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Rachel Weiner
Clinical Perspectives on Non-
Suicidal Self-Injury in Adolescents:
A Qualitative Study

ABSTRACT

There has been an increase in the number of adolescents who engage in non-suicidal self-injury (NSSI). This qualitative study explored clinical social workers' perceptions of the causes of NSSI and the processes whereby social workers develop treatment for this behavior. This research was based on 10 in-person interviews conducted with Massachusetts licensed clinical social workers (mean average experience=20 years) who treat adolescent self-harm. Findings suggest adolescents often feel pressure to cut in order to fit in and therefore are more likely to engage in self-harm if their peers are encouraging this behavior. Further findings suggest that many participants seemed less aware than the literature implied about how neuroscience and attachment theory can be utilized to explain self-harming behavior.

In order to develop effective treatment methods, it is imperative that clinicians increase their understanding of the motivations for NSSI, especially the influence of peer relationships. At the graduate level, social work students should learn how to apply theoretical frameworks to guide their interventions and clinical practice. The results of this study expand knowledge of NSSI in adolescents as well as how to best educate emerging social workers about effective treatment methods.

CLINICAL PERSPECTIVES ON NON-SUICIDAL SELF-INJURY IN ADOLESCENTS:

A QUALITATIVE STUDY

A project based upon an independent investigation,

submitted in partial fulfillment of the requirements

for the degree of Master of Social Work.

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Thank you to the clinicians who made this study possible. Much gratitude is owed to each and every one of you for taking time out of your busy lives to participate in this study. Your wisdom, thoughtfulness and tireless devotion to your clients is inspiring.

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To my thesis advisor, Dr. Susanne Bennett, I am grateful for your support and guidance this last year. I absolutely could not have done this without you.

And finally, thank you to every adolescent for your strength each day in the face of adversity. As Marianne Williamson so beautifully wrote "Maturity includes the recognition that no one is going to see anything in us that we don't see in ourselves. Stop waiting for a producer. Produce yourself."

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CHAPTER I

Introduction

Non-suicidal self-injury (NSSI) has been defined as the intentional destruction of body tissue, including behavior such as cutting, burning, carving, and severe scratching without suicidal intent (Brausch & Girresch, 2012; Hamza & Willoughby, 2015; Tatnell, Kelada, Hasking, & Martin, 2013). More recently, NSSI has received increased attention as a unique diagnostic category in the DSM V (American Psychiatric Association, 2013). Although prevalence rates for NSSI can be difficult to determine, self-injury seems to occur in 40-80% of adolescent populations (Schade, 2013). The onset of NSSI is often between the ages of 13-15 (Tatnell et al., 2013). It is essential to treat adolescent NSSI, as there is a significant relationship between self-injury and suicide attempts.

Of those adolescents interviewed in an inpatient setting who engaged in self-harm, 70% of them reported at least one suicide attempt (Brausch & Girresch, 2012). Every year, nearly one million adolescents attempt suicide (Diamond et al., 2010). Self-injury is associated with developmental, psychological, and interpersonal challenges (Quirk, Wier, Martin & Christian, 2015). NSSI can occur within the setting of a variety of mental health diagnoses such as depressive disorders, anxiety disorders, eating disorders, substance-use disorders and posttraumatic stress disorders (Fischer, Brunner, Parzer, Resch, & Kaess, 2013). Thus, it is imperative that clinical social workers have an understanding of the motivations for self-harm in order to develop effective treatment methods.

There are limited studies that have evaluated the effectiveness of treatment methods for non-suicidal self-injury, particularly with adolescents (ages 12-17). In order to develop the most effective treatment methods for NSSI, it is necessary to identify why adolescents engage in self-harming behaviors. Most of the literature around NSSI relates disruptions in attachment to the development of self-harming behavior. Thus, attachment based interventions could address the underlying factors associated with self-injurious behavior. However, there may be other theoretical frameworks that clinicians utilize to understand and treat NSSI. To examine these issues, I proposed the following research question for this study: What are social workers' perceptions of the causes of adolescent NSSI, and what particular treatment processes do social workers use in their engagement with adolescents who have NSSI?

I utilized a qualitative inductive research design to interview clinicians who treat adolescents who engage in NSSI. In asking clinicians about their understanding of self-harming behavior, I gained an increased understanding about how adolescent NSSI is treated. The qualitative nature of the design allowed for observations and exploration about clinicians' use of particular theoretical approaches. I learned about clinicians' understanding and conceptualization of the clinical work they are doing by conducting descriptive interviews with clinicians. In the following section I explore previous research related to this topic and outline how this study expands the gap in knowledge about the treatment methods for self-injury in adolescent populations.

CHAPTER II

Literature Review

In the following literature review, I focus on the two theoretical frameworks that are most commonly researched in relation to the development of NSSI– attachment theory and cognitive behavior theory. Attachment theory has been linked to NSSI because children learn emotional regulation skills and expression from their caregivers, and regulation is related to attachment processes (Halstead, Pavkov, Hecker, & Seliner, 2014; Quirk et al., 2015). If children do not receive emotional validation and understanding, they may be more likely to develop maladaptive coping skills such as NSSI (Sim, Adrian, Zeman, Cassano, & Friedrich, 2009). Cognitive behavior theory has also been applied to the development of self-harming behavior. Adolescent's cognitive development relates to their emotional regulation skills and ultimately guides their behavior (Rudd & Brown, 2011). If individuals have limited cognitive capacity, they may struggle to manage their emotions and understand the consequences for their actions, which could lead to unsafe, impulsive behavior (Wagner & Zimmerman, 2006). During adolescence, the prefrontal cortex, which is responsible for emotional control and planning behavior, is not fully developed.

Most of the literature related to treatment modalities for NSSI focuses on attachment based interventions such as Emotionally Focused Family Therapy (EFFT), Attachment Based Family Therapy (ABFT) as well as Cognitive Behavior Therapy (CBT). The following review highlights the gaps in the literature in terms of alternative theoretical frameworks and treatment

modalities. I will emphasize the need for further exploration in this area as there are few empirically based treatment interventions that are effective for working with adolescents with NSSI. Therefore, it is imperative that more research is done to explore how clinicians conceptualize and develop treatment methods for NSSI.

Attachment Theory and Attachment-Based Treatment

      Attachment theory of self-injury. Most of the literature on NSSI links the development of self-injury to theories of attachment (Ainsworth, 1989; Farber, 2008; Kissil, 2011). As an early attachment theorist, Ainsworth (1989) provided a framework for understanding attachment relationships beyond the initial bond between the infant and the primary attachment figure, often the mother. Ainsworth and Bowlby (1991) expanded on attachment theory by drawing on developmental, social, biological, and systems theories to understand how early attachments influence adolescents and adult personality development. More recent literature builds upon attachment theory by emphasizing that early caregiver relationships are the primary ways that individuals form the capacity for emotional and interpersonal regulation (Quirk et al., 2015). Quirk et al. (2015) found that parental rejection is related to the formation of negative views of the self and that these views contribute to the motivation for self-injury. Specifically, disturbed attachments with caregivers impact an individual's ability to self-regulate and to develop healthy and safe coping skills (Qurik et al., 2015). These results relate to the proposed study as they emphasize that attachment deficits relate to the development of maladaptive coping behavior such as self-harm.

      Halstead et al. (2014) focus on the relationship between family dynamics and NSSI by surveying participants who have a history of self-injurious behavior. Similar to the participants in other studies focused on NSSI, the participants in this study were adults. The results demonstrate

that family dynamics are related to the duration and frequency of self-injurious behavior. Individuals whose family of origin tends to value communication and cohesion are more likely to reduce self-harming behavior sooner than those individuals who do not have families with these traits. Both Quirk et al. (2015) and Halstead et al. (2014) offer empirical results that bridge the gap between attachment theory and the development of self-harm. These studies support the use of attachment based treatments in treating individuals who engage in self harm. Although there is a strong connection between disruptions in attachment and motivations to engage in self-injury, neither of these studies go a step further to suggest treatment methods for self-injury within an attachment framework.

Many studies emphasize the link between an individual's attachment style and the development of emotional regulation skills. This body of literature is significant to the current study because NSSI is related to a flaw in one's affect regulation (Connors, 2011; Tatnell et al., 2014). Tatnell et al. (2014) reviews how adolescents who grow up in family environments with minimal emotional support may develop poor emotional regulation skills and other psychological challenges.

Another study that links self harm to attachment quality and emotional regulation skills, Sim et al. (2009) assert that adolescents raised in family environments that are emotionally invalidating are more likely to develop NSSI with higher frequency. The way that parents respond to their children's emotions impacts the child's emotional awareness and their psychosocial functioning (Sim et al., 2009). Those individuals who report that they engage in self-harming behavior also report poorer emotional awareness and emotional regulation skills. These findings are consistent with other studies that have viewed self-harming behavior as a maladaptive strategy used to regulate emotions that are deemed intolerable.

Limited studies have looked at gender as a factor in self-harming behavior. However, Sim et al. (2009) report that females are more likely than males to engage in self-harm, which may be related to the tendency of females to internalize their emotions, whereas males tend to externalize. Sim et al. (2009) further found that 70% of the adolescents who engage in self-harm report they felt emotions such as overwhelmed, anger, sadness, and self-hatred. Some adolescents describe self-harm as a way to transform emotional pain into physical pain. These adolescents seem to have poor emotional control and have learned to inhibit their emotions, which may lead to the development of NSSI. This inhibition of emotion is linked to gender as more females than males engage in self-harm as they are more likely to internalize their emotions.

Limited studies have explored the variety of factors that cause or contribute to NSSI, but Tatnell et al. (2014) examined the relationship between NSSI, attachment, and emotional regulation. In their study of nearly 2000 students from 40 schools in Australia, adolescents (ages 12-18) were asked to complete questionnaires measuring their self-harming behavior, self-esteem, and other interpersonal factors. These results were compared to reports at baseline, maintenance, and at the cessation of their self-harm. The findings support a relationship between attachment anxiety and the development of NSSI (Tatnell et al., 2014). Adolescents who engaged in self-harm often had insecure attachment with caregivers during childhood. These findings support previous research that found poor attachment relationships in childhood and adolescents can lead to the development of poor affect regulation in adolescents (Tatnell et al., 2014). These results are consistent with previous research that indicates family support as a protective factor in the elimination of self-harm.

Similarly, Connors (2011) emphasizes the association between affect regulation and attachment by reviewing research on attachment styles during infancy. Children learn affect regulation skills within the context of early attachment relationships, and attachment styles relate to psychopathology later in life. Individuals with a preoccupied attachment style are at risk for engaging in suicidal behavior (Connors, 2011).

Attachment based treatment for self-injury. Attachment theory has provided the framework for a variety of therapeutic modalities, though only few empirical studies support the effectiveness of attachment based treatments (Bloch & Guillory, 2011). Farber (2008) proposes that self-harming behavior can develop when a child is either unable to form stable attachments or has become attached to those who have inflicted pain. By incorporating the research of attachment theorists such as Bowlby and Ainsworth, Farber identifies attachment based treatment models as effective in working with individuals who engage in self-injurious behavior. An attachment-focused approach to treatment involves the client building a strong bond with the therapist. Although some of the literature suggests the use of attachment based treatment methods, the methodology of these studies has been limited to single case designs rather than methods studied through randomized control trials (RCT). Farber (2008) uses only one case example and does not describe alternative treatment methods for self-harm. However, one study that does use RCTs, Diamond et al. (2010) compared the effectiveness of Attachment-Based Family Therapy (ABFT) and Enhanced Usual Care (EUC) on improving the suicidal ideation and depressive symptoms with adolescents.

ABFT is a process and emotion focused therapy that also uses behavior, cognition, and psycho-education to target depression and suicidal ideation (Diamond, 2014). Ewing, Diamond, and Levy (2015) review four studies that have explored the efficacy of ABFT with treating

adolescent depression and suicidality. The studies provide empirical data that relates a variety of family factors to the frequency of adolescent self-harming behavior. They assert that children have a developmental instinct to seek out parental figures for comfort and emotional support. However, when parents are unable to provide emotional validation or model affect regulation, children may develop an insecure or anxious attachment, which can lead to maladaptive coping skills. The ABFT therapist focuses on the attachment between the adolescent and the parents, as attachment relationships can change across lifespans (Ewing et al., 2015). Diamond et al. (2010) found that patients who engaged in ABFT reported more immediate improvement in both suicidal ideation and depressive symptoms than those individuals who had EUC. These results are based on self-reports and also the reports from clinicians who met with the adolescents individually and in family meetings. Although many studies have explored empirically based interventions for working with adolescents, there are limited attachment based treatment models designed specifically for self-injury in adolescents.

Schade (2013) asserts that most literature about NSSI focuses on individual treatment methods instead of attachment based family treatment. However, due to the link between insecure parental attachment and rates of NSSI, Schade (2013) suggests that Emotion Focused Family Therapy (EFFT) can decrease self-harm by increasing the responsiveness of parents to children. Based on attachment theory, EFFT emphasizes the tie between NSSI and emotional regulation within the family context. These results are relevant to the proposed study as they highlight the importance of utilizing attachment theory as a framework for treating self-harming behavior. Kissil (2011) provides another example of the treatment of adolescent self-injury with attachment-based family therapy, but the study only utilizes a case example, thereby limiting generalizability. By using one case example, there is insufficient evidence to generalize the

effectiveness of attachment-based family therapy for a larger adolescent population. The previous articles reflect the current gaps in the literature in terms of other practice models that can be helpful in treating self-harming behavior in adolescents.

Most of the literature that does begin to explore the use of EFFT only utilizes case examples, which will be explored in this section. Stavrianopoulos, Faller, and Furrow (2014) provide an overview of EFFT by utilizing several case examples where the therapist uses an attachment lens to understand the family's distress and the adolescent's symptoms. Similarly, Bloch and Guillory (2011) utilize a case example to highlight the ways in which the EFFT therapist attempts to strengthen the parent/child bond. The goal of EFFT is to restructure the interactions between the adolescent and caregivers by reframing the emotional responses and interactions within the family system. EFFT therapists assess the attachment styles and quality of the relationships between the adolescent and their caregivers (Bloch & Guillory, 2011; Stavrianopoulos et al., 2014). Individuals who develop secure attachments are able to rely on caregivers for emotional support and comfort. The EFFT therapist views the adolescent's self-harming behavior as relating to the negative cycles of interactions and disrupted attachment between the adolescent and caregivers. Secure attachment occurs when parents are able to understand the adolescent and communicate effectively (Stavrianopoulos et al., 2014). When parents are able to emotionally validate their child, the adolescent is more likely to have healthy psychological functioning. It is important that the therapist encourages emotional expression between the adolescents and their caregivers and connects these emotional processes to attachment needs. Additionally, the therapist should maintain an alliance with the adolescents and with their parents, so that they can explore emotions safely (Bloch & Guillory, 2011). More

research needs to be conducted in order to evaluate the efficacy of these attachment-based treatments, in order to increase generalizability.

When individuals are not able to form secure attachments, they have difficulty with self-regulation and are more likely to engage in self-harming behavior. The prevalence of self-injury is highest in adolescent populations and therefore it would be useful to evaluate attachment based treatment methods in adolescents. Most literature has not focused on effective methods for treating adolescents who self harm within an attachment framework. Those studies that have reviewed treatment approaches for NSSI have focused on mostly CBT and DBT approaches, which fail to address attachment as a basis for self-injury. In the few studies that have explored attachment-based treatments for adolescents, there was a lack of generalizability. However, there is a large body of research that supports the efficacy of Emotionally Focused Therapy (EFT) for the treatment of couples. Dalton, Greenman, Classen, and Johnson (2013) utilize RCTs to determine the effectiveness of EFT for couples struggling with issues of childhood abuse. The results supported previous research that has shown the efficacy of EFT in improving relationship satisfaction (Dalton et al., 2013). Currently, Emotionally Focused Family Therapy (EFFT) is now being adapted to treat adolescents and the parental unit (Dalton et al., 2013).

Cognitive Behavioral Theory and Cognitive Behavioral Treatments

Cognitive behavioral theory of self-injury. In addition to attachment theory, cognitive and behavioral theories are common theoretical frameworks linked to the development of NSSI. Most literature relates suicidality to challenges in affect regulation and negative cognitions about the self, including low feelings of self worth, hopelessness, and a lack of control. Due to the overlap between self-harming behavior and suicidality, it is important to understand the cognitive and behavioral theories underlying NSSI. Rudd (2000) conceptualizes self-injurious

behavior as resulting from maladaptive schemas that are connected to cognitive, affective and behavioral systems.

Similarly, Wagner and Zimmerman (2006) assert that cognition influences one's ability to self regulate as cognition is related to motivational and regulatory systems. There are a variety of factors that influence cognitive development, such as early attachment relationships and environment. When children are raised in an environment that is supportive and encourages cognitive development, they are more able to develop coping skills than those children raised in an invalidating environment where attachment relationships have been disrupted (Wagner & Zimmerman, 2006).

In another study that explores cognitive behavioral theory as it relates to self-injury and the suicidal belief system (SBS), Rudd and Brown (2011) describe the connection among affective systems, motivational, and behavioral systems. The affective system is related to one's emotional experience and physiological responses to triggers. Individuals are more vulnerable to developing SBS when they have distorted thoughts about the self, limited ability to regulate emotion and poor problem solving skills (Rudd & Brown, 2011). Maladaptive behaviors such as self-injury are reinforced via the motivational system of the brain. Individuals process information in a manner that reinforces core beliefs about the self, others and the future.

Mikolajczak, Petrides, and Hurry (2009) focus on the relationship between emotional regulation skills, emotional intelligence (EI), and self-harming behavior. This study utilized nearly 500 adolescents (ages 16-19) in England. The results were consistent with current literature in that individuals with more emotional intelligence have a lower likelihood of engaging in self-harming behavior than those individuals with less emotional intelligence (Mikolajczak et al., 2009). Those individuals with less emotional intelligence tend to have

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difficulty regulating their emotions and developing adaptive coping skills, therefore they may develop unhealthy strategies to manage their emotions such as self-harm. Mikolajzcak et al. (2009) found that individuals tend to use self-injurious behavior to regulate emotions such as helplessness and self-blame. Mikolajzcak et al. (2009) provide empirical evidence that there is a relationship between EI and emotional regulation strategies.

Neurobiology of self-injury in adolescence. During adolescence, there is a great deal of cognitive development that occurs where individuals begin to have more goal-directed thinking and an increased understanding about the consequences for their behaviors. The last region in the brain to develop is the prefrontal cortex, which is responsible for impulse control and emotional processing (Wagner & Zimmerman, 2006). Therefore, adolescents may be limited in their cognitive development and often lack problem solving skills. Children who are inhibited emotionally are more likely to demonstrate avoidant coping mechanisms and engage in high-risk behavior. These individuals have more difficulty regulating emotions such as sadness and anger (Wagner & Zimmerman, 2006).

Currently, more researchers are studying the neurobehavioral systems that are related to the development of self-injury. Schreiner, Dougan, Begnel, and Cullen (2015) identify the neurobiological underpinnings of NSSI, including the negative valence system, positive valence system, cognitive systems, systems for social processes, and arousal/regulatory systems. Similar to previous research, Schreiner et al. (2015) conceptualize self-injury as a behavior that alleviates negative affect. It was found that individuals who reported self-injurious behavior had a stronger response in their amygdala and hippocampus when exposed to emotional pictures, thus demonstrating that individuals who engage in NSSI tend to have a higher stress response than those individuals who do not self-harm. Although it is important for individuals to have a fear or

stress response, it becomes maladaptive when the threat system repeatedly responds when there is not a threat for potential harm. Schreiner et al. (2015) describe the positive valence system, or reward system, as relating to the habit formation of self-injury because the reward system becomes activated when individuals engage in NSSI. These cognitive systems are also linked to perception and how one experiences the external environment. As individuals move past adolescence, their prefrontal cortex develops, and they are better able to interpret and regulate their emotions, making NSSI behavior less likely (Schreiner et al., 2015).

CBT treatment for self-injury. There are limited treatment models that address self-injury in adolescence. Most of the literature that does begin to evaluate the efficacy of treatments focuses only on cognitive behavior therapy (CBT) treatments. In one of the studies that addresses the issue, Brausch and Girresch (2012) review the empirical studies that have evaluated treatments for NSSI among adolescents. In exploring treatment methods, the authors evaluate the extent that the treatment interventions target the common underlying factors of NSSI. Brausch and Girresch (2012) recommend that further research is needed to determine the efficacy of treatment for NSSI. One of the limitations of their study is that it is focused more on CBT treatments instead of utilizing an attachment-based approach that takes into account attachment as an underlying issue of NSSI.

In another study that reviews evidence-based treatment for NSSI, Gonzales and Bergstrom (2013) addresses the lack of literature on the treatment for adolescent NSSI. According to Gonzales and Bergstrom (2013), the most valid interventions explored are CBT and dialectic behavior therapy (DBT). Although other treatments are identified, there is not evidence of additional valid empirical interventions for treating NSSI in adolescent populations. Gozales and Bergstrom (2013) recommend further studies that compare DBT and CBT to other

treatment methods. Both Brausch and Girresch (2012) and Gonzales and Bergstrom (2013) look at evidence-based treatments for NSSI, yet they only focus on CBT and DBT treatment methods. This reflects a significant gap in the literature in terms of the development and evaluation of other treatments for NSSI.

There is a great deal of literature that has explored the efficacy of CBT and DBT treatment for treating self harm in adults, but fewer studies have applied these treatments to adolescents. DBT was originally developed for chronic suicidal and emotional dysregulation. Numerous RCTs have found DBT as related to improvements in suicidal ideation and NSSI in adults with borderline personality disorder (BPD) (MacPherson, Chavens, & Fristad, 2013). Therefore, researchers have adapted DBT for adolescents with similar behavioral and affect dysregulation. Although there have been some studies (Rathus & Miller, 2002; Woodberry & Popenoe, 2008) that have included youth with BPD features, these studies were mostly exploratory, as they lacked comparison groups. Therefore, the results of this study are not generalizable. Additionally, these studies feature mostly females in outpatient settings; therefore, diverse sampling was omitted.

NSSI relates to deficits in affect regulation; therefore, treatments that target emotional regulation skills are thought to improve behavior. According to the biopsychosocial theory of BPD, an individual may have a biological predisposition to develop the disorder, which is exacerbated by the presence of an emotionally invalidating family environment where emotional regulation is not taught (MacPherson et al., 2013). However, more RCTs with adolescents who engage in self-harming behavior are needed in order to determine the most effective treatment methods for eliminating self-harming behavior.

Summary

   In recent years, the number of adolescents engaging in self-harm has increased (Schade, 2013). However, there are limited studies that have explored empirically based treatments for NSSI within adolescent populations. Most of the current literature around NSSI associates attachment deficits to the development of maladaptive coping skills such as self-harming behavior (Farber, 2008; Kissil, 2011). Yet, there are few attachment-based interventions specifically designed to treat adolescents who engage in self-harm. Those studies that have explored attachment-based interventions are more exploratory in nature. The studies that do begin to evaluate the efficacy of treatments focus mostly on cognitive behavior therapy (CBT) treatments, but fewer studies have adapted these treatments to adolescents. This reflects a significant gap in the current literature.

   In order to expand knowledge of treatment methods and to determine the most effective treatment modalities for NSSI, it is important to understand the theoretical underpinnings and motivation to self injure. This literature review has emphasized the need for further exploration in this area, because there are few empirically based treatment interventions that are effective for working with adolescents with NSSI. Therefore, it is imperative that more research is done to explore how clinicians conceptualize and develop treatment methods for NSSI.

   In order to address the gaps in the literature on NSSI, the following research question served as an underpinning for the current study: What are social workers' perceptions of the causes of adolescent NSSI, and what particular treatment processes do social workers use in their engagement with adolescents who have NSSI? In the next section, I outline the methodology used for this qualitative study, including information about my sample, data collection, and the

process of data analysis. I also discuss how I managed threats to trustworthiness and rigor in this qualitative study.

CHAPTER III

Methods

Research Purpose

There is a significant relationship between self-injury and suicide attempts (Brausch &
Girresch, 2012). It is imperative that clinical social workers have an understanding of the
motivations for self-harm in order to develop effective treatment methods for Non-Suicidal Self-
Injury (NSSI). This study explored the following research question: What are social workers'
perceptions of the causes of adolescent NSSI, and what particular treatment processes do social
workers use in their engagement with adolescents who have NSSI? This research provides an
increased understanding about how adolescent NSSI is treated and expands the gap in knowledge
about treatment methods for self-injury.

Research Method and Design

I used a qualitative inductive design for this study in which I interviewed 10 clinicians
who treat adolescents (ages 12-17) that have engaged in NSSI. The questions that I posed to
clinicians explored their understanding of adolescent NSSI and their perceptions of motivation
and treatment modalities. By gathering information about how social workers conceptualize and
treat adolescent self-harm, there is an increased understanding about how the social work
community understands NSSI in adolescents. This study necessitated the utilization of a

qualitative design, as I wanted to explore the therapeutic process of clinicians. The qualitative

nature of the design allowed for observations and exploration about clinicians' use of particular

theoretical approaches. In utilizing a qualitative design, I was able to better understand self-harm

in adolescents from the perspective of professionals working with adolescents (Vaismoradi,

Turunen, & Bondas, 2013). In conducting semi-structured open-ended interviews with clinicians,

I had the opportunity to learn more about their understanding and conceptualization of the

clinical work they are doing. These interviews allowed me to delve deeper into the experiences

of clinical social workers working with adolescents who self harm in a way that I would not have

been able to with any other design method (Padgett, 2008).

Sample

Participants for this study were 10 clinical social workers who treat adolescents in a

mental health setting (i.e. community mental health center, private practice, outpatient practice).

I used nonprobability, purposive techniques to obtain the participants appropriate to qualitative

research. I utilized purposive sampling as I was focused on choosing participants based on their

expertise and ability to provide information that would help to answer my research question

(Padgett, 2008). Due to the nature of my research question, I was interested in sampling a

particular group of the population. Therefore, in terms of inclusion criteria, participants were

social work clinicians in Massachusetts. Due to the small sample size of my study, I wanted to

ensure that all my participants had the same degree and training as social workers. These

clinicians had at least five years of experience practicing clinical social work and had treated at

least 8-10 adolescents (ages 12-17) who engage in self-harming behavior. I was interested in

having clinicians with adequate experience who have seen a number of adolescents who self

harm. Due to the specific nature of the interview questions and the focus on theory, I required

clinicians to be at least five years post masters to ensure that they would be able to speak confidently about their clinical work.

Ethical Concerns

Prior to beginning the recruitment process, I received approval by the Human Subjects Review Board (HSRB) of Smith College School for Social Work (See Appendix D for HSRB form). I also received approval from the HSRB to amend my eligibility criteria and expand my sample from the Boston area to the state of Massachusetts (See Appendix E). There are a number of ethical issues that needed to be acknowledged throughout the course of my research. The participants signed consent forms before participating in the study (See Appendix B for Informed Consent). In terms of ethical issues, I was aware of confidentiality issues, as clinicians shared information about clients during their interview. For this reason, all research materials including recordings, transcriptions, analyses, and consent forms were stored in a secure location and were password protected. I kept consent forms in a separate location from audio files and audio transcripts, which were password protected. In order to maintain anonymity with the participants, I created a system where I assigned each participant with a number and the transcript of their interview was labeled with this code. Audio transcripts were only used for educational purposes. All documents were kept in a locked file cabinet in which this researcher was the only individual with access. In accordance with federal regulations, all research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years. If these materials are needed beyond this period, they will be kept secure until no longer needed and then destroyed.

The consent forms that were issued to potential participants reviewed the purpose of the interview questions and the benefits and risks of participating in the study. Participants were

asked not to provide any identifying information about their clients. Prior to their participation in the study, I notified participants that participation in my study was voluntary and that they could choose to stop at anytime. The study was considered low risk to participants, as they were all social work professionals. If during the course of the interview, clinicians shared information about their clients that caused them to feel distressed, I reminded them they could decide to stop the interview if they chose.

Data Collection Methods

After receiving approval by the Smith College HSRB, I utilized public sites such as LinkedIn and Facebook as sources for obtaining participants. I also utilized the snowball sampling method in which I asked clinicians who had agreed to participate in the study if they could refer me to other clinicians. Snowball sampling is commonly used in exploratory, qualitative studies. I was interested in interviewing a minimum of 10 clinicians (as required by the HSR board for qualitative studies). I posted a brief explanation of my study and the research I planned to conduct on various Facebook groups, including local groups for current Smith School for Social Work students and alumni (See Appendix A for recruitment letter).

In utilizing the snowball sampling method, I was able to have clinicians who were interested in the study but perhaps did not meet the eligibility requirements, distribute my recruitment letter to their colleagues. I reached out to Smith alumna living in the Boston area, and if they agreed, I had them share my recruitment letter with their colleagues and friends who were social work clinicians in Boston. I contacted my previous boss at an agency that provides home-based counseling, and she offered to send out my recruitment letter to the clinicians working at that agency. In all cases I was contacted directly by participants, and I did not contact them before they reached out to me.

If participants were interested in participating in the study, they either called my cell phone or e-mailed me, as indicated in the recruitment letter. If they wished to participate in the study, I either e-mailed or faxed participants a copy of the informed consent letter. After the participants signed and returned the informed consent form to me, I emailed or called them to schedule a time and a place to interview them that was both convenient for them and allowed for privacy.

The data for this study was collected through interview questions that I asked the participants who volunteered to participate in this study. The interviews were semi-structured and open-ended (See Appendix C for the interview guide). This structure allowed me to remain flexible, because I developed interview questions ahead of time, but I also asked follow up questions. Throughout the interviews, I asked probe questions that allowed the clinicians to share their experiences in more depth (Padgett 2008).

All of the interviews occurred from January 2016-March 2016, and they lasted approximately 45-60 minutes. I held each of the interviews at a private location that was convenient for the participant and of their choosing. I interviewed nine of the participants at their respective offices and one participant at a local restaurant. I began each interview by thanking the participant for agreeing to participate in the study and reviewing the structure of the interview with them. Then, I spent some time building rapport with the participants so that they felt comfortable and at ease during the interview. After a few minutes of engaging in small talk, I asked the participants to provide demographic information including their gender identity, race/ethnicity, degree certifications, number of years practicing, and nature of practice setting. No participant was excluded from the study due to gender identity, race, or ethnicity.

Next, I explained to participants that I would be asking them a series of questions about their process in working with adolescents who self harm. These questions focused on conceptualization of self-harm, theoretical frameworks, and treatment modalities. I made sure to allow 30 minutes for participants to answer these questions, leaving about 10 minutes at the end of the interview for them to ask any questions. After each interview, I completed field notes where I reflected on the interview process, including any observations about the environmental or emotional content of the interview.

I audio recorded each of my interview sessions and used two audiotapes for good measure. I wanted to use more than one audio recorder in case some of the recording was difficult to hear or the sound was muffled. In order to minimize the potential limitations to this data collection method, I tested all equipment before my interviews, and I had back up batteries and equipment in case of technical difficulties. I then transcribed these interviews myself.

Prior to beginning the interviews, I conducted a pilot interview with a former colleague with an LICSW who was five years post-Masters. The purpose of the pilot interview was for me to have the opportunity to gain familiarity with the interviewing process and to ensure that the interview questions I developed in my guide were comprehensive and easy to understand. During this interview, I was able to receive feedback from my former colleague about my interview style and any questions that were unclear. This also gave me the opportunity to test my audio recording equipment and to make sure that I was able to conduct the interview in a timely manner.

Data Analysis

I transcribed each interview completely to ensure accuracy. After transcription, I identified themes and patterns in each line and paragraph of the interviews using inductive

analysis. This process helped me to consider different interpretations of themes that were relevant to my research questions (Vaismoradi et al., 2013). In utilizing inductive analysis, I was able to search for common themes across the different sets of interviews. I also noted common response and unusual responses that I received. This inductive approach is useful for developing themes found in raw data. The openness of this approach allowed me to observe patterns and consistently assess my assumptions (Thomas, 2003). The purpose for using inductive reasoning is that it allowed for me to systematically read through transcripts and think about potential meanings that could be drawn from raw data. I was able to condense the data and develop themes that linked to my research question, so that I could begin to develop theories about the experiences of the social work clinicians I interviewed (Thomas, 2003).

The first step in inductive coding involved formatting the data such that each interview transcript was identically formatted. I also removed any identifying information relating to my participants. I used a qualitative software called ATLAS.ti to facilitate the coding process and to manage the data. I began the coding process by importing each of my transcripts into ATLAS.ti. Then, I read closely through each transcript and began to code each line in an open coding process. I used the constant comparative analysis method to compare the initial coding to other rounds of coding (Tracy, 2012). After completing the initial coding process, I created a code list to organize the themes and patterns that I observed, and I developed a definition for the meaning of each code. I shared the codes on Atlas.ti with my thesis advisor throughout the coding process for guidance in an effort to strengthen the reliability and decrease bias in the analysis. After I assigned each sentence of the transcript a particular code, I was able to observe the variety of themes that emerged. I initially had approximately 200 codes, but I continued to collapse the codes by merging similar codes together. I continued this process of collapsing codes until I had

about 30 codes, which I organized into code families. At that time, I continued to note the primary themes and patterns that emerged among the code families. All of the interview transcripts were read multiple times as the codes were generated and modified. Throughout the process of analyzing these codes, I referred back to the original research questions to ensure that data informed the research question (Padgett 2008).

Trustworthiness and Rigor

In utilizing interviews, I attempted to control for interviewer bias and to maintain a level of consistency and comparability in the questions I developed. Also, it was important that I considered my own social identities and positionality as a social work intern, as this related to the interview questions that I posed. As an emerging social worker, I hold certain biases and therefore I was unintentionally looking for certain results. For example, attending a school that is more psychodynamically oriented, I was inclined to ask questions that focused on psychodynamic treatment. I examined my expectations in terms of the results, so that I was not too invested in a particular outcome. I recognized that I had certain expectations and hopes for the findings of this study based on my previous experiences with self-harm in adolescents.

The threat of interviewer bias was high in this study. In order to increase trustworthiness for this study, I carried out the study in a manner that was ethical and fair. In doing this, I made every effort to verify that the findings of the study reflected the experiences of the participants. Furthermore, I asked for clarification during my interviews, to ensure that I understood the participants' responses and did not add my own interpretations. I also considered that participants could have been withholding information, such as only sharing what has been effective in terms of treatment with this population.

To increase the rigor of this study, I tried to have a continued awareness of my own biases and reactivity as the researcher and interviewer and remain self-reflective about the work I did (Lietz et al., 2006). Other ways that I tried to control for researcher bias was by asking questions in my interview that were open ended and did not lead the participant to respond in a particular way. I was also aware of my presence in the interview and tried to maintain a curious and non-judgmental stance, so as to encourage participants to share their experiences (Padgett 2008). I tried to ensure trustworthiness by having my research advisor review the methodology and data analysis. In the following section I will discuss my findings from the 10 interviews I conducted with clinical social workers who work with adolescent self-harm in the state of Massachusetts.

CHAPTER IV

Findings

This chapter presents findings from 10 semi-structured interviews with licensed clinical social workers in the state of Massachusetts who treat adolescents (ages 12-17) that have engaged in NSSI. The purpose of these interviews was to explore the following research question: What are social workers' perceptions of the causes of adolescent NSSI, and what particular treatment processes do social workers use in their engagement with adolescents who have NSSI? The interviews were conducted in person and the questions that I posed to clinicians explored their understanding of adolescent NSSI and their perceptions of motivation and treatment modalities. The following chapter will describe the demographic data, the definition of self harm, the underlying causes of adolescent self-harm, how clinicians build rapport with adolescents and the process whereby clinicians develop treatment methods.

In interviewing these 10 participants, I was aware of how the interview process and the findings that follow were influenced by reflexivity. As a female student interviewing mostly female clinicians, I easily identified with many of the participants, which allowed them to feel comfortable during the interview. Throughout the interview process, I became aware of my position as a social work student entering the field. In speaking with some clinicians with over 20 years of experience in the field, I believe that my role as a student was especially useful, as I was able to remain curious and eager to learn. I found that the more interviews I conducted, I was able to develop a greater understanding of what I wanted to explore, and therefore I asked

more direct questions of the participants. In asking clinicians about their process for developing theoretical frameworks and treatment methods, I was aware of how my social work education at a school that privileges psychodynamic theory may have impacted the way in which I analyzed the data. In the following chapter I will present the demographics of the sample and the participants' definition of non-suicidal self-harm.

Demographic Data

Of the 10 total clinicians who were interviewed, 9 were female and 1 was male. The mean age of the participants was 47.7, the range was 30-64, and the median was 48.5. All participants identified as Caucasian, though one participant also identified as Italian American. Participants' range in length of practice was 6-33 years, with a mean of 20.4 years. The participants received their Masters in Social Work from the following schools: Boston College (two clinicians), Boston University (two clinicians), Smith College (one clinician), SUNY Albany (one clinician), Columbia University (one clinician), Bridgewater State University (one clinician), University of Wisconsin (one clinician), and Simmons College (one clinician).

The participants were asked about the total number of adolescents they have treated with NSSI. The range in number of adolescents who self harm was 10-300. Every participant interviewed was a full time clinical social worker. Two clinicians taught in a social work graduate program and worked in a private practice setting, one clinician worked at a non-profit agency, two clinicians worked in both a school and a private practice setting, and five clinicians worked solely in private practices.

Clinicians reported utilizing a variety of treatment methods in working with adolescents who self harm. Three clinicians reported using a cognitive behavioral therapy (CBT) approach, two reported that they use a combination of solution focused and CBT, one reported using a CBT

and family systems approach, one reported using an internal family systems and CBT approach, one clinician reported using an internal family systems approach, one clinician reported using an interpersonal therapy approach, and one clinician reported using an eclectic approach. Of note, none of the participants reported utilizing a psychodynamic approach in working with adolescents who self-harm. See Table 1 for a summary of demographic findings.

Table 1

Demographic findings

n=10

Age	mean		= 47.7
	range		= 30-64
	median		= 48.5
Years of Experience	mean		=20.4
	range		=6-33
Gender	female		9
	Male		1
Race/Ethnicity	Caucasian		9
	Caucasian and Italian American		1
Social Work Program	Boston University School for Social Work		2
	Boston College School for Social Work		2
	SUNY Albany		1
	University of Wisconsin		1
	Bridgewater State University		1
	Smith College School for Social Work		1

	Simmons College School for Social Work	1	
Clinical Setting	Private Practice	5	
	School Setting and Private Practice	2	
	Social Work School and Private Practice	2	
	Non Profit Agency	1	
Treatment modality	CBT	3	
	Solution Focused and CBT	2	
	Internal Family Systems Therapy	1	
	Internal Family Systems Therapy and CBT	1	
	Family therapy and CBT	1	
	Interpersonal Therapy	1	
	Eclectic	1	
Adolescents who self harm	range	=10-300	

Definition of Non-Suicidal Self-Injury

Every participant defined self-harm as a behavior directed against oneself that includes, but is not limited to, cutting, burning, and scratching, as well as engaging in dangerous, extreme behavior, such as using drugs, alcohol, and having sex. The participants all identified a significant difference between self-harming behavior and suicide. Suicidal behavior was conceptualized as an intent to no longer be alive, whereas self-harming behavior was viewed as a desire to escape the pain. One clinician (P10) described the difference between suicide and self-harming behavior as follows: "It's not that they're trying to not exist or kill themselves in any way…they're trying to do something to concretize their internal angst and confusion and affective overwhelming-ness." Participant 4 shared the importance of gaging the adolescents'

level of hope and motivation about the future in order to better understand their experience. Many clinicians (P1, P2, P4, P5, P7, P9) discussed the process of assessing the self-harming behavior to determine the intent. Clinicians (P1, P2, P3, P5, P6, P9) understood self-harm as a way for adolescents to express in a physical way the emotional pain they experience. One clinician (P5) explained: "I often listen if kids are experiencing emotional pain. I'm listening if the manifestation of physical pain is a way for them to make it concrete, understandable, legitimate and physical to others." In order to determine the most effective treatment methods for working with adolescent non-suicidal self-injury, participants must understand the underlying causes of adolescent self-harm.

Underlying Causes of Adolescent Self-Harm

In reviewing the findings, there seemed to be three major causes that speak to the challenges during the period of adolescence: (1) adolescent brain development, (2) identity exploration and peer relationships, and (3) family dynamics and trauma. The following describes these causes in more depth.

Adolescent brain development. Many clinicians had a similar clinical view of self harm and understood it as a coping skill that adolescents utilize to manage their emotions and the unique set of challenges they face during this developmental period. Adolescents who have not learned how to "metabolize" (P2) emotions may shut them down because emotions feel intolerable.

One clinician (P2) described it in this way:

I think if you don't have an awareness or permission to experience a lot of complex emotions or have someone to guide you through that, you do end up shutting down the

feeling, because feelings can be very terrifying if there's not someone there to guide you through it.

Reportedly, when adolescents have feelings that are out of control, they may engage in self-harming behavior as a way to deal with feelings of numbness or emptiness. Adolescents are experiencing a great deal of change both in their bodies and their brain development, which impacts their behavior and emotions. Several clinicians (P1, P2, P8) noted that adolescents may be more impulsive due to the lack of development in their frontal lobe. Reportedly, due to their level of brain development, adolescents have not yet learned how to process difficult emotions. Therefore, they tend to feel overwhelmed, and the physical act of self-harming can provide them with a sense of release. Participant 2 explained how adolescents have not yet developed "good tools" and "ways of modulating the affect and the arousal in their brain," so that they seek "something very drastic."

Identity exploration and peers. Every clinician noted that adolescence is a time when individuals begin to develop a sense of identity, and peer relationships become increasingly important. Many clinicians (P2, P3, P4, P5, P6, P7, P10) asserted that self-harming behavior has become more popular, and adolescents often feel pressure to cut in order to fit in. One clinician (P8) said, "I had a kid who got on the internet and found chat rooms where people were all self harming together, and they would all cut together…she was this really vulnerable kid who felt really socially isolated." Another participant (P7) shared how self-harming behavior has increased in popularity such that when "one person does it in a friend group, then the rest of the friends" begin engaging in self-harm.

Several clinicians (P2, P3, P7) believed that our society does not foster healthy emotional expression. One clinician (P2) expressed that "society doesn't really promote emotional

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awareness" and an array of emotions that people are allowed to experience. There are no role models for people for how to manage complex emotion. Another clinician (P7) described it this way:

> I think the only other thing that's newer in the last 5-10 years is the high school kids in the suburbs are just under an exorbitant amount of pressure…so I think self harm may be more prevalent, but I do think it's again symptomatic of kind of a host of systemic issues…I do think that self harm has replaced a good night sleep…

Family dynamics and trauma. It is important to recognize that complex family dynamics and trauma are part of the underlying triggers that motivate adolescents to engage in self-harming behavior. Several clinicians conceptualized self-harm as a symptom of complex issues within a family system or trauma exposure. Participant 2 explained that engaging in self-harming behavior may be the only way to get attention in a family system. She said: "It might be that that's the only way to express yourself where the people that matter in your life will listen." Sometimes past trauma impacts a family's ability to process emotions and it can be intolerable for adolescents to acknowledge or think about it. That same clinician (P2) explained that parents can worry about their child experiencing pain, yet they "don't provide emotional intelligence" to their child to help the child manage the pain.

Not all adolescents who self harm have had an extensive trauma history. Some may have experienced one particular incident that was traumatizing, and that traumatic memory may lead to a decision to self-harm. For example, many clinicians (P1, P2, P4, P6, P7, P10) cited bullying as a potential trigger for an adolescent engaging in self-harm. When adolescents are bullied or teased, these experiences may impact the way that they view themselves. Another clinician (P4) described that when adolescents experience betrayal within the context of primary relationships,

the betrayal gives them a sense of worthlessness. As a result, adolescents who feel worthless may make poor choices, including engaging in self-harming behavior. That same participant said: "I almost feel like chronic teasing really drains a person's soul and ability to have an objective view of themselves."

In summary, the three underlying causes of self-harming behavior in adolescents are adolescent brain development, identity exploration and peers, and family dynamics and trauma. Before clinicians can even begin to build rapport with the adolescent or develop treatment methods for the self-harm, they must first understand the underlying causes that motivate the individual to engage in the self-harming behavior. The following section describes how clinicians build rapport and maintain a therapeutic alliance when working with adolescents.

Building Rapport

Every clinician asserted that one of the most important aspects of treatment with adolescents who self- harm is being able to build trust and connection within the therapeutic relationship. One clinician (P3) said: "I can't speak highly enough about the importance of the relationship…and to develop a sense of trust and connection where they can really start to feel safe enough to open up about what they're really feeling." Another clinician (P2) described how the therapist can act as a consistent presence in an adolescent's life. Five of the clinicians interviewed (P2, P3, P4, P8, P9) noted how the therapist should maintain a supportive, non-judgmental position where they are validating the adolescent's experience. Reportedly, in order to build and maintain a therapeutic alliance with an adolescent, the clinician must have an understanding of the challenges that occur during adolescence, such as developmental challenges, identity and peer relationships, and individuation from the family system.

Developmental challenges. An important way for the therapist to maintain rapport with the adolescent is to have an understanding of the stressors that they face during this period of development. One clinician (P6) described these challenges this way:

You're pulling away from your parents, you're developing your own person, you're developing who you're going to be. You're trying to set the standard for what the rest of your life is going to look like. And then you throw on top of that your regular high school drama…rumors…and the cliques.

Reportedly, adolescence is a period of increased external stress, however adolescents are not always equipped to process their emotions in a safe and healthy manner. Many clinicians (P1, P5, P6, P7, P10) identified that one of the major stressors that currently faces adolescents is academic pressure, which can lead to a variety of different problem behaviors. Another clinician (P4) explained that adolescents can be ambivalent about engaging in therapy as it disrupts their work schedule. She advised that in order to maintain a sense of understanding and rapport within the therapeutic relationship, it is important for the therapist to have compassion about this particular challenge.

Identity exploration and peers. Reportedly, another way clinicians try to build connection with the adolescent is to understand the value that adolescents place on peer relationships and the culture that has emerged through the use of technology. Participant 2 shared that adolescents sometimes feel that they have to "show their misery to fit in." She explained "this dichotomy of either you're the popular kid or you're the miserable kid… In order to have an identity you have to be this really angry dark person." That same participant shared how important it is for clinicians to have an understanding of the cultural influences in society and how they impact adolescent's identity development. Peer relationships can be developed when

the adolescents share similar self-harming behaviors. Participant 3 described how adolescents may be more likely to engage in cutting if they are living in a dorm or community setting and if their peers are doing it. He adds how in order to maintain rapport with the adolescent, the clinician must recognize how difficult it can be for the adolescent to stop engaging in self-harm if they live in such a community setting.

Every participant noted the increased use of technology during adolescence. Participant 5 believed that adolescents are most "triggered by social media events" when they are the "most vulnerable," which impacts them significantly. Several participants reported that one of the current challenges with adolescents is that they have difficulty with social skills as result of "spending time texting and on computers. " Participant 5 explained how "modern technology" and communication can be utilized in more private ways than in the past, "limiting parent's access to their child's technology." According to the participants, it is important to support the adolescent in establishing boundaries around their use of social media and encourage them to become involved in other activities.

Separation and individuation from family. Many therapists (P1, P2, P3, P4, P5, P6, P7, P9, P10) identified that a challenge in working with adolescents is maintaining rapport with their parents, while recognizing the adolescent's need for autonomy. One way to do this is for the clinician to maintain regular contact with the parents around the adolescents' treatment, while still respecting the adolescent's confidentiality. A clinician (P7) explained how she navigates this with adolescents by giving them the option to discuss the self-harming with their parents. She said: "We have to talk about what can we do in the moment to support you. Can we invite them in or do you want to tell them and I'll catch up with them via my phone afterwards?" The

therapist can also help the adolescent learn skills about how to effectively communicate with their parents in order to strengthen the parent-child relationship.

When the clinician believes that the adolescent's self-harming behavior may be related to issues within the family system, the clinician facilitates family meetings with the adolescent or makes a referral for family therapy. Participant 3 explained how he often brings in the adolescent's family to explore how the different members of the family view the adolescent and the behavior. Other participants said it was important for clinicians to understand the barriers in working with the adolescent's family system.

Two clinicians (P1 and P5) stated families with a higher socioeconomic status tend to have more difficulty acknowledging their adolescent has a problem and can be "more guarded." In contrast, Participant 1 explained her experience working with adolescents in DCF custody: "You know when you have a kid…who's in DCF custody, it's very obvious…there's issues in the home that have contributed to whatever is going on and it's harder for the parents to deny that." Another participant (P2) described a barrier in working with families is that they can be "resistant to treatment" when they are "so entrenched in their dysfunction."

In order to build rapport with adolescents, it is important that the clinician understand the developmental challenges, identity exploration and peer relationships as well as how adolescents individuate from their parents. The following section will discuss the process whereby clinicians develop their theoretical framework and treatment modalities. Also, clinicians identify their experiences regarding the most effective treatment methods for working with adolescent non-suicidal self-injury.

Treatment Process

In interviewing the participants, many described how their process for developing theoretical frameworks began in graduate school and evolved throughout their years of practice. Half of the clinicians (P1, P3, P7, P8, P9) reported that psychodynamic theory was the primary framework taught in their graduate schools. The participants acknowledged that psychodynamic theory can be useful in understanding self-harm, but it is not as effective in terms of helping facilitate change in clients. Four participants (P3, P7, P8, P9) described their process of looking more at what causes change to occur. Participant P3 explained:

> I've really moved away from the whole psychodynamic thing, I mean it makes a lot of sense…but again, how do you use that? Can you use that in a way that really helps people? I come to the answer that no…people benefit a lot more from cognitive strategies, behavioral strategies, and the relationship.

Many clinicians (P1, P3, P5, P6) reported that they learned about effective treatment methods for self-harm by attending trainings and reading literature about the topic. One clinician (P5) asserted that social workers are taught to understand the client as "operating within the larger system," whereas other disciplines within psychology may not have this perspective. Many of the participants shared that although many treatments can be effective in working with adolescents who self-harm, the most important intervention is maintaining the therapeutic alliance. Participant P8 described it in this way:

> Scott Miller has done outcome studies…The factors for successful treatment are strong therapeutic alliance, the client has well formed goals, and the client has hope. And when those three things exist it doesn't matter what your technique is.

Some of the participants (P1, P2, P3, P6, P9, P10) noted the importance of understanding the nature of the setting where they are working, in order to develop appropriate treatment for adolescent self-injury. Participant 3 reported that when working in a school, he tends to use more of a "behavioral" approach and does "more problem solving" compared to when he is working with adolescents in an outpatient setting where he said he has "the time to be able to go deeper with people." Additionally, these participants believed that their particular treatment setting may impact the outcome of treatment, in that the severity or chronic nature of the self-harming behavior may vary. Several clinicians (P3, P5, P9) described how they present treatment techniques as optional and experimental, "not as a prescription," so that the adolescent can determine which interventions are most helpful for their needs. Another clinician (P3) reported that throughout the treatment process, it is important to check in with the adolescent to understand how the adolescent is experiencing their emotions and where the treatment is landing.

In treating non-suicidal self-injury in adolescents, participants focused on addressing the developmental challenges, identity exploration and family dynamics utilizing Solution Focused, CBT, Internal Family Systems Therapy and Interpersonal therapy, or a combination of these modalities. The following describes these approaches in more depth.

Interpersonal therapy. Many participants described the importance of teaching adolescents healthy and safe coping skills to manage their overwhelming emotions. Reportedly, adolescents' brains are not fully developed and therefore they can have difficulty coping with the variety of challenges they face during this period. One approach that addresses the challenge of overwhelming emotions is therapy based on interpersonal neurobiology. Participant 5 explained how clinicians trained in interpersonal neurobiology utilize a "trauma informed approach" to understand the "somatic manifestation of trauma." That same clinician described how she tries to

understand the "sensory experience" that the adolescent is having while engaging in self-harm. Participant 2 reported how adolescents engage in non-suicidal self-injury to "release tension" that builds, and therefore it is important to introduce replacement strategies that provide a similar sensory experience such as "holding an ice cube, putting ice on your face, or using a rubber band on your wrist," which "stimulate a sensation of pain." Participant 5 explained that when adolescents have a "small window of tolerance for emotions" they either become "hypo or hyper aroused." Sensory tools such as the weighted blanket can be calming and help bring adolescents "back into their window of tolerance." She shared how she provides psychoeducation to the adolescent about their brain development and introduces them to these sensory tools, so that the adolescent increases their understanding of their brain and body.

Cognitive behavioral therapy. Many participants described the importance of teaching adolescents healthy and safe coping skills to manage their overwhelming emotions. Participants (P2, P6) explained the importance of developing realistic treatment goals for the individual. Reportedly, in using a CBT model, the clinician is interested in the individual's thought process and how this impacts one's actions and behaviors. Many clinicians (P2, P3, P6, P7, P9, P10) believed that utilizing a CBT model can help the adolescent find replacement strategies and coping skills such as "journaling, other forms of artistic expression, and mindfulness techniques." Participants (P3, P6, P7, P8, P9, P10) described that the CBT approach encourages the adolescent to understand the triggering thoughts that precipitate self-harming behavior. Two clinicians (P3, P9) noted that adolescents benefit most from this treatment when they attend a CBT group in conjunction with individual therapy.

Many clinicians shared how important it is for the clinician to help the adolescent find activities that are age appropriate, safe, and foster their sense of identity. One clinician (P2)

described how she encourages adolescents to participate in activities they enjoy to provide them with a sense of mastery. Participant 3 shared that the clinician can utilize the therapeutic relationship to help the adolescent develop more adaptive behaviors than self-harm. That same participant (P3) described how the clinician can help the adolescent with their identity development: "What we want to do, just in general…is just building self esteem, teaching adolescents emotional intelligence."

Participants 6 and 7 reported that CBT is especially useful in helping adolescents to identify how social media triggers an emotional response that may lead to a decision to engage in self-harm. Additionally, these clinicians were interested in providing adolescents with alternative ways to manage these emotions. Reportedly, adolescents rely more heavily on technology than ever before and are also more likely to misuse this technology. Four participants (P1, P5, P6, P7) described how they provide psychoeducation to the adolescent around ways to create healthy boundaries around technology use, particularly with regards to social media.

Solution focused therapy. Two participants (P7, P8) reported that in addition to CBT, a solution-focused approach can be useful in exploring where the adolescent would like to go in terms of their treatment. Reportedly, clinicians asked the adolescent "exception questions" so that the adolescent could think about times when they did not engage in self-harm and why this did not occur. Participant 8 explained that when she used a psychodynamic framework, she "never knew if clients were getting better" and that solution focused is more "goal oriented." Participants 7 and 8 expressed that a solution focused approach seemed to fit more with their individual personalities and that it is important as a clinician to find a modality that "resonates." Participant 7 shared that she initially asks adolescents what they are experiencing and how they

would like to be feeling in the future. She adds: "I have to say, even kids in residential don't want to be feeling the way they're feeling." Participant 8 described it in this way:

I'm a solution focused clinician and I don't think of self harm as the problem. I think of it as the proposed solution that the person is using and what we have to do is figure out…when you self harm and it goes well for you, what is different?

These same clinicians reported that solution focused therapy can be utilized effectively with cognitive behavioral therapy to treat adolescents who self harm.

Internal family systems therapy. Several clinicians (P4, P5, P9) reported that more recent treatment modalities such as Internal Family Systems (IFS) and trauma informed therapies have gained popularity in recent years and can be effective in working with adolescent self-harm. Two clinicians (P4, P9) believed an internal family systems approach is effective when working with adolescents who self-harm and it can help them explore the more complex aspects of their identity. Participant 4 reported that one of the first steps in working with the adolescent is to have them explore in more depth "the part of them" that self harms and to begin "to feel compassion for that part." That same participant described the three primary "parts" as the "managerial, or protective parts," the "firefighters, which are reactive" (i.e. drugs, rage), and then the "exiles," or "wounded parts." She shared that she tries to maintain a non-judgmental stance and "reflects to the adolescent what is being noticed in terms of their self-harming behavior," using parts language. Participant 4 explained how she tries to offer "compassion and understanding to these parts" and in doing this, the adolescent may experience a "sense of calm."

Systems approach. Many clinicians (P2, P4, P6, P7) described the ideal treatment for self harm as utilizing a systems or wrap around approach where treatment can occur at the individual, family, school and social level. These clinicians believed that it is important to

involve the adolescent's school. Participant 2 reported that if the adolescent experiences bullying or academic struggles, the clinician can help to advocate for the adolescent to receive additional support at school. In addition to communicating with the adolescent's school, many participants (P1, P3, P7, P10) shared their hope for more schools to implement programs into the curriculum that teach emotional intelligence, healthy living skills and suicide/self harm prevention to adolescents.

Family therapy. Every participant discussed the importance of involving an adolescent's family in the treatment process. Participant 3 explained that bringing in the adolescent's family can allow the clinician to observe what is going on at the family level and how the patient interacts with their family. Reportedly, it can be difficult to work with an adolescent if the parents are not engaged in treatment or if they have their own mental health issues. Participant 5 discussed how she assesses the parents' "window of tolerance for emotion." She explained it in this way:

> There's a significant parallel between the parent/caregiver's ability to tolerate affect and the child's ability…I will work with the caregivers to see if their capacity to expand and to develop a more positive association to emotion is possible.

Many clinicians (P1, P3, P4, P6, P7, P9) reported that adolescents can be ambivalent about confiding in their parents, but it can be helpful for the clinician to communicate with the parents about the adolescent's treatment. Participant 3 explained how family work can include teaching the parents to "allow the adolescent to feel a range of emotions." Other clinicians (P2, P3, P4, P6, P7) shared how useful it can be for the clinician to teach the adolescent how to communicate effectively with their parents. Participant 7 described that an aspect of the

clinician's role is to help the adolescent begin the process of individuating from their family in a healthy way. She explained it in this way:

> With adolescents, one of their goals in life is being able to launch…so we talk about the "I versus we" when it comes to family of origin…and separating in a healthy way…maintaining contact and support and love and care and all that stuff, but also being able to prioritize yourself.

Many clinicians (P1, P3, P6) reported that it is important when working with adolescents who self-harm to develop a safety plan and to help the adolescents identify supports either within their family or in the community. Reportedly, in working with the families, the clinician can provide psychoeducation to the parents about the nature of the self harming behavior and how the parents can best support the adolescent. Some clinicians (P4, P6, P7) reported that it can be useful for the parent and the clinician to assess the adolescent's safety using a scale, so that the parents, the adolescent, and the clinician are all using the same language.

Conclusion

This chapter presented the findings from 10 in-person interviews with licensed clinical social workers who work with adolescent NSSI. The interviews explored clinicians' understanding of adolescent NSSI and their perceptions of motivation, as well as treatment modalities. This section described participants' demographic information, their definition of self-injury, as well as how participants' understand the underlying causes of self injury in adolescents, how clinicians build rapport with adolescents and the process whereby clinicians develop treatment methods for adolescent NSSI.

Participants' identified three major causes that speak to the challenges during the period of adolescence: (1) adolescent brain development, (2) identity exploration and peer relationships,

and (3) family dynamics and trauma. These developmental challenges informed how the clinicians understood self-harm and their treatment process. Based on participants' reports, they developed their theoretical frameworks and treatment models during graduate school and have continued to develop these models throughout their years of practice. The modalities that clinicians utilized most often in their treatment of adolescent non-suicidal self-injury were solution focused, CBT, internal family systems therapy, systems approach, family therapy, and interpersonal therapy, or a combination of these modalities.

In the next chapter, I will explore how the findings relate to the literature reviewed. I will also discuss the implications for clinical practice and areas for further research.

CHAPTER V

Discussion

The purpose of this study was to explore clinical social workers' perceptions of the

causes of adolescent non-suicidal self-injury (NSSI) and the processes whereby social workers

develop treatment for NSSI. The following chapter will discuss the key findings of this study, the

relationship between these findings and the previous literature, the implications of these findings

in terms of social work practice, and recommendations for future research in the area of

adolescent non-suicidal self-injury.

Key Findings Supported by the Literature

The findings of this study are based on 10 in-person interviews conducted with licensed

clinical social workers who treat adolescent self harm. In conceptualizing the causes for NSSI in

adolescents, participants' cited the following: (1) adolescent brain development, (2) identity

exploration and peer relationships, and (3) family dynamics and trauma. Participants shared their

process for developing treatment methods for adolescent self-harm based on their understanding

of the causes of the NSSI.

Every clinician identified that one of the most important aspects of treatment with

adolescents who self- harm is being able to build a therapeutic alliance where the adolescent

feels a sense of trust and connection. The participants recognized that psychodynamic theory,

specifically attachment theory, can be useful in understanding self-harm, but it is not as effective

in terms of facilitating change. The treatment modalities that clinicians reportedly utilized most

often in working with adolescent non-suicidal self-injury were solution focused, CBT, internal family systems therapy, systems approach, family therapy, and interpersonal therapy, or a combination of these modalities. These findings are generally supported by the literature. In this chapter I will compare the results of this study to the previous literature, and I will also discuss findings that I did not come across in the literature.

Conceptualization of non-suicidal self-injury. Participants' understanding of self-harm and the underlying causes of self-injurious behavior were generally consistent with the literature. Many participants understood self-harming behavior as a maladaptive strategy that adolescents use to regulate emotions that are deemed intolerable. Mikoljcak et al. (2009) found that individuals tend to use self-injurious behavior to regulate emotions such as helplessness and self-blame. Participants also identified that adolescents tend to lack emotional awareness, which is consistent with Sim et al. (2009), reporting that individuals who engage in self-harming behavior also suggest poorer emotional regulation skills. Both the literature and the participants all identified a significant difference between self-harming behavior and suicide.

The clinicians described several underlying causes that may lead to the development of self-harm in adolescents including developmental challenges, peer issues, and family dynamics. Wagner and Zimmerman (2006) asserted that the last region in the brain to develop is the prefrontal cortex, which is responsible for impulse control and emotional processing. Similarly, many of the participants noted that adolescents may be more impulsive due to the lack of development in their frontal lobe.

The findings were consistent with previous literature in terms of the relationship between family dynamics and the development of self-harming behavior in adolescents. Many participants described self-harm as a symptom of complex issues within a family system or

trauma exposure. One participant shared that when adolescents experience betrayal within the context of primary relationships, the betrayal gives them a sense of worthlessness, which may lead to a decision to engage in self-harming behavior. These findings are supported in the literature. Quirk et al. (2015) found that parental rejection is related to the formation of negative views of the self and that these views contribute to the desire to engage in self-harming behavior.

Several participants reported that past trauma impacts a family's ability to process emotions, and it was difficult for adolescents to acknowledge it. However, one of the differences between the literature and findings was that participants reported that not all adolescents who self harm have had an extensive trauma history. Some may have experienced one particular incident that was traumatizing, and that traumatic memory may lead to a decision to self-harm. Another finding that differed from the literature was the idea that parents are concerned about their child experiencing pain, but they do not provide teens with tools to manage pain. Several participants shared how disrupted attachments with caregivers impact an individual's ability to self-regulate and to develop healthy and safe coping skills. These findings are consistent with Halstead et al. (2014), who asserted that family dynamics are related to the frequency of self-injurious behavior. Individuals whose families of origin tend to value communication and cohesion are more likely to reduce self-harming behavior sooner than those individuals who do not have families with these traits.

Treatment processes for adolescent self-harm. The treatment modalities that participants utilized when working with adolescent non-suicidal self-injury are mostly consistent with the treatment methods discussed in previous literature. According to participants, CBT was identified as the most effective treatment method in working with NSSI in adolescents. Most of the literature related to treatment modalities for NSSI focuses on Cognitive Behavior Therapy

(CBT) as well as attachment based interventions such as Emotionally Focused Family Therapy (EFFT) and Attachment Based Family Therapy (ABFT).

Although clinicians discussed the importance of involving the family in treatment, participants reported that most of the work was solo treatment with the adolescent. Stavrianopoulos et al. (2014) asserted that the therapist should encourage emotional expression between the adolescents and their caregivers and connect these emotional processes to attachment needs. Many participants described that an important aspect of treatment is engaging parents and strengthening the bond between the adolescent and caregivers, a finding which was supported by the literature.

Every clinician noted the importance of building rapport with the adolescent; in order to do this, the clinician must have an understanding of the developmental challenges that the adolescent experiences. Additionally, participants noted that the nature of the setting where a clinician practices impacts the treatment approach. For example, clinicians who worked as school-based counselors reported that they were more focused on utilizing a behavioral approach and were less focused on uncovering underlying trauma.

Unexpected Findings

There were several noteworthy findings in this study that were unexpected. An important cause that participants identified as leading to self-injury was identity formation and peer relationships, though the literature did not focus as much on the peer factors associated with the increase in self harming behavior. Each of the participants shared that self-harming behavior has become more popular in recent years, and adolescents often feel pressure to cut in order to fit in. Participants discussed the importance of recognizing the value that adolescence place on peer relationships and that adolescents are often triggered by social media events. Another finding

that was not found in the literature relates to the recent academic pressure that adolescents'

experience and how this stress contributes to the development of self-harming behavior.

Participants shared their belief that society—specifically schools—does not promote emotional

awareness, which contributes to the challenges that adolescents face around emotional regulation

skills.

One of the major findings of this study was related to the utilization of attachment-based

interventions. Based on previous literature, I had anticipated that participants would use more

attachment based treatment methods in working with adolescent NSSI, but that idea was not

supported by these findings. It is possible that the clinicians I interviewed did not study about

attachment based theories and interventions in school and may not have been aware of the recent

literature around neurobiology. Many participants seemed less aware of neuroscience and may

not understand how attachment theory has been utilized to explain self-harming behavior.

Previous literature suggests that there are not as many evidence-based practices based on

attachment theory as there are practices based on cognitive behavioral theory. The reason for this

is that it is difficult to measure changes in the attachment process. There are limited attachment

based treatment models designed specifically for self-injury in adolescents, and those that exist,

are based primarily on reports from clinicians who met with the adolescents individually and in

family meetings (Diamond et al., 2010). The only two participants who taught at the graduate

school level reported that their primary treatment modalities were solution focused and cognitive

behavioral therapy. Participants also reported that they often receive pressure from insurance

companies to eliminate self-harming behavior as fast as possible so that they are more likely to

utilize evidence based practices that are more behavioral.

Strengths and Limitations

The purpose of this study was to explore social workers' perceptions of the causes of adolescent NSSI and the treatment processes social workers utilize in their engagement with adolescents who have NSSI. The qualitative nature of the design allowed for exploration of the therapeutic process of clinicians. In conducting semi-structured open-ended interviews with clinicians, I had the opportunity to learn more about their understanding and conceptualization of the clinical work. I developed a series of questions that would encourage the participants to discuss their process in working with adolescents who self harm. These questions focused on conceptualization of self-harm, theoretical frameworks, and treatment modalities. The sample included social workers who treat adolescents in a mental health setting. Although the sample lacked diversity in terms of gender and race/ethnicity (most of the sample consisted of white women), the clinicians varied in terms of years of experience and treatment modalities. I used purposive sampling because I was interested in choosing participants based on their expertise. I had the opportunity to interview clinicians with years of professional experience, which provided me with useful information about self-harming behavior and treatment methods. The interviewing process was definitely a strength of the current study.

One of the limitations of this study is that the sample size was small. Due to the small sample size and nature of the methodology, the findings of this study can not be generalized beyond the participants. Though I made a conscious effort to acquire more participants to increase the diversity of the sample, this proved more difficult than I had initially anticipated due to the eligibility requirements I had developed. I also tried to maintain a level of consistency and comparability in the questions I developed in my interview guide. However, there were times when I may have asked leading questions or questions that reflected my biases.

I tried to address issues of trustworthiness and rigor throughout this study. One of the ways I did this was by remaining aware of my biases as a researcher and my positionality as an emerging social worker, particularly at a school that is more psychodynamic. During interviews with participants, I asked for clarification from participants and made an effort not to make assumptions about their responses. Another way that I attempted to strengthen the rigor of this study was by sharing my codebook and project with my thesis advisor on a regular basis. I also consulted with my thesis advisor during the data analysis process to minimize bias.

Implications for Social Work Practice, Policy and Research

  Implications for social work practice. This study explored how clinicians conceptualize non-suicidal self-injury and their process for developing treatment methods when working with adolescent non-suicidal self-injury. Although the sample size in this study was relatively small, participants offered valuable insight about their treatment practices. However, in speaking with participants about their process for developing treatment methods, it was evident that these clinicians were not always aware of how theory could inform the development of treatment methods.

  At the graduate level, social work students should learn in more depth a variety of theoretical frameworks and how these theories guide their interventions and clinical practice. Although many clinicians reported that they learned psychodynamic theory in graduate school, these clinicians did not learn how these theories could inform behaviorally based treatment. Therefore, it would be useful for social work students to learn how to link theory to practical, behavioral interventions. Social work schools should offer a variety of electives that teach evidence-based treatment modalities including CBT, solution focused, and internal family systems. Many clinicians discussed how they incorporate mindfulness-based practices into their

work with adolescents. It would be beneficial for social work schools to offer more classes that integrate mindfulness techniques into their practice as well.

Implications for social work policy. Many clinicians described an ideal treatment in working with adolescents as involving a wrap around or systems approach. In this approach, the adolescent's school, family, and outpatient therapy team work collaboratively to support and engage the adolescent in treatment. The research that has been done in recent years around the efficacy of wrap around services suggest that this treatment approach can strengthen the relationship among an adolescent's family, school, and community. The purpose of wrap around treatment is to bridge the gap in services so as to provide the best possible treatment to adolescents and their families (Furman & Jackson, 2002). However, participants recognized how utilizing this approach can be problematic in terms of insurance, because clinicians are not typically able to bill insurance companies for collateral work. More public and private secondary schools should implement classes into the curriculum that teach emotional education to students, as well as workshops that raise awareness around suicide and self-harm. Every participant identified a lack of emotional awareness as one of the causes that may lead to the development of maladaptive behaviors such as self-harm. Thus, it would be beneficial for schools to teach students how to identify and regulate their emotions.

Implications for social work research. Although this study began exploring non-suicidal self-injury in adolescents, future research is needed. One clinician wondered about how the results of this study would compare if other professionals were interviewed about their process for working with adolescents who engage in non-suicidal self-injury. Participants highlighted the importance of involving the various systems in an adolescent's life including their school, therapist, and family. Therefore, it would be useful to understand how psychiatrists,

psychologists, occupational therapists, nurses and teachers conceptualize adolescent NSSI, so that professionals across these disciplines can work together to support the adolescent.

Moving forward, additional research must be conducted that compares various treatment approaches that clinicians utilize in working with self-harming behavior in adolescents. The findings of this study were consistent with previous literature in that most of the studies around treatment for NSSI were exploratory, and these studies lacked comparison groups. A mixed methods design would allow for researchers to issue surveys to clinicians about their treatment approaches as well as to conduct interviews with adolescents to gain as much information as possible. This design would be ideal for comparing treatment modalities and, ideally, would provide researchers with a large sample of participants, making the results more generalizable.

Another important area for future research would include either directly interviewing adolescents who currently engage in self-injurious behavior or interviewing emerging adults who previously engaged in self-harm. However, due to the vulnerable nature of this population, it may be difficult to receive approval from the Human Subjects Review Board. It would be important to ask adolescents how they conceptualize their self-harming behavior and whether they have found particular treatments to be effective, as this would provide social workers with an even deeper understanding of self-injury.

Conclusion

In recent years, there has been an increase in the number of adolescents who engage in self-harming behavior. There are limited studies that have evaluated the effectiveness of treatment methods for non-suicidal self-injury, particularly with adolescents (ages 12-17). In order to develop the most effective treatment methods for NSSI, it is necessary to identify why adolescents engage in self-harming behaviors. This qualitative study explored clinical social

workers' perceptions of the causes of adolescent non-suicidal self-injury (NSSI) and the processes whereby social workers develop treatment for NSSI. I utilized a purposive and snowball sampling method and conducted 10 in-person interviews with licensed clinical social workers who treat adolescent self-harm.

The findings of this study provide valuable information to the field of social work. One of the significant findings was related to the increased popularity of self-harming behavior among peer groups. Adolescents often feel pressure to cut in order to fit in and therefore are more likely to engage in self-harm if their peers are encouraging this behavior. Additionally, adolescents are often triggered by social media events, which leads to incidents of self-harm. The implications of these findings in terms of social work practice are that clinicians must recognize the value that adolescents place on peer relationships and how this impacts treatment with adolescent populations. Another important finding in this study is that many participants seemed less aware of how neuroscience and attachment theory can be utilized to explain self-harming behavior. At the graduate level, social work students should learn how to apply theoretical frameworks to guide their interventions and clinical practice. Ultimately, these findings expand our knowledge of NSSI in adolescents as well as how to best educate emerging social workers about effective treatment methods.

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Appendix A

Dear Classmates, Colleagues, and Social Work Community,

I am working on my master's thesis for Smith College School for Social Work. I am conducting a qualitative research study that explores social worker's perceptions of the causes of non-suicidal self-injury (NSSI) and the therapeutic processes for treating adolescents who engage in NSSI. I am sending this message to ask for your help with recruiting eligible participants for my research study, which involves one interview that lasts 45-60 minutes. If you are personally eligible for participation, I invite and encourage you to participate in my study.

The criteria to participate in this study are the following:

-You are a licensed MSW clinician in Massachusetts.

-You have been practicing for at least five years.

-You have seen at least 5 adolescents (ages 12-17) who engage in non-suicidal self-harm.

By participating in this study, participants can help expand our knowledge of NSSI and hopefully develop more effective treatment methods. Data can provide insightful information to clinicians who work with adolescents who engage in self-harming behavior as well as to increase our understanding of the motivation and theoretical underpinnings of NSSI in adolescents. If you have any questions about this study or the involvement of participation, please feel free to contact me at…Thank you for your time and interest in my research study!

Sincerely,

Rachel Weiner

MSW Candidate, Smith College School for Social Work

SMITH COLLEGE

Consent to Participate in a Research Study

Smith College School for Social Work ● Northampton, MA

....
....

Title of Study: Clinical Perspectives on Non-Suicidal Self-Injury in Adolescents: A Qualitative Study

Investigator(s): Rachel Weiner, Smith School for Social Work

....

Introduction

- You are being asked to be in a research study that will explore how social work clinicians perceive Non Suicidal Self Injury (NSSI) in adolescents and the clinicians' use of treatment modalities when working with the population.
- You were selected as a possible participant because you are an MSW clinician in Massachusetts who has been practicing for at least five years and has seen at least 5 adolescents (ages 12-17) who engage in non-suicidal self-harm.
- You should read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to explore how clinical social workers understand non-suicidal self-injury in adolescents and the clinicians' process of utilizing treatment modalities when working with adolescent NSSI.
- This study is being conducted as a research requirement for my masters of social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: Participants will be involved in one brief interview that will last 45-60 minutes.
- The interview will take place in a private location of your choosing.
- The interview will be audiotaped and then transcribed by the researcher.

Risks/Discomforts of Being in this Study

- You may share information about your clients that causes you to feel distressed. You may decline to answer a question or choose to end the interview at any time if you find it too distressing.

Benefits of Being in the Study

- The benefits of participation are that you will have the opportunity to share treatment methods for working with adolescents who self harm.
- The benefit to social workers is an increased understanding of clinicians' perceptions of NSSI and of treatments for adolescent NSSI.

Confidentiality

- Your participation will be kept confidential. This researcher will keep consent forms in a separate location from audio files and audio transcripts, which will be password protected. Audio files and audio transcripts will only be used for educational purposes. All documents will be kept in a locked file cabinet and this researcher will be the only one with access.
- The interviews will take place in private locations determined by the participants.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.
- The researcher will not include any information in any published report that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by March 1, 2016. After that date, your information will be part of the thesis.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by the researcher before, during or after the research. If you have any further questions about the study, at

any time feel free to contact the researcher, Rachel Weiner. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.
………………………………………………………………………………….

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

……………………………………………………………………………..

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] **taped for this interview:**

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____**Form updated**

Appendix C

Interview Guide

Introductory Statement

"I want to learn about the process whereby social workers treat adolescents who engage in non-suicidal self-injury. Your responses will provide valuable information about treatment methods for working with a population that is often overlooked. I will first ask for your demographic information and I will then ask a series of questions that allow you to reflect on your clinical process in working with adolescent NSSI."

Demographic Information

1. What is your gender identity?

2. What is your racial/ethnic identity?

3. What is your age?

4. Where did you receive your MSW?

5. How many years have you been practicing?

6. What is the nature of the setting that you work in currently?

7. How many years of experience do you have working with adolescents who self harm?

8. How many clients (approximately) have you worked with that have had adolescent NSSI?

Conceptualization of Self-Harm

1. What is your definition of NSSI?

2. How do you understand the difference between a suicide attempt and self harm- what do you think about that?

3. What do you think motivates individuals, particularly adolescents to engage in self-harming behavior?

4. What are underlying causes that trigger someone to cope in this way? Whats going on for them?

Theoretical Framework

1. How would you explain NSSI theoretically/clinically? What are the underlying issues

that you see as prevalent among all of your clients with NSSI? Or do you find it's so individual that you don't see something in general?

2. How do you decide upon the theoretical framework that you utilize to guide your interventions?

3. How does your theoretical understanding of NSSI inform your treatment approach?

Treatment Modality:

1.Please describe for me a recent example that demonstrates your use of a particular treatment modality

when working with an adolescent who self harms

2.How does the nature of the setting you work influence your use of a particular treatment modality?

3. How did you decide to use this modality?

4. Tell me about what situations might prompt you to utilize certain treatment modalities with adolescent

NSSI and those situations that would prompt you to use another modality?

5. Ideally (without any insurance restrictions) how should social workers utilize treatment modalities to

guide their practice with adolescent NSSI?

6. What is the nature of your expectations in terms of a desirable outcome for treatment in working with

adolescents who self harm?

7. What in your experience have been the challenges of working with this particular population?

8. What is your sense of why these challenges have occurred?

9. What has been your experience in terms of the types of treatment modalities that seem to work best

with adolescents who engage in self-harm?

10. Is there anything else that you haven't told me that you think I should know about this topic?

SMITH COLLEGE

November 23, 2015
Rachel Weiner

Dear Rachel,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

 Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

January 22, 2016

Rachel Weiner

Dear Rachel:

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor