite this fact, this is a positive and effective response to learning about their adolescent's self-injurious behavior.

Description of the parent-child relationship. A theme identified regarding the parent-child relationship involved the parent and adolescent being *distant*. This was due to various responses that *the adolescent* and *the parent* contributed to the relationship. Another theme noted was *stress in the relationship* and *stress within themselves as individuals*. Research has shown that families who have an individual that self-injures often share a negative emotional climate (Conterio & Lader, 1998; Crowell et al., 2008; Favazza, 1996; Hawton et al., 2006; Levenkron, 1998; Ng, 1998; Sim et al., 2009; Strong, 1998; Walsh & Rosen, 1988; Wedig & Nock, 2007; Yates et al., 2008; Yip et al., 2003). This may be due to a variety of reasons such as emotionally intrusive parenting, emotional absent parenting, rigid standards or expectations, anxiety, trauma, instability, abuse, illness, or separation (Conterio & Lader, 1998). In the situations of each parent within this study, several of these aspects of the family environment were present.

A *close* relationship was noted by two parents. Although the relationship was not consistently *close*, these parents felt it was important to identify this relationship dynamic within the interview. This again suggests the instability of the family environment and ensuing relationships among its members (Conterio & Lader, 1998).

How the parent-child relationship influenced the self-injurious behavior.

Issues relating to the *family unit* and dynamic were identified among all participants of this study. Specifically, *abuse*, *separation*, and *response to consequences* were noted by the parents as affecting their child's participation in self-injurious behavior. *Abuse* and *separation* have been shown to influence an individual's use of self-injury (Conterio & Lader, 1998). Nock & Prinstein (2004) identified social negative-reinforcement as a

potential function for self-injurious behavior. This would include self-injuring to avoid doing something unpleasant or to avoid paying consequences for certain behaviors.

Self-injurious behavior as a form of *communication* within the relationship was identified by two parents. Self-injury as a means to communicate distress or feelings has been supported in the research (Alderman, 1997; Conterio & Lader, 1998; Lloyd-Richardson et al., 2007; Machoian, 2001; Nixon et al., 2002; Nock & Prinstein, 2004; Plante, 2006; Rodham et al., 2004). The inability to communicate in an appropriate and healthy manner may be influenced by the negative family emotional climate and environment that surround these individuals. As noted previously, “anything less than a dramatic gesture goes ignored” (Conterio & Lader, 1998, p. 78) in these family environments.

Two parents initially stated that the *parent-child relationship had no influence* to their child’s participation in self-injurious behavior. Future research needs to explore this response further. This will be noted in the recommendations for future research. However, this reaction may be due to the lack of knowledge and confusion that parents have in regards to self-injury and the reasons it occurs as well as the functions that the behavior serves (Rissanen et al., 2008). Considering the unhealthy family dynamics and environments that are often associated with individuals who self-injure, a minimization of parental responsibility in the action or parental criticism toward the adolescent child may be the reason for not acknowledging a parent-child relationship influence to the individual’s self-injurious behavior (Conterio & Lader, 1998).

Other family members’ influence on the self-injurious behavior. A noted *influence of other family members* was present among each parent in this study. More

specifically, the parents noted *abuse*, *exposure to domestic violence*, *separation*, and *negative interactions* as possible situations with other family members that may have influenced their child's participation in self-injurious behavior. Again, the research in this area supports these dynamics and family interactions (Conterio & Lader, 1998).

Current thoughts about self-injurious behavior. Two themes emerged among the parents in regards to their current thoughts about their adolescent's self-injurious behavior including a *lack of understanding regarding the self-injurious behavior* and thoughts about *reoccurrence*. As noted previously, Rissanen et al. (2008) also identified a parent lack of knowledge regarding this issue. *Reoccurrence* is a new theme identified among parents who have adolescents that participate in self-injurious behavior. This may relate to the *lack of understanding regarding the self-injurious behavior* as well as the diverse emotional reactions that are often found among parents within this population (Alderman, 1997; Conterio & Lader, 1998; Levenkron, 1998; Plante, 2006; Walsh & Rosen, 1988). This also could connect to the identified theme of feeling *scared* that two of the parents felt when they first learned about their child's self-injurious behavior. More research is needed to explore this issue of *reoccurrence* present in the thoughts of parents who have an adolescent that participates in self-injurious behavior. This is mentioned in the recommendations for future research section.

Current feelings about self-injurious behavior. *Concern* was an identified theme in the current feelings the parent participants had in regards to their adolescent's self-injurious behavior. This is supported by the various emotions that parents feel as noted previously (Alderman, 1997; Conterio & Lader, 1998; Levenkron, 1998; Plante, 2006; Walsh & Rosen, 1988). It may also be related to the theme of *reoccurrence* that

was noted among the current thoughts that parents have. Future research would have to probe this relationship further as is noted in the recommendations for future research section of this chapter.

Feeling *hurt* and *numb* were additional themes identified by the parent participants. Again, this supports the research that notes there are diverse emotional experiences among family members who find out about the self-injurious behavior of a loved one (Alderman, 1997; Conterio & Lader, 1998; Levenkron, 1998; Plante, 2006; Walsh & Rosen, 1988). Future research may benefit to explore how these emotions may influence the relationship dynamics between the parents and children. Additionally, how these feelings may influence active participation in their adolescent's treatment would also be useful particularly when they are being treated at this level of care. These are noted in the recommendations for future research.

Current actions about self-injurious behavior. Conversely, *positive* and *punitive communication* were identified as themes by the interviewed parents as current actions taken when dealing with their adolescent child's self-injurious behaviors. Yip et al. (2003) noted similar responses as one parent facilitated a positive interaction between two family members and two parents provided material compensation to ease the adolescent child's negative emotions instead of involving positive communication. Also in the research is support for parental criticism that is often present in families who have an individual who participates in self-injurious behavior which serves as an additional aspect of negative communication styles within these family environments (Wedig & Nock, 2007; Yates et al., 2008).

Further *learning* on the topic of self-injurious behavior and specific to their adolescent child was noted by two parent participants. This again suggests the *lack of knowledge* and confusion that parents experience in regards to this issue (Rissanen et al., 2008). This theme may relate to the parent's thoughts of *reoccurrence* and feelings of *concern*. Future research may want to look at the thoughts and motives behind learning more about self-injury when involved with a family member who participates in this type of behavior. This is noted in the recommendations for future research.

Protective actions were only noted by one parent. This was based on steps she would take to protect the home, the individual members, and the adolescent who participates in self-injurious behavior. This action response to learning about a family member's self-injurious behavior has not been reviewed in the literature and may be a future direction for other research which is again noted in the recommendations for future research.

How the parent-child relationship has changed. *Increased learning about the adolescent and parent-child communication* was identified by three parent participants. This again suggested a *lack of knowledge* to begin (Rissanen et al., 2008). The observation of learning more about the adolescent child may relate to the emotionally absent parenting or negative family emotional climate that surrounded the parent and child before the disclosure of the self-injury was made (Conterio & Lader, 1998). Communication is a noted challenge for the individual who self-injures particularly when one includes a negative family environment (Gratz, 2006; Klonsky & Muehlenkamp, 2007; Zlotnick et al., 1996). More open communication within the parent-child

relationship is an important condition for families who have an individual who participates in self-injurious behavior (Alderman, 1997).

Positive changes and negative changes in the relationship were mentioned by the parents studied as an after product of their adolescent's self-injury. More "compassion" and "love" was identified among the parents as positive aspects of change within the parent-child relationship. An increased loss of trust and continued strain on the relationship were discussed as negative changes within the relationship. The literature notes instability in the family relationships of individuals who participate in self-injury (Conterio & Lader, 1998). These themes support the continued inconsistency within the parent-child relationship even after the disclosure of an individual's self-injurious behavior.

Revisiting Conceptual or Substantive Assumptions

Two assumptions were made at the beginning of this research study. First, it was assumed that the parent participants would have a variety of responses to finding out about their adolescent's self-injurious behavior. This assumption was supported in the data that were collected. Each parent identified different and various thoughts, feelings, and actions in regards to learning this information. Although their cognitive, emotional, and behavioral responses were analyzed based on their thematic content within each case and then across cases, each parent reported unique experiences and there were distinctions in their recollections.

The second assumption was that the parents would identify that the parent-child relationship influenced the adolescent's self-injurious behavior to a certain extent. This assumption was also supported with the collected data. Each parent identified this

influence. There were two parents that initially reported there was no relationship influence to their child's self-injurious behavior; however, they then went on to discuss situations within the relationship that may have been influential such as their need to consequence negative behaviors.

Revisiting Systems Theory

Systems theory in the context of a family unit looks at individuals in interaction and relationship with one another (Becvar & Becvar, 1982; Goldenberg & Goldenberg, 2000, 2005). This study explored how the self-injurious behaviors of the family's adolescent child have influenced the parent with a specific focus on the parent's thoughts, feelings, and actions as well as their perception of the parent-child relationship. This was done with a qualitative, in-depth exploration of the parent experience. The study also examined the influence that the family unit, including the parent, may have had on the self-injurious behaviors of the adolescent. Each participant noted having been influenced by the actions of their child. They also addressed how the family unit, including relationships and interactions between the members, may have influenced the adolescent child's participation in self-injurious behavior. This supports the systems theory assumption that the actions of one individual affect the whole system just as the system influences the individual (Goldenberg & Goldenberg, 2000, 2005).

Systems theory is an important framework to use due to the large number of people that are affected by self-injurious behavior (Briere & Gil, 1998; Klonsky, Oltmanns, & Turkheimer, 2003; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Nock & Prinstein, 2004; Ross & Heath, 2002; Whitlock, Eckendore, & Silverman, 2006). The basic systems theory assumptions that all individuals within a system are connected,

that an individual's issues are related to the system in which they are part of, and that everything within the system affects the system itself and vice versa (Klein & White, 1996) emphasizes the importance of understanding an individual in context of the family system in which they reside. This is significant in order to comprehend the individual's mental health issues. In considering this family environment, one might be able to identify the reasons behind self-injurious behavior as well as solutions to the problem.

Clinical Implications

There are some important clinical implications for the uses of this research. Several themes emerged throughout the study and the usefulness of implementing these themes within a clinical environment may prove helpful when working with this population. The clinical implications are as follows:

- Parent education about self-injurious behavior is necessary. Parents have a lack of knowledge and several misconceptions concerning many variables related to self-injury. How self-injurious behavior is defined, what the functions of self-injury are, and how the behavior can be handled appropriately are areas in which parents may benefit from more information.
- Family participation in therapy with adolescents who self-injure is suggested. There is a noted influence of the family on the individual who participates in self-injurious behavior. The reverse is also true. The individual who self-injures influences the family unit. Therapy addressing these dynamics may serve to help the family's interactions and dysfunction; thus, also influencing the self-injurious behavior.

- Therapeutic treatment from a trauma-informed perspective would be useful in working with adolescents who participate in self-injurious behavior and their families. This is particularly noteworthy since trauma was noted among all of the study's participants. Features of this type of treatment prevent further victimization and provide a supportive and collaborative aspect to therapeutic care. The focus is a strengths-based approach. Building more healthy relationships and environments is an additional component. The framework treats the whole person with the understanding that trauma is impactful with devastating short-term and long-term consequences (Conradi & Wilson, 2010).
- Normalizing the parent's experience of diverse and often intense thoughts, emotions, and actions would prove beneficial in building a positive rapport. This connection would then be useful in working with the families of individuals who self-injure to build better communication and family dynamics.
- Teaching positive communication skills between parents and adolescents is recommended. A general lack of communication, the presence of poor communication, or an inability to communicate emotional reactions has been noted within these families and individuals. Improving these communication styles may serve to help the family environment in which the self-injury originated.
- Building an understanding with family members about the severity of self-injurious behavior and what the adolescent is trying to say is suggested. Due to the several issues that the adolescent children of this study's parents presented with to treatment, the self-injurious behavior was minimized. Educating parents

on the messages that self-injury gives such as communicating emotional experiences or processing trauma may help families to better interact, understand, and work with the individual who is participating in the self-injurious behavior. This may additionally help to address the other presenting problems as well.

- Parents need and desire to know how to respond to their adolescent child's self-injurious behavior. Therapy involving safety planning, communication strategies, behavioral strategies, and coping skill training is recommended in working with families and adolescents who self-injure. Protective actions to take should also be addressed in therapy sessions.
- Family relationship skill building is suggested as a clinical intervention. Teaching families on how to spend positive quality time with each other as well as how to handle stress and anger in appropriate ways is recommended in helping with the family environment that contributes to the self-injurious behavior.

Limitations of the Study

One limitation of this study pertained to the demographic characteristics of the participants. These issues regarding the selected participants need to be considered when reviewing the results of this study. First, each parent participant and adolescent child was Caucasian. Although research has shown that Caucasians participate in self-injurious behavior at higher rates than non-Caucasians (Hawton et al., 2002; Klonsky & Muehlenkamp, 2007; Lloyd-Richardson et al., 2007; Muehlenamp & Gutierrez, 2004; Ross & Heath, 2002), the lack of diversity among the ethnicities of the participants could

serve as a possible weakness. Second, all parent participants were single mothers. Research has not explored the influence of this type of family unit on self-injurious behaviors, but parenting styles and difficulties brought on by being a single mother may contribute to the negative family environment (Conterio & Lader, 1998; Crowell et al., 2008; Favazza, 1996; Hawton et al., 2006; Levenkron, 1998; Ng, 1998; Sim et al. 2009; Strong, 1998; Walsh & Rosen, 1988; Wedig & Nock, 2007; Yates et al., 2008; Yip et al., 2003) and need to be considered within the constructs and limitations of this study. Third, the participants were parents who had a child admitted into an inpatient psychiatric residential facility. Among adolescent clinical populations, self-injurious behavior is shown to occur in anywhere from 40%-82% of the population (Darche, 1990; DiClementa, Ponton, & Hartley, 1991; Nock & Prinstein, 2004). This high percentage suggests the importance of researching this study's participants. However, self-injurious behavior among community adolescents is shown to occur in as much as 46% of the population (Lloyd-Richardson et al., 2007). This suggests that looking at the parents of adolescents who self-injure within the community is also important.

The unique environment of an inpatient psychiatric residential facility also needs to be considered as a limitation. The patients within this type of setting typically have a wide variety of issues that range in severity. As noted, these individuals are unable to succeed within the community for several reasons. There has often been a long history of therapy and medical interventions that have not shown effective in managing the adolescent's unique mental health and behavioral issues. This level of care employs several therapeutic inventions including family therapy. Each participant's child had been in the inpatient psychiatric residential facility for varying amounts of time. These issues

may be limitations in how the results can be generalized to other populations and may have affected how each parent participant perceived and understood her adolescent's self-injurious behavior.

Interviews were conducted with only parent participants. Another limitation to this study is the exclusion of interviewing the adolescent child. In order to verify the accounts and perceptions of each parent, the adolescent voice would show to be useful.

An additional limitation was that there was only one formal interview with each participant lasting approximately forty-five minutes to one hour in length. Pre-screening phone sessions and telephone debriefings were conducted on each participant to encourage rapport building and open communication over a period of time. Member checking was also conducted with each participant; however, for one participant, this was conducted via email correspondence. More than one interview may have produced more in-depth discussion and information about each parent's response to their adolescent child's self-injurious behavior. With additional interviews, the participants may have become more comfortable with the interview content, format, and increased rapport could have been developed.

My personal interpretations of the information collected and my own responses to interview answers are another limitation. Based on my own experience in the field as well as my own familiarity of the subject, my questions and statements may be marked by this knowledge. It is possible that my rephrasing of responses given by the participants were limiting instead of asking for clarification.

A final limitation is that the adolescent children identified for the study had additional treatment issues other than self-injurious behavior. Although each adolescent

had self-injurious behavior as a presenting problem and treatment plan issue, other intense or threatening actions were also present. Additionally, each adolescent had a different set of diagnoses. The severity of these other mental health issues and behaviors particularly in comparison to the self-injurious behavior may have been a factor in the responses of each parent to the interview question.

Recommendations for the use of Present Findings

This study will be useful for counselor educators. In order to prepare future counselors for working with this population of adolescents and their families, it will be important to educate them on the parent experience and response to the self-injurious behavior. Understanding the responses, beliefs, and relationship dynamics that present within these families is influential in appropriately treating this population. It can assist in rapport, education, and therapeutic interventions used when counseling these individuals and their families.

This research will also serve to benefit practicing clinicians in the mental health field. Counselors working with adolescents who self-injure as well as families who have an individual who participates in self-injurious behavior can gain valuable insight from this study by considering the perceptions, relationship dynamics, and responses that family members have regarding this issue. This information can assist in building rapport, educating, and treating this population. Clinicians can assist families through developing knowledge on self-injurious behavior and fostering increased positive communication.

This study is additionally useful to families who have a member that participates in self-injurious behavior. The struggles and frustrations experienced when one has a family member participating in self-injury are expressed and shared within this study. To

support the responses that each member had, this study served as a way to give a voice to individuals who are dealing with an issue that is often considered hidden and shameful. It can serve as a way to reduce the stigma of a subject that is difficult to understand.

Families can look at what responses appeared beneficial and others that were counterproductive in dealing with an adolescent's self-injurious behavior. It also allows for families to gain information and knowledge in how to best educate themselves and handle the behavior within a family unit.

Recommendations for Future Research

Future research should gain more diversity in the parent participants and adolescent children studied. This study used four Caucasian mothers who each had a Caucasian daughter admitted to an inpatient psychiatric residential facility. Future research could replicate the present study only with the voice of additional ethnicities and genders.

I believe it would also be important for future research to look at a sample of parent participants who have an adolescent child that participates in self-injurious behaviors within a community setting. The intensity and amount of therapy and medical interventions experienced by this population may influence the responses that the parents have in regards to this behavior. The knowledge of self-injury or other mental health issues may also show to be different within a community sample versus parents within a clinical setting.

This study sought to gain insight into the parent response to an adolescent child's self-injurious behavior. To develop a more in-depth description of this experience, it would be useful for future research to interview parents and their adolescent child. This

would identify misconceptions in the parents' beliefs and perceptions versus what is believed and felt by the adolescent child.

Several considerations for future research were noted in the discussion of the identified themes within the literature. A general minimization of the self-injurious behaviors and lack of knowledge regarding self-injury was noted. Exploring how parents prioritize presenting problems and how they decide to learn about these issues would be an important area to explore particularly when considering therapeutically treating adolescents that self-injure and have other mental health issues and their families.

Taking a closer look at the adolescent disclosure, or lack of disclosure, of their personal self-injury to the parent would also be an interesting area to consider. What influences a parent-child relationship in which the child feels secure enough to share this information could be explored. What prompts sharing this behavior is another issue to review. These findings can, in turn, help in building family relationships that are open and honest, another important issue for planning therapeutic practices and interventions.

To assist in helping families who come to therapy with an initial disclosure of a family member's self-injurious behavior, it would prove useful to further research the first responses of parents upon learning of this behavior. Themes of wanting to fix the situation but not knowing how to respond, trying to gain an understanding of why the behavior was occurring, and having a noted behavioral response were noted in this study. Specifically, considering these aspects of the parent experience and taking a more in-depth look at these thoughts, feelings, and actions may be beneficial.

The response of believing the parent-child relationship has no influence on the adolescent's self-injurious behavior is an important element found in this study that

should be further researched. What supports this thinking should be explored. Identifying the rationale behind this thinking may target specific elements of education regarding self-injurious behavior that needs to be given to parents who are in a similar situation.

Future research could additionally explore the parent concern regarding reoccurrence of the behavior following treatment. Looking at how parents think about the self-injurious behavior post-treatment may be useful. Also, the protective actions that they have implemented upon learning about the self-injurious behavior should be considered. If the level of concern regarding the feelings a parent has in response to their adolescent's self-injury is related to the level of concern about reoccurrence would additionally be interesting to note.

It would be useful for future research to consider the feelings that parents have in regards to their adolescent's self-injurious behavior. It would be beneficial to note how these emotions correlate with the parent-child relationship specifically noting whether the relationship becomes closer or more distant. How these feelings affect the parent participation in the treatment process would also be noteworthy.

A final consideration for future research in the area of family systems and self-injurious behavior would be looking at the thoughts and motivations behind parent learning about the subject area. What purpose parents hope this learning will have should be considered. Where they go to learn about the subject matter and why they choose these arenas may be useful to identify outlets for distribution of accurate information on the subject. Also, how they use the information that they gain would be important in understanding further family responses to a family member's self-injurious behavior.

Conclusion

Self-injurious behavior is an issue that influences the lives of many people (Briere & Gil, 1998; Klonsky et al., 2003; Lloyd-Richardson et al., 2007; Nock & Prinstein, 2004; Ross & Heath, 2002; Whitlock et al., 2006). The family members of individuals who self-injure experience a variety of responses, positive and negative (Alderman, 1997; Conterio & Lader, 1998; Levenkron, 1998; Plante, 2006; Walsh & Rosen, 1988). Through this research, themes have emerged regarding the responses that parents have in response to learning about their adolescent's self-injurious behavior. Also, identified in this research were themes regarding parent understanding of the issue of self-injury and how they perceive the family unit to influence this behavior.

There is limited research that examines the unique voice of parents that have an adolescent who participates in self-injurious behavior from an in-depth qualitative viewpoint. This study provides one opportunity for four parents to share their experiences. It is important to use these stories to further educate this population, counselor educators, and practicing clinicians in order to implement more effective strategies for working with these families and the serious issue of self-injurious behavior.

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Appendices

Appendix A

Pre-Interview Screening Tool

1. Do you have a child between the ages of 13 and 17?
2. Do you have physical custody of your child?
3. Do you have legal custody of your child?
4. Has your child participated in self-injurious behaviors?
5. What self-injurious behaviors has your child participated in?
6. What is the most recent mental health diagnosis that has been given to your child?
7. Does your child have a developmental disability?
8. In order to be included in this study, I will need you to sign a form giving your consent and permission to participate in the research and to release your medical records from the current psychiatric residential facility to me for review and analysis. Do you accept these conditions?
9. Also to be included in this study, you will have to travel to the psychiatric residential facility that your adolescent child is currently placed in. This is to ensure that all participants have the same interview conditions. Do you accept this condition?
10. To be included in this study, you must be willing to participate in a 1-2 hour initial interview to discuss your responses to your adolescent's self-injurious behaviors and be contacted at a later time to review transcripts of our interview. Do you accept this condition?
11. The information discussed verbally during our interview will be audio recorded and then transcribed for research purposes. You will provide me with an

alternative name in order to remain anonymous at the beginning of our interview.

Do you accept that your information will be read by others involved in this research study provided you remain anonymous?

12. Do you have a confidential phone number or email address where I may contact you for further aspects of this research study?

Appendix B



Informed Consent to Participate in Research

Information to Consider Before Taking Part in this Research Study

IRB Study # Pro00001362

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. This form tells you about this research study.

We are asking you to take part in a research study that is called:

“Parent Response to Adolescent Self-Injurious Behavior: A Collective Case Study”

The person who is in charge of this research study is Kylee S. Tuls. This person is called the Principal Investigator. The Principal Investigator will be working with Carlos Zalaquett, Ph.D.

The research will be done at Manatee Palms Youth Services, 4480 51st Street West, Bradenton, Florida, 34210.

Purpose of the study

The purpose of this study is to explore the responses of parents who have an adolescent that participates in self-injurious behaviors. Your understanding of the dynamics of self-injurious behaviors, your cognitive, emotional, and behavioral responses to finding out about your adolescent’s self-injury, and your perception of the impact of the parent-child relationship on your adolescent’s self-injury will be discussed.

This study is being conducted as a dissertation requirement for the fulfillment of a Doctor of Philosophy degree in Counselor Education at the University of South Florida.

Study Procedures

If you take part in this study, you will be asked to complete a face-to-face interview. This interview will take approximately two hours and will take place at Manatee Palms Youth Services, Bradenton, Florida. The interview will be scheduled at your convenience. During the interview, the Principal Investigator will be taking written field notes. You will also be asked to review the transcripts of your interview and meet with the Principal Investigator in person, via

phone, or via email to discuss any feedback that you have from this content. This second meeting will take approximately thirty minutes. Audio recording of each contact with the Principal Investigator will be used. In addition to the interview sessions and field notes, the Principal Investigator will review your child's current medical records to gather additional information including family demographic data, family history, treatment history, and current treatment issues. The Principal Investigator, a transcriptionist, a dissertation committee composed of University of South Florida professors, and an external auditor will have access to these audio recordings. The recordings will be coded by a pseudonym that you provide to endorse confidentiality. The audio recordings will be kept on a password protected hard drive for five years. After this time, the audio recordings will be permanently deleted from the hard drive.

Alternatives

You have the alternative to choose not to participate in this research study.

Benefits

We don't know if you will get any benefits by taking part in this study.

Risks or Discomfort

Speaking about your adolescent's self-injurious behaviors, your personal reactions, and your parent-child relationship may create anxiety or discomfort. If this should occur or you would like to speak more about your experience, the Principal Investigator will be able to assist you with resources or professional referrals.

Compensation

We will not pay you for the time you volunteer while being in this study.

Conflict of Interest Statement

The Principle Investigator is a therapist on staff at Manatee Palms Youth Services. This may create a conflict of interest. However, all interactions of the Principal Investigator and the parent will remain confidential and will not be released to Manatee Palms Youth Services.

Confidentiality

We must keep your study records as confidential as possible. All data gathered will be kept on a computer that is password protected. Audiotapes will be kept for five years. The Principal Investigator, a transcriptionist, a dissertation committee composed of University of South Florida professors, and an external auditor will have access to these audio recordings.

However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator.

- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety. These include:
 - The University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
 - The Department of Health and Human Services (DHHS).

We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are.

Voluntary Participation / Withdrawal

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study, to please the investigator or the research staff. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

Questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, call Kylee S. Tuls at 941-792-2222, ext. 131.

If you have questions about your rights as a participant in this study, general questions, or have complaints, concerns or issues you want to discuss with someone outside the research, call the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-9343.

If you experience an unanticipated problem related to the research call Kylee S. Tuls at 941-792-2222, ext. 131.

Consent to Take Part in this Research Study

It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

I freely give my consent to take part in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

Signature of Person Taking Part in Study

Date

Printed Name of Person Taking Part in Study



Pseudonym Identifier Used for Study Purposes

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person signs this form, to the best of my knowledge, he or she understands:

- What the study is about.
 - What procedures/interventions/investigational drugs or devices will be used.
 - What the potential benefits might be.
 - What the known risks might be.
-

Signature of Person Obtaining Informed Consent

Date

Printed Name of Person Obtaining Informed Consent



Assent to Participate in Research

Information for Persons under the Age of 18 Who Are Being Asked To Take Part in Research

IRB Study # Pro00001362

Title of study: Parent Response to Adolescent Self-Injurious Behavior: A Collective Case Study

Why am I being asked to take part in this research?

You are being asked to take part in a research study about your parent's response to your self-injurious behaviors. You are being asked to take part in this research study because we would like to review your medical records to gather information about your family, your family history, your treatment history, and your current treatment. You will have no active involvement in this research study.

If you take part in this study, you will be one of about eight people in this study.

Who is doing this study?

The person in charge of this study is Kylee S. Tuls of University of South Florida. She is being guided in this research by Carlos Zalaquett, Ph.D.

What is the purpose of this study?

By doing this study, we hope to learn about the different responses parents have when they learn about their child's self-injurious behaviors.

Where is the study going to take place and how long will it last?

The study will be take place at Manatee Palms Youth Services. Your parents will be asked to come to Manatee Palms Youth Services during the study. Each of those visits will take about 60-90 minutes. The total amount of time your parents will be asked to volunteer for this study is approximately two hours over the next one month.

What will you be asked to do?

- Your parent will be asked to participate in an interview that will ask questions about their personal responses to your self-injurious behaviors. Notes will be taken by the Principal Investigator, Kylee S. Tuls, during this interview. Your current medical records will also be reviewed to gather more information.
- When reviewing your medical record, the following information will be gathered: your family demographic data (ethnicity, ages, sex, biological/adopted of each family

member), your family genogram, family history (abuse, moves, illness, deaths, etc...), treatment history of you and your family, presenting problems to your current treatment, treatment goals, treatment progress, and any other information related to your self-injurious behavior.

- It is important to know that while this information is being gathered your name and any identifying information will be excluded from the study. Your parent will make up a false name to use for all research purposes.
- Again, it is important to note that you will have no active involvement in this research study. We are asking permission to view your current medical record from Manatee Palms Youth Services.

What things might happen that are not pleasant?

To the best of our knowledge, the things you will be doing will not harm you or cause you any additional unpleasant experience.

Will something good happen if I take part in this study?

We cannot promise you that anything good will happen if you decide to take part in this study. However, the information gathered may be used to help with future treatment planning and education purposes for families who have adolescents that participate in self-injurious behaviors.

What other choices do I have if I do not participate?

You have the alternative to choose not to participate in this research study.

Do I have to take part in this study?

You should talk with your parents or anyone else that you trust about taking part in this study. If you do not want to take part in the study, that is your decision. You should take part in this study because you really want to volunteer.

If I don't want to take part in this study, what will happen?

If you do not want to be in the study, nothing else will happen.

Will I receive any rewards for taking part in this study?

You will not receive any reward for taking part in this study.

Who will see the information about me?

Your information will be added to the information from other people taking part in the study so no one will know who you are.

Can I change my mind and quit?

If you decide to take part in the study you still have the right to change your mind later. No one will think badly of you if you decide to not participate.

What if I have questions?

You can ask questions about this study at any time. You can talk with your parents or other adults that you trust about this study. You can talk with the person who is asking you to volunteer. If you think of other questions later, you can ask them.

Assent to Participate

I understand what the person running this study is asking me to do. I have thought about this and agree to take part in this study.

Name of person agreeing to take part in the study

Date

Name of person providing information to subject

Date

Fake Name for Study Purposes

Appendix C

Interview script

Thank you for choosing to participate in this research study. Our interview today will be audio taped and transcribed. The transcription will be read by other individuals associated with this research study. However, you will remain anonymous as you have already given me an identifier other than your real name. The information retrieved throughout the course and duration of this research study will be respected and your confidentiality will be valued and upheld to the highest standards.

If you feel uncomfortable or do not want to continue at any time during the research process, please let me know. We can arrange to accommodate your needs by taking some brief time away from the interview setting or by terminating the interview.

I am now providing you with a form which gives your consent to participate in this research study and to release your adolescent child's current medical records to me. Please read over this form carefully and let me know if you have any questions or concerns. If you need help reading this form, let me know and I will read it to you.

1. Have you carefully read the consent form?
2. Do you have any questions or concerns regarding the consent form?
3. Do you agree to participate in this research study?
4. Do you agree to release your adolescent's current medical records to this researcher?
5. May I have your consent to begin taping at this time?

I am now going to ask some basic informational questions regarding your adolescent child. I will then move into more specifically discussing your adolescent's self-injury. Please remember that if at any time during the interview process you feel uncomfortable or wish to end the session, let me know.

6. How old is your adolescent child?
7. Is your child a male or a female?
8. What is your child's ethnicity?
9. What were your child's presenting problems when admitted to this psychiatric residential treatment facility?
10. What is your adolescent's current mental health diagnosis?
11. How would you define self-injurious behavior?
12. How did you find out about your adolescent's self-injury?
13. What do you think are the reasons your child participates in self-injurious behaviors?
14. What thoughts did you have when you found out about your adolescent's self-injury?
15. What feelings did you have when you found out about your adolescent's self-injury?
16. What actions did you take when you found out about your adolescent's self-injury?
17. How would you describe your relationship with your adolescent child?
18. How do you think that your parent-child relationship influenced your adolescent's participation in self-injurious behaviors?

19. How do you think other members of your family have influenced your adolescent's participation in self-injurious behaviors?
20. What thoughts do you now have about your adolescent's self-injury?
21. What feelings do you now have about your adolescent's self-injury?
22. What actions do you now take in response to your adolescent's self-injury?
23. In what ways has this relationship changed since learning about your adolescent's self-injury?
24. Is there anything you would like to add at this point in time?

At this time, I have no more questions for you. Here is my phone number and email address. If at any time in the next week you think of something more you would like to add to our interview content, contact me. Do you have any questions or concerns for me?

I will be sending you the transcripts of this interview for you to review. How can I get them to you? Please carefully read through these transcripts and note any additional information that you feel is important. We can arrange to meet in person, via phone, or you can email me your feedback on these transcripts. Let me know of any additions or further clarifications that you might have.

I will also be contacting you by phone within the next 48 hours to debrief our interview session today. How can I reach you? Thank you again for participating and sharing your personal information and experience with me.

Appendix D

Phone Debriefing

This is Kylee Tuls and I am calling to discuss your responses to our recent interview. It is normal to experience a mix of emotions and feelings following the discussion of difficult and personal information. If you are experiencing an uncomfortable amount of stress regarding this experience, please contact your doctor, therapist, local community mental health facility, or hospital. If needed, I can refer you to someone who can appropriately help you with these thoughts and emotions.

1. Do you have any questions regarding our recent interview? If so, what are they?
2. How are you feeling after our interview?
3. Are you experiencing an uncomfortable amount of stress in regards to our interview?
4. Do you have a support system available to you to help with this stress?
5. Is there any way I can assist you at this time?

Thank you again for your participation. I will be in touch shortly with our interview transcripts. Please do not hesitate to contact me if you need anything further.

Appendix E

Pilot Test

Thank you for participating in this research study looking at parental responses to adolescent self-injurious behavior. Your information will be used as part of a pilot study. This means that I will be recording your responses and taking notes during our session together; however, your responses will not be analyzed and used for the findings of this research study. Instead, I will be asking you a series of interview questions. I would like for you to provide me feedback in response to these questions. If you need clarification or think of a better way for the question to be asked, please let me know. Please ask for further explanation if you need it. Please answer the questions based on your own experience and understanding of what is being asked. Do you have any questions at this time? We will now begin with the interview questions.

Appendix F

Field Note Form

Date/Time: _____ Interview _____ Debriefing _____ Member
Checking

Participant Name: _____ Face-to-Face _____ Phone _____ Email

Observations:

Body Gestures (Kinesic)-

Speed of Speech (Chronemic)-

Volume of Voice (Paralinguistic)-

Other Observations-

Memo:

Researcher Signature: _____

Date: _____

Appendix G
Medical Records Data Collection Sheet

Participant Name:

Family Demographic Data (ethnicity, ages, sex, biological/adopted of each family member):

Family Genogram:

Family History (abuse, moves, illness, deaths, etc...):

Treatment History:

Presenting Problems:

Treatment Goals:

Treatment Progress:

Additional Information:

Notes:

Researcher Signature: _____ Date: _____

About the Author

Kylee Sue Tuls has been pursuing her studies for several years. This dissertation serves as a requirement for a Doctor of Philosophy degree in Curriculum and Instruction with an emphasis in Counselor Education from the University of South Florida. This follows a Master of Arts degree in Rehabilitation and Mental Health Counseling from the University of South Florida and an undergraduate degree in Psychology from Hope College.

In addition to her studies, Kylee has developed clinical experience working as a Licensed Mental Health Counselor in the state of Florida. Kylee's specialties include children's mental health and self-injurious behavior. She has worked in various settings including community mental health agencies, an inpatient residential program, a detoxification unit, and a crisis stabilization unit.

In her free time, Kylee enjoys reading, running, traveling, cooking, and gardening. She lives in Southwest Florida with her husband and two cats.