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Strategies for Healthcare Professionals in Dealing with Adolescents with Self-Harming Behaviors

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STRATEGIES FOR HEALTHCARE PROFESSIONALS IN DEALING WITH ADOLESCENTS WITH SELF-HARMING BEHAVIORS

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CHAPTER ONE

Self-mutilation is becoming a larger phenomenon in the United States. Statistics show that as many as one percent of the United States population repeatedly engage in self-harming behaviors (http://www.marywood.edu/departments/psychology/students/mutilation/self-mutilation.htm). Self-mutilation is defined as any sort of self-harm that involves inflicting injury or pain on one's own body. Self- harming is occuring increasingly in adolescents. Research has been done on why this is occuring and what health care professionals can do to help these adolescents. This research shows there is a need for more education and training for health care professionals who deal with adolescents who self-harm. How health care professionals deal with self-harming adolescents is vital to the adolescent's recovery. According to McAlaney, Fyfe, and Dale (p. 37), emergency room staff "may be the first and only contact a patient has with a health care professional following a deliberate self-harming incident and how the health care professional responds to that patient may have vital and long-term consequences." Many occupational therapists work with patients who have psychiatric problems. They, along with all other health care professionals should be equiped and able to effectively treat adolescents who are self harming. The following chapters will take you on the journey we partook in when researching how health care professionals can best treat adolescents with self-harming behaviors. The second chapter of this scholarly project covers an extensive review of literature regarding adolescents who self-harm. Consistent throughout the literature review was a need for more education and resources for

effectively treating adolescents with self-harming behaviors. Chapter 3 describes how we first decided to explore this issue, what we discovered through the review of the literature, and what products we decided to develop to aid health care professionals in treating adolescents who self-harm. The fourth chapter reveals these products entirely. The scholarly project is then wrapped up in chapter five, in which we discuss what conclusions we came up with and recommendations we would make to somebody trying to further research on this topic.

CHAPTER TWO
REVIEW OF LITERATURE

As many as one percent of the United States population repeatedly engage in self-harming behaviors (Sheypuk & Slater, 2000). This phenomenon is beginning at earlier ages and adolescents are the main population who are engaging in and exhibiting self-harming behaviors. An extensive review of current literature regarding self-harming behaviors was completed. The literature found was then organized into four areas. The first area addresses the population affected by self-harming behavior. The second area explores risk factors associated with individuals who engage in self-destructive behaviors. Common assessment tools are described in the next section. The final area addresses healthcare professionals' current role in treatment and interventions presently used in the clinic to help evaluate and treat these individuals. Consistent throughout the literature review was a need for more education and resources for effectively treating adolescents with self-harming behaviors.

According to Ross and Heath (2002), in a study of 440 students, 59% of this sample reported starting self-harming behaviors in seventh and eighth grades and 24.6% reported starting in sixth grade or earlier. In the United States, 1 in 8 teenagers experience depression or anxiety and many use self mutilation as a coping mechanism (Derouin & Bravender, 2004). Research indicates that boys are more likely to be affected by depression in their pre-teen years (Derouin & Bravender). However, the occurance of depression in adolescent females is higher than adolescent males. According to Derouin

and Bravender (p. 15), "by age fifteen, females are twice as likely as males to suffer from a major depressive disorder".

Anxiety is associated with self-harming behaviors. According to Ross and Heath (2003), "individuals who self-mutilate may be more likely to manifest higher levels of generalized anxiety and may also be more likely to report feelings of anxiety immediately prior to self-mutilating" (p. 278). Gender difference have been noted in how males and females respond to anxiety, anger, and violence. Both sexes can respond negatively though differences may be apparent. Females typically react inwardly, often experiencing emotional distress and/or self-mutilation. Males more commonly react in a outward fashion using violence. The occurrence of self-harming behaviors in females and males is a ratio of 3:2 (McAlaney, Fyfe, & Dale, 2004).

Risk factors are associated with self-harming behaviors in adolescents. These factors may be different for each individual, some individuals may have mutiple risk factors, while others may have only one. Risk factors can affect an individual from childhood through adulthood. Common risk factors for those who self-harm include: physical, mental, and/or sexual abuse; Axis I disorders and Axis II disorders; childhood trauma; family history of violence or suicide; lack of effective coping skills; peer pressure/conflict; and poor parenting, i.e. neglect, abandonment (Dallam, 1997; Derouin & Bravender, 2004; King et al., 1995; Miller, 1999).

Family affects how an individual grows and matures. Observing parents is one way adolescents learn how to communicate and interact with others. This impacts the way adolescents negotiate resolution of conflicts. If effective coping strategies are not used, this affects the family dynamics and in turn impacts the adolescents' life skills.

According to Derouin and Bravender (2004), teenagers are more likely to self-harm if they come from dysfunctional families or families where the parents are separated or divorced.

Abuse and neglect are associated with the occurrence of self-harming behavior. Examples of abuse and neglect commonly affecting individuals who self-harm include: physical, sexual, and mental abuse; emotional and physical abandonment/neglect; childhood separation and loss; and unhealthy childhood relationships. Decreased coping skills, minimal healthy relationships, and poor communication and social skills can all lead to an adolescent engaging in self-harming behaviors.

According to Dallam (1997), intrusive and frequent childhood sexual abuse may lead to subsequent self-harming behaviors. Gratz (2003), found slightly over 10% of college students reported engaging in self-harming behaviors during childhood. Sexual abuse was reported by 52% of these individuals. Gratz also studied the impact of other childhood experiences such as separation, loss, physical and emotional abuse; however, she found sexual abuse to be the most significant in predicting future self-harming behaviors. Sexual abuse is associated with individuals seeking excessive control over everything in their lives.

Various psychiatric disorders are common among individuals who self-harm. Some disorders correlated with self-harming behavior include: depression, anxiety disorder, personality disorders such as antisocial disorder and borderline personality disorder, post-traumatic stress disorder, conduct disorder, oppositional defiant disorder, attachment disorder, psychosis, and schizophreniform psychosis. Most literature focuses on psychiatric disorders in general, rather than identifying a specific disorder. In a study

of individuals who engage in self-harming behaviors, Skegg, Nada-Raja, and Moffitt (2004), found all women in their study who self-harmed also had a psychiatric disorder. This was in contrast to finding there was a higher incidence of self-harm in males with an absense of a coexisting psychiatric disorder. The authors of this study do not offer a potential reason for this gender difference, therefore more research needs to be done to examine this.

Excessive control over life events has also been found to be associated with the occurrence of an eating disorder. Farber (1997), found women primarily reported bulimia and self-mutilation as coexisting with the onset in adolescence or preadolescence. It was found that 35% of women who self-mutilate had binge-purge symptoms, contending that individuals with eating disorder behavior, primarily bulimia, are at high risk for self-mutilation. Childhood physical and sexual abuse has been associated with binge-purging self-harming behavior and Borderline Personality Disorder (Farber).

People learn effective and non-effective coping strategies in their adolescent years and these strategies carry through to adulthood. Peer groups may be the largest influence in an adolescent's life. Research completed by Derouin and Bravender (2004), found teenagers who find comfort from self-mutilation may share this experience with peers, who in turn may be tempted to try this strategy for themselves. This may lead to a higher occurrence of this behavior among peer groups.

Ineffective coping strategies are one of several reasons why adolescents engage in self-harming behaviors. Other reasons for these self-mutilating behaviors include: feeling overwhelmed with emotional pain, self punishment (for selfishness, anger, sexual impulses, and for feelings of self-loathing), increased anxiety, decreased control, punish

loved ones (inability to effectively deal with stress), alleviate feelings of loneliness and alienation; and attention seeking. Adolescents may exhibit self-harming behaviors in order to allow the physical pain to reduce the emotional pain and provide themselves with a sense of control. (Dallam, 1997; Whotton, 2002)

Machoian (2001), reported that some adolescents find that when they do not feel they are being listened to by adults, they are heard when they physically harm themselves. This results in increased self-harming behaviors because the individual realizes that this behavior will get them the attention that they are seeking.

Machoian's study (2001) reported only one of the many factors that lead an adolescent to self-harm. One of the most important aspects of treating a person with self-harming behaviors is effectively evaluating the factors influencing this. Research shows that there are a number of tools that can be used, ranging from assessments that specifically target self-harming behaviors to assessment tools identifying influencing factors, such as depression, alcohol or drug use. The following are a few assessment tools that specifically target suicide potential and measure the predictability of self-harming behaviors. Appendix A provides a comprehensive list of tools used to measure factors related to the engagement of self-harming behaviors.

The Measure of Adolescent Potential for Suicide (MAPS) is a tool that measures three broad areas: direct suicide risk factors, related risk factors, and protective factors. Direct suicide risk factors include suicide exposure, attitudes/beliefs, suicide ideation, suicidal behaviors and past versus present threat (Eggert, Thompson, & Herting, 1994). Related risk factors include emotional distress, level of stressors, and deviant behaviors. Personal resources and social resources are assessed as elements that address protective

factors. There are two parts to this tool; the Suicide Risk Screen is Part I of the MAPS (questionnaire) which is given to determine whether further assessment is needed. Part II of the MAPS (computer assisted interview), assesses the suicide potential of the adolescent. Evidence shows the MAPS is a reliable, valid research tool to assess levels of suicide potential(Eggert, Thompson, & Herting). The Suicide Risk Screen (part I) is an effective method of initially identifying suicidal vulnerability in adolescents.

The Suicidal Ideation Questionnaire (SIQ) is a self-report that measures an adolescent's current level of suicidal ideation (Muehlenkamp & Gutierrez, 2004). The SIQ can be used with individuals or in a group setting and is suitable for a clinic or school setting. This tool has been found to be beneficial in the evaluation of prevention and intervention programs (Muehlenkamp & Gutierrez). There are two versions of the SIQ available which are suitable for different age groups (King, et al., 1995). "The SIQ professional manual reports internal consistency reliability coefficients of .93 to .97 for each form, with total sample reliabilities ranging from .94 to .97. The validity of the SIQ has been demonstrated through content, construct and clinical studies" (Sigma Assessment Systems, 2001, para. 2).

The Functional Assessment of Self-Mutilation (FASM) is an assessment tool with two component parts. The first component uses the patient's self-report on how frequently he or she has purposely engaged in any of 11 self-mutilative behaviors in the past year (Esposito, Spirito, Boergers, & Donaldson, 2003). Self-harming behaviors addressed include: cutting/carving, burning, self-tattooing, scraping skin to draw blood, erasing skin to draw blood, hitting self on purpose, pulling out hair, biting self, inserting objects under nails or skin, picking at wounds, and picking skin to draw blood. The

second component asks the participant to rate a list of 22 potential reasons for self-harm. Examples include: to get attention and to stop bad feelings (Penn, Esposito, Schaeffer, Fritz, & Spirito, 2003).

There are many tools that can help a health care professional diagnosis self-mutilation and self-harm in adolescents. The treatment following the assessment, however, can be very hard to provide. According to Miller (1999, p. 414), "many different therapeutic interventions (e.g. psychodynamic, cognitive-behavioral, group, family, pharmacologic) have been applied to this difficult-to-treat population; yet, to date, there is not a single empirically supported psychotherapy developed specifically for suicidal multi-problem adolescents". Many health care professionals are not educated or equipped to deal with individuals who are presenting with self-injurous behaviors. How health care professionals deal with self-harming adolescents is vital to the adolescent's recovery. According to McAlaney, Fyfe, and Dale (2004), emergency room staff "may be the first and only contact a patient has with a healthcare professional following a deliberate self-harming incident and how the health care professional responds to that patient may have vital and long-term consequences." (p. 37) This study found services for people who had deliberately self-harmed were inadequate, indicating a need for more specialized services to provide effective care to this population (McAlaney et al.).

Self-mutilation is considered a taboo in society. Family members as well as the adolescents who are self-harming are often embarrassed by this inappropriate behavior, and do their best to hide it. Because of the secrecy involved, health care professionals may only become aware of self-injury if it requires medical intervention or if it is discovered in an unrelated exam (Dallam, 1997). Derouin and Bravender (2004) found

that discovery of self-mutilation is often misinterpreted as a suicide attempt. Self-harm can however, escalate into suicide if the adolescent does not receive help. This highlights the importance of health care professionals being familiar with signs and symptoms of self-harming behaviors in addition to suicide. According to Derouin and Bravender, between 1.5 and 2% of adolescents are affected by health care professionals overlooking signs and symptoms.

Research has shown that up to 77% of adolescents who attempt suicide will not attend or will drop out of outpatient treatment before learning how to better tolerate distress and regulate their emotions with skills that would serve to reduce suicidal and other extreme behaviors (Miller, 1999). Besides the difficulties with outpatient treatment, shorter stays in inpatient hospital units leads to poor continuation of treatment with this population. King et al. (1995) studied a group of adolescents displaying suicidal behavior to determine how they react to psychiatric hospitalization. There was a high rate of suicidal behavior within several months following discharge from the hospital, thus exhibiting a trend towards hospitalization being ineffective. More effective treatment regarding suicidal thoughts and behaviors is needed. Without treatment, adolescents are continuing to engage in destructive behaviors.

Farber (1997) examined the treatment provided by healthcare professionals to adolescents. It was found that healthcare professionals want to stop this destructive behavior and may tend to overmedicate, improperly diagnose or unnecessarily hospitalize some females. This has an adverse effect on some adolescents who self-mutilate when they arrive at the emergency room for treatment. Somewhere in this process, when the person who is self-harming seeks help, there is miscommunication and the needs of the

patient are not met. Healthcare professionals have a role to be understanding and help their patients in the best way possible. "When clinicians can appreciate and can help their patients to appreciate those aspects of these self-destructive behaviors that serve compensatory and adaptive needs, they are more likely to maintain the more constant sense of empathic connection with them that successful treatment requires" (Farber, p. 91).

Health care professionals need to be able to provide effective and quality treatment to adolescents who self-harm once it has been established that this behavior is occurring. Developing an effective therapeutic relationship with patients is important to therapy (Machoian, 2001). This is the first step in treatment because the adolescent needs to be able to trust and be honest with the health care professional. There are many things health care professionals can do to develop this type of relationship with adolescents who self-harm. Some adolescents who self-harm feel that if adults just listened to them they wouldn't need to attention-seek by cutting (Derouin & Bravender, 2004; Machoian).

For health care professionals, the initial steps after determining an individual is self-harming are: asking about self-injurious practices and making close inspection of the skin, and trying to elicit further information in an empathetic, non-threatening manner (Dallam, 1997). Once self-harm is established or suspected, assessment should involve a thorough evaluation of the client's medical, psychological, and family history, as well as previous injuries, self-destructive behaviors, interaction patterns, relationships, current stressors, and coping style (Dallam). The clinician should inquire as to whether a suicide attempt is planned and should assess the lethality of suicidal thoughts or plans. Effective treatment combines education, self-management techniques, and psychotherapy.

Interventions with victims of child abuse should include: focusing on supporting and empowering the client to develop a sense of self-worth, competence, and control. Health care professionals need to determine risk, increase the individual's ability to identify and express feelings verbally and teach them to use constructive behavioral alternatives to mutilation. Other options include: developing a "no suicide contract" with the patient, directing them to a 24-hour-a-day phone number if they need help, and letting the client know the therapist is available without having to self-harm (Dallam).

The primary goals of intervention for adolescents who self-mutilate are to: decrease environmental stress by increasing the feelings of "connectedness" to parents and social circles, improve communication skills, develop effective measures of self-soothing that do not include self-harm and improve mood and emotional regulation (Derouin & Bravender, 2004). It is important to work on improving the individual's self-worth, providing a supportive social setting, resolving the individual's crisis, and increasing positive identity development. These adolescents need to identify stressors they have in the home, focus on increasing support within and outside family, improving family communication, and increasing options for controlling of the environment.

Treatment options include: individual, family, or group therapy, music therapy, assertiveness training, communication skills training, and medication (Derouin & Bravender, 2004). These authors introduced a multifaceted therapy program that engages the child, family, and trusted primary care and mental health providers. This approach has been found in multiple studies to significantly decrease or eliminate self-cutting behavior (Derouin & Bravender; Suyemoto & MacDonald, 1995). Therapy sessions introduced in Derouin and Bravender's study include group discussions, music therapy,

journal writing, meditation, and/or role-playing, assertiveness training, sessions that enhance personal strengths/assets and provide training in effective communication. Street drugs, as well as caffeine and alcohol should be avoided completely. The use of antidepressant medication is common in conjunction with cognitive and behavioral therapy. Safety issues are the main concern. Health care professionals need to carefully assess each adolescent by listening carefully and observing behavior during visits.

Frankel (2001), battled with the ethical issue of breaking confidentiality by letting the girl's parents know about her self-destructive behavior. Many therapists struggle with the issue of breaking a patient's trust versus keeping the patient from harming themselves. This is an area that needs more research in order to provide health professionals more direction in treatment.

Machoian (2001) stressed that clinical intervention must include assessment of past traumatic events in the patient's life, focusing on the patient's disassociation of these events and the need to "ground" the patient by orientating them to the present time. Exploring the meaning and reasons behind the cutting and identifying triggers for self-injurious behaviors are important factors that need to be addressed in therapy.

Whotton (2002) emphasized the importance of each patient receiving a psychological assessment. The assessment should occur once the adolescent has recovered from a self-harming incident. She discovered that 75% of reported cases of deliberate self harm did not lead to contact with services. She discussed areas that were important for a health care professional working with adolescents who self-harm to consider in their approach to intervention. These include: being non-judgmental; having an active communicative role in listening, exploring, and assessing crisis situations; be

equipped to provide appropriate facilities where intervention can take place in a confidential manner; and having knowledge of developmental stages of adolescents (Whotton).

Dialectical Behavior Therapy (DBT), is a cognitive-behavioral therapy for patients with Borderline Personality Disorder. It has been shown to be effective in reducing suicidal behavior, hospitalization, and voluntary withdrawal from treatment by improving interpersonal functioning and anger management (Gratz, 2003; Swenson, Sanderson, Dulit, & Linehan, 2001). Inpatient DBT treatment techniques include contingency management procedures, skills training and coaching, behavioral analysis, structured response protocols to suicidal and egregious behaviors on the unit, and consultation team meetings for DBT staff.

In a research study done by Miller (1999), DBT was used in treating adolescents with borderline personality traits to focus on reducing suicidal and destructive behaviors which interfere with the adolescents' quality of life. The study focused on identifying strategies to keep the adolescents engaged in treatment. The adolescents engaged in 12 concurrent weekly individual and group therapy sessions. Topics of the sessions included problem-oriented change strategies, acceptance strategies, and balancing or knowing when to use each strategy. Learning new skills regarding the adolescents' abilities, motivation, and family interactions were also addressed. Following the completion of this 12-week program, a 12-week patient consultation group was made available (Miller). The 12-week consultation group helped the adolescents use and generalize skills from the 12-week DBT program as well as develop a peer-support group to reduce reliance on individual therapists. The DBT program conducted in this study

showed promise in treatment of this population. An increase in available functional treatment options leads to more health professionals aiding at-risk youth (Miller).

An education program including stress management and effective coping strategies could be useful for some adolescents. Additional education given to this population would be a valuable aid in prevention/discontinuation of this behavior. The first step is educating the health professionals who in turn may provide education to self-harming individuals (Ross & Heath, 2002, 2003).

This literature review discussed the population affected by self-harming behavior, risk factors associated with individuals who engage in these behaviors, common assessment tools used with this population, healthcare professionals' current role in treatment, and possible interventions that may be used to help evaluate and treat these individuals. Based on the literature review two products were developed. Chapter 3 provides an overview of the process used to develop these products, an in-service program and an occupational therapy group for adolescents engaging in self-harming behaviors.

CHAPTER THREE
METHOD

There is not an abundance of information concerning adolescents who engage in self-harming behavior or effective treatment for this population. This project started through the research of current literature regarding the topic of adolescents who engage in self-harming behavior. A variety of search engines were used including CINAHL, Kluwer Online, PubMed, and OT Search. When reviewing the literature, it was found that there was a significant lack of research related to health care professionals' knowledge of issues related to self-harming behaviors and effective treatment for this population. A literature review was written, compiling data gathered from various journal articles and internet resources.

Based on the most prevalent needs identified in the literature review, two products were developed. A PowerPoint in-service was created as an educational tool for health care professionals. The in-service was critiqued to ensure application of effective principles of education and comprehensiveness of the materials. Objectives and learning activities were developed.

In addition, an eight week occupational therapy outpatient group protocol was designed for adolescents who self-harm. The group protocol was critiqued and revised to provide occupational therapists working with this population with appropriate resources that are age appropriate and effectively engage adolescents in the treatment process. Overall objectives of the protocol, group session outlines, and outcome measures were

developed. The Model of Human Occupation was used as a guide in the development of the protocol specifically addressing pertinent areas such as volition, habituation, and performance capacity.

Chapter four provides an overview of the products developed. The complete educational packet can be found in Appendix B. Appendix C provides the occupational therapy protocol and suggested group sessions.

CHAPTER FOUR
PRODUCTS

The purpose of this Scholarly Project was to design education materials and resources for health care professionals working with adolescents who engage in self-harming behaviors. Two products were developed based on the most prevalent needs identified in the literature review. The first resource was the development of a PowerPoint in-service to employ with health care professionals. The second resource is an occupational therapy group protocol designed for adolescents who self-harm.

The in-service provides health care professionals with information regarding adolescents who self-harm. Specific areas addressed include: describing the trends of self-injury in adolescents, identifying risk factors for self-injury, descriptions of the assessment tools used to assess self-harm, and developing strategies for effectively treating adolescents who engage in self-harming behaviors. Included in the PowerPoint are comprehensive notes for the presenters and learning activities. A handout for participants and a reference list are also provided. See Appendix B for the in-service materials.

The occupational therapy outpatient group protocol is designed to meet for an hour and one-half once a week for an eight-week period and cover a variety of areas that relate to adolescents and their self-harming behavior. Areas addressed in the protocol include: a description of self-harming behaviors, including signs and symptoms; coping skills; self-esteem; anger management; stress management; developing effective

communication skills; nutrition and exercise; support systems; and community resources. Weekly session outlines are provided for each topic area, along with suggestions for activities. See Appendix C for the complete group protocol.

The objective of this project was to design resource materials useful for the health care professional in providing treatment to adolescents who engage in self-harming behaviors. Chapter five provides a summary of the process, recommendations for implementing the resource materials, and suggested areas for further research.

CHAPTER FIVE
SUMMARY

There is a need for health care professionals to be better educated and equipped to treat adolescents with self-harming behavior. Research is needed in exploring the increasing trend of more adolescents engaging in self-harming behavior, determining assessments that are beneficial to use with this population, and effective treatment approaches for adolescents with self-harming behaviors. It is recommended that all health care professionals who are involved in the treatment of adolescents who self-harm take part in an in-service session or continuing education seminars to become more familiar with this topic. It is vital that health care professionals be equipped to effectively treat patients who self harm and to stay current on literature and research. When health care professionals effectively treat adolescents engaging in self-harming behaviors, the occurrence of this self-destructive behavior will begin to decrease.

Two products, an in-service for health care professionals and an occupational therapy outpatient group protocol, were developed based on a comprehensive review of the literature. One limitation of this scholarly project is the limited existing research on adolescents engaging in self-harm. It will be important to assess and document the effectiveness of the materials designed in meeting the needs of health care professionals and adolescents who engage in self-harming behaviors. The group protocol was designed for an outpatient setting; it could be adapted and modified for inpatient settings.

Further research is needed to explore the effectiveness of various treatment options for this population. This research will assist health care professionals, parents, and teachers in being responsive to the needs of adolescents who self-harm.

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Appendices

Appendix A

APPENDIX A: ASSESSMENT TOOLS FOR SELF-HARMING ADOLESCENTS

The following tools may be useful in the assessment and treatment of adolescents with self-harming behaviors. This list is not a comprehensive list; it merely contains a sample of tools that may be used with this population.

American Medical Association's Guidelines for Adolescent Preventative Services (GAPS): The GAPS assesses teens for health risks and risky behaviors. (Derouin & Bravender, 2004).

The **Beck Anxiety Inventory (BAI)**: is a tool used to measure anxiety. This tool only measures anxiety, and does not include symptoms of depression like other tools, such as the State-Trait Anxiety Inventory and the Revised Children's Manifest Anxiety Scale. This self-report inventory has 21 items that uses a 4-point Likert scale (0-3). Fourteen questions represent somatic symptoms and seven assess specific cognitive and subjective features of anxiety. Scores from 26-63 indicate severe anxiety. (Ross, & Heath, 2003).

The **Beck Depression Inventory (BDI)**: is a tool used to measure depressive symptoms. This tool is one of the most common self-report measures used for depression in adolescents and adults. The scale measures cognitive, affective, motivational vegetative and physical manifestations of depression. It has 21 items and each item has four statements that are ranked from 0-3 indicating symptom severity. All participants were given the BAI, those who indicated that they self-harmed were individually given the BDI, where the researcher read the questions aloud due to potential reading difficulties. (Ross, & Heath, 2002).

Children's Depression Rating Scale: This tool uses an interview format and covers 15 symptom areas relevant to childhood depression. (Penn et al., 2003).

Drug Use Questionnaire: This assessment consists of 12 items that assess number of days adolescents used different types of drugs over the past 6 months, including marijuana, cocaine, LSD, PCP, inhalants etc. (Penn et al., 2003).

Hamilton Rating Scale for Depression (HRSD): assesses the presence and severity of depressive symptoms. (King et al., 1995).

Hopelessness Scale for Children (HSC): Measures negative expectancies toward one's self and one's future using a 17-item true/false scale. (Esposito et al., 2003).

Hostility and Direction of Hostility Questionnaire (HDHQ): This measures trait hostility. Adolescents were to check items on the questionnaire that described how they felt their emotional state was prior to the self-mutilation. This data would show indication of anxiety or hostility present prior to the adolescents harming themselves. Regarding anxiety and self-mutilating behavior, non-mutilating adolescents reported mild levels, whereas adolescents who engaged in this behavior reported moderate levels of anxiety. 54% of adolescents who self-mutilate reported feelings of both anxiety and hostility. Results from this study indicate that anxiety, hostility/anger is prevalent in relation to self-mutilating behavior. (Ross, & Heath, 2003).

Multidimensional Anxiety Scale for Children-10 (MASC-10): THE MASC-10 is a unidimensional measure that combines the four anxiety factors: physical symptoms, harm avoidance, social anxiety, and separation anxiety. (Penn et al., 2003).

Multi-Attitude Suicide Tendency Scale (MAST): measures attitudes on four different components (attraction to life/death, repulsion to life/death). (Muehlenkamp, & Gutierrez, 2004).

Regulation of Affect and Impulses (RAI): This assessment tool measures mainly affect regulation, but the subscales of this assessment tool also measures modulation of anger, self-destructive behavior, suicidal preoccupation, and excessive risk taking behavior. (Esposito et al., 2003).

Reynolds Adolescent Depression Scale (RADS): is a self-report that assesses depressive symptomology. (Muehlenkamp, & Gutierrez, 2004).

Self-Harmful Behavior Scale (SHB): is a free response questionnaire which assesses the degree the person has engaged in self-harmful activities and history of suicidal behavior. Significant differences were found among the control group as compared to the self-harm groups. Both self-injurious behaviors and suicide attempts can be assessed, but it is difficult to measure because the differences may be more subtle that originally thought. (Muehlenkamp, & Gutierrez, 2004).

Spectrum of Suicidal Behavior Scale (SSBS): is a five-item clinician-rated scale used to assess suicidal behavior on a continuum from no suicidal thought or behaviors to serious suicide attempt. (Penn et al., 2003).

The Center for Epidemiologic Studies-Depression Scales: This assessment tool is a 20-item measure of depressive symptomology. (Esposito et al., 2003).

The State-Trait Anger Expression Inventory (STAXI): The STAXI consists of 44 items designed to measure both the experience of anger and the expression of anger. (Esposito et al., 2003).

The Adolescent Drinking Questionnaire (ADQ): The ADQ is comprised of four items from the Adolescent Behavior Questionnaire. It assesses frequency of drinking, quantity of drinking, and frequency of drunkenness over the past 3 months. (Esposito et al., 2003).

Youth Risk Behavior Surveillance Survey: This survey is designed to monitor health-risk behaviors among youths and young adults. (Penn et al., 2003).

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Appendix B

Adolescents With Self-Harming Behaviors

By: Andrea Keever MOTS & Tara Remund MOTS

Objectives

- Describe trends of self-injury in adolescents
- Identify risk factors for self-injury
- Describe assessment tools for assessing self harm
- Develop strategies for effectively treating adolescents who engage in self-harming behaviors.

Questions for discussion

- What experience do you have working with adolescents?
- Self-harming adolescents
- Discuss some of your experiences
- Identify personal goals for this in-service

Possible idea: Split people into groups to discuss these questions – will share with larger group.

Terminology & Trends

- What is self-injury?
- What is self-mutilation?
- What population is affected?
- Why is this phenomenon important to healthcare professionals?

•Self-harm, self-injury, and self-mutilation are often used interchangeably.

•Some researchers have categorized self-mutilation as a form of self-injury. Self-injury is characterized as: any sort of self-harm that involves inflicting injury or pain on one's own body. In addition to self-mutilation, examples of self-injury include: hair pulling, picking the skin, excessive or dangerous use of mind-altering substances such as alcohol, and eating disorders.

•Pathological self-mutilation is defined as: the deliberate alteration or destruction of body tissue without conscious suicidal intent. A common example of self-mutilating behavior is cutting the skin with a knife or razor until pain is felt or blood has been drawn. Burning the skin with an iron, or more commonly with the ignited end of a cigarette, is also a form of self-mutilation. (Suyemoto and MacDonald, 1995)

•What population is affected?

Adolescents are the main population who are engaging in and exhibiting self-harming behaviors.

•Why is this important to healthcare professionals?

•How healthcare professionals deal with self-harming adolescents is vital to the adolescent's recovery.

•According to (McAlaney,et al), emergency room staff "may be the first and only contact a patient has with a healthcare professional following a deliberate self-harming incident and how the health care professional responds to that patient may have vital and long-term consequences."

Risk Factors

- Physical, mental, and/or sexual abuse
- Axis I disorders and Axis II disorders
- Childhood trauma
- Family history of violence - ex: suicide
- Lack of effective coping skills
- Peer pressure/conflict
- Poor parenting – ex: neglect, abandonment

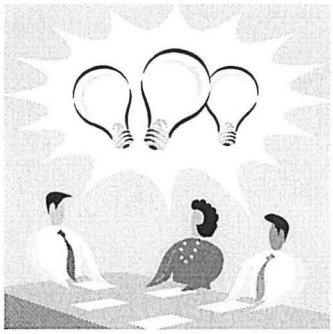
-According to Dallam, intrusive and frequent childhood sexual abuse leads to more subsequent self-harming behaviors.

•Axis I and II disorders commonly associated with self-harm include: eating disorders; depression; anxiety disorder; personality disorders such as antisocial disorder and borderline personality disorder; post-traumatic stress disorder; conduct disorder; oppositional defiant disorder; attachment disorder; psychosis; and schizophreniform psychosis

• According to Derouin and Bravender (2004), teenagers are more likely to self-harm if they come from dysfunctional families or families where the parents are separated or divorced

Brainstorm

- Why do adolescents feel the need to self-harm?



Flip chart/marker board activity (write ideas on flip chart)

- Feel concrete pain
- Punish themselves
- Reduce anxiety and despair
- Gain sense of control
- Express anger and disappointment towards others
- Reduce numbness and promote sense of being real
- To receive support and caring from others
- Keep traumatic memories away

Assessment Tools

- Measure of Adolescent Potential for Suicide (MAPS) (Eggert, L.L., Thompson, E.A., & Herting, J.R., 1994)
- Suicidal Ideation Questionnaire (SIQ) (Muehlenkamp, J.J., & Gutierrez, P.M., 2004)
- Functional Assessment of Self-Mutilation (FASM) (Penn, J., Esposito, C., Schaeffer, L., Fritz, G. & Spirito, A.,2003)

Introduction: Specific information will be discussed in following slides

Measure of Adolescent Potential for Suicide (MAPS)

- Measures direct suicide risk factors, related risk factors, and protective factors.
- <u>Direct Risk Factors:</u>
  - suicide exposure
  - attitudes/beliefs
  - suicide ideation
  - suicidal behaviors
  - past versus present threat

Measure of Adolescent Potential for Suicide (MAPS)

- Related Risk Factors:
  - emotional distress
  - level of stressors
  - deviant behaviors
- Protective Factors:
  - personal resources
  - social resources

- There are two parts to this tool: Suicide Risk Screen is Part I of the MAPS (questionnaire) which is given to determine whether further assessment is needed.

- Part II of the MAPS (computer assisted interview), assesses the suicide potential of the adolescent.

- Evidence shows the MAPS is a reliable, valid research tool to assess levels of suicide potential.

- The Suicide Risk Screen (part I) is an effective method of initially identifying suicidal vulnerability in adolescents.

Suicidal Ideation Questionnaire (SIQ)

- Self-report that measures an adolescent's current level of suicidal ideation
- Used with individuals or in a group setting
- Can be used in clinic or school
- Also used for evaluation of prevention and intervention programs

-There are two versions of the SIQ available which are suitable for different age groups (King, et al.). The main version of the SIQ has a 30-item format and is used for grades 10-12. The other version, the SIQ-Jr. uses a 15 item format for grades 7-9.

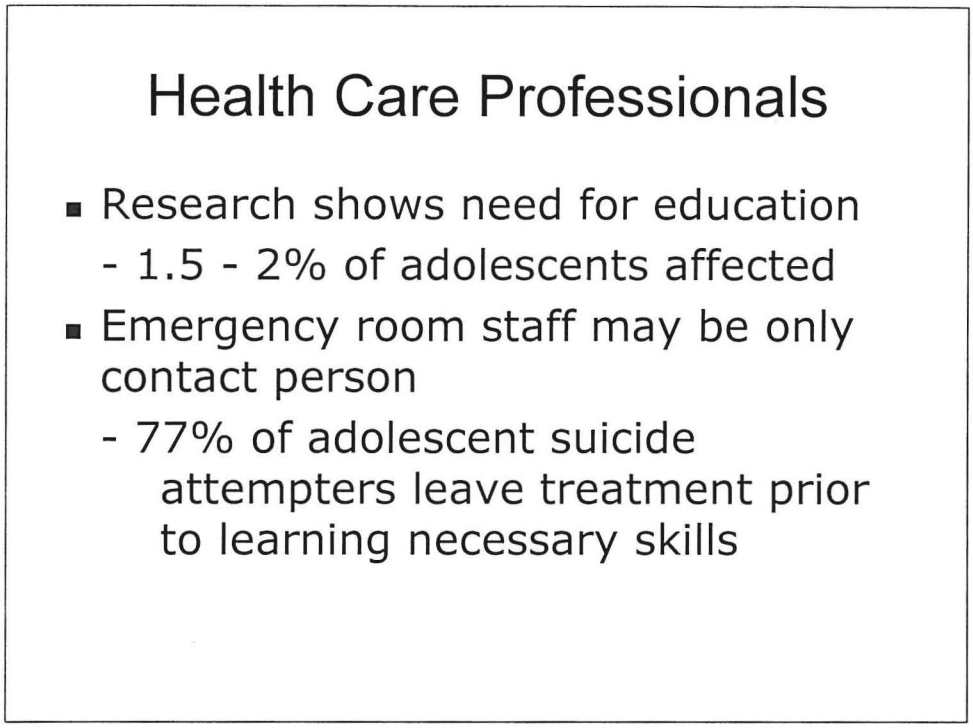
-The validity of the SIQ has been demonstrated through content, construct and clinical studies " (Sigma Assessment Systems, Inc., 2001, para. 2).

Functional Assessment of Self-Mutilation (FASM)

- Self-report
- Patient indicates how often they engaged in 11 self-mutilative behaviors in the past year
- Participant also rates a list of 22 potential reasons for self-harm

•Self-mutilative behaviors addressed include: cutting/carving, burning, self-tattooing, scraping skin to draw blood, erasing skin to draw blood, hitting self on purpose, pulling out hair, biting self, inserting objects under nails or skin, picking at wounds, and picking skin to draw blood.

•Examples of potential reasons include such things as to get attention, to stop bad feelings etc.



•According to Derouin and Bravender (2004), between 1.5 and 2% of adolescents are affected by health care professionals overlooking signs and symptoms.

-According to McAlaney, J., Fyfe M., & Dale, M. (2004, pg. 37), emergency room staff "may be the first and only contact a patient has with a healthcare professional following a deliberate self-harming incident and how the health care professional responds to that patient may have vital and long-term consequences."

-Many adolescents will base whether or not they seek and follow-through with treatment on how they were treated initially by health care professionals

-Research has shown that up to 77% of adolescent suicide attempters will not attend or will drop out of outpatient treatment before learning how to better tolerate distress and regulate their emotions with skills that would serve to reduce suicidal and other extreme behaviors (Miller, 1999).

-This phenomenon may not be seen unless medical attention is sought – need to know how to recognize signs as well as develop repoire so that adolescent will feel safe seeking help.

Health Care Professionals

- Trend for health care professionals to:
  - overmedicate
  - improperly diagnose
  - unnecessarily hospitalize

Farber, S.K. (1997)

Case Study

- Brian, a 15 yr. male has been demonstrating self-injurious behaviors for the past year.
- Recently admitted to hospital for severe cuts on forearms.
- Angry, defiant, using alcohol on weekends since age 13

Brainstorm Activity

- What steps would you take in treating this patient.
  - Goal ideas
  - Intervention ideas
- What other information might you want?

May want to walk around room and mingle among groups. Give possible ideas etc.

Full Case Study

- Brian was diagnosed with major depression, hospitalized 1x one yr. ago for 7 days
- Lives with mother, stepfather, and two siblings
- Stepfather physically abuses mother, unsure whether abuse extends to Brian
- Active in band, enjoys heavy metal music and soccer

Full Case Study (Cont.)

- Brian's usual grades are a C average, during last depressive period fell to D/F average
- Two close friends who engage in similar activities such as sports and alcohol use
- Cutting discovered in gym class when teacher noticed cuts on arms 2 weeks ago
- Principal, parents, and school counselor were notified

Brainstorm Activity

- How would you goals change?
- Which assessments might you try?
- What new treatment ideas do you have?

Hint: How goals may change: now have issue of abuse to deal with, know diagnosis of major depressive disorder, might be able to interest him using now known hobbies.

Initial Treatment

- 1st step: develop good therapeutic relationship with adolescent
- Ask about self-harming practices
- Make close inspection of skin
- Try to elicit further information
- Evaluation of medical, psychological, and family history
- Inquire about possible suicide attempt

-Ask group to give ideas on how they might establish this therapeutic relationship

These may be the outcomes of effective treatment goals.

Possible Treatment Modalities

- Individual therapy
- Family therapy
- Group therapy
- Music therapy
- Assertiveness training
- Communication skills training
- Medication management

•Family therapy is important because the majority of adolescents who self-harm have a dysfunctional family background. (Suyemoto & MacDonald, 1995)

•Group therapy provides opportunities for peers to assist each other in identity development. (Suyemoto & MacDonald, 1995)

•Using different types of approaches/interventions ensures that the root of the reason behind self-cutting is being addressed. These types of treatment modalities have been found to significantly reduce or eliminate self-cutting behavior. (Derouin & Bravender, 2004)

Multifaceted Therapy

- Found to significantly decrease and eliminate self-harm
- Engages:
  - adolescent
  - family
  - primary care provider
  - mental health providers

•This is a holistic approach and because of the influence family and health care providers have on adolescents, this can work effectively in treatment (Derouin & Bravender, 2004).

Treatment

- Individual, family counseling, and group sessions
- Sessions might include:
  - group discussions
  - music therapy
  - journal writing
  - assertiveness training
  - effective communication training
  - role playing
  - ↑ self-esteem
  - meditation

Dialectical Behavior Therapy (DBT)

- Cognitive-behavioral therapy
- Effective in reducing:
  - suicidal behavior
  - hospitalization
  - treatment dropout
- Improves:
  - interpersonal functioning
  - anger management

•Used extensively with people with Borderline Personality Disorder

•Swenson, Sanderson, Dulit, and Linehan (2001), found it effective in reducing suicidal behavior, hospitalization, and treatment dropout

•Inpatient DBT treatment techniques include: contingency management procedures, skills training and coaching, behavioral analysis, structured response protocols to suicidal and egregious behaviors on the unit, and consultation team meetings for DBT staff.

Summary

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- Identify risk factors for self-injury
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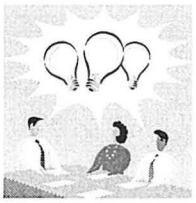

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  - 77% of adolescent suicide attempters leave treatment prior to learning necessary skills

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- Evaluation of medical, psychological, and family history
- Inquire about possible suicide attempt

Treatment Goals

-Decrease stress
-Improve communication skills
-Improve relaxation techniques
-Emotional regulation
-Provide supportive setting
-Resolve crisis
-Develop positive identity
-Increase family support
-Improve family communication

Possible Treatment Modalities

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Appendix C

Survival Skills for Adolescents who Self-Harm
By
Tara L. Remund, MOTS & Andrea J. Keever, MOTS

TABLE OF CONTENTS

Survival Skills for Adolescents who Self-Harm
by
Tara L. Remund, MOTS & Andrea J. Keever, MOTS

This is an eight week therapy program facilitated by an occupational therapist. It would be beneficial for the therapist to have extensive training in the evaluation and assessment of the adolescent with emotional/behavioral problems. Adolescents who self-mutilate are a vulnerable population and assessment needs to be done continually to assess the risk for suicide or self-harm among group participants. This group will introduce various topic ideas to the adolescent group members to assist in learning and practicing important skills for 'survival' in living a healthy lifestyle.

Frame of Reference: The Model of Human Occupation was used as a base for developing this protocol as it addresses important areas such as volition, habituation, and performance capacity.

Rationale: This model is used with people who are having difficulty with occupations in their life. This model has been successfully used with adolescents in mental health (Kielhofner, 2002). Autonomy is a pertinent part of developing into an adult and therefore valuable as a motivating factor in living a healthy lifestyle. Adolescence is a period of change relating to the roles and habits that regulate one's behaviors each day. When the occupation of self-harming behaviors becomes a dominating habit, this can have hazardous outcomes. Adolescence is also a time of gaining a better awareness and comprehension of the world as well as learning to interact and communicate more effectively. These areas are addressed in the following activities to assist in learning important skills for the future of each of the group members.

Group membership and size: Six to eight adolescents represent the best group size suitable for this type of treatment.

Goals:

1. Identify and practice effective coping skills.
2. Recognize and acknowledge personal positive qualities.
3. Identify current stressors.
4. Develop strategies for effectively dealing with the stressors.
5. Develop and demonstrate effective communication & assertiveness skills.
6. Recognize the significance of a healthy/balanced diet and exercise.
7. Identify available resources and support systems.

Rationale: These goals relate to the patient population participating in this treatment group. The goals look at the needs of many of these patients and address areas that are necessary to work on. Also, these areas are covered in the activities of this group.

Precautions: It is important that the therapist be aware of self-harming behaviors and actively assess for these behaviors during each session. If any group members has engaged in this behavior it must be reported to the individual's primary therapist and other healthcare providers if needed. Therapists need to pay attention to the materials and tools utilized and employ caution in using sharps.

Outcome criteria: Each adolescent will complete a survey prior to the start of the 8 week group. Surveys will also be used immediately after the 8 week group is finished and three months later as a follow-up. (See attached surveys).

Method: The group will be held once a week and each week a different topic will be covered in the group. The protocol is designed for ninety minute sessions. Each session includes a warm-up activity, the main activity and follow-up discussion questions. The warm-up activity relates to the main activity. The purpose of the follow-up discussion is to elicit thoughts and feelings from the day's activities, as well as discussing how this information can be applied to the participants' lives. The topic ideas covered in this program include: A description of self-harming behaviors, including signs and symptoms; coping skills; self-esteem; anger management; stress management; developing effective communication skills; nutrition and exercise; support systems; and community resources, and other topics as needed by the individuals referred to this group. Additional sessions may be needed to meet the specific needs of the individual group members.

Description of types of activities: Various media will be used to complete the activities in this group protocol. These include group discussions, role play, handouts, educational games, and worksheets.

Time and place of meeting: This program is designed as an outpatient program. Ideally it would meet in late afternoon following the school day. This group is designed to be held in a classroom type setting with a table and chairs to promote a discussion group atmosphere.

Supplies and costs: The costs involved for materials are nominal. Supplies needed include writing utensils, copies of handouts/worksheets, a marker board, markers, and small prizes to use as incentives for the group member participation.

Week 1: ***What are self-harming behaviors including signs and symptoms?***

Purpose: To educate the adolescents about self-harming behaviors and what the signs and symptoms are that correlate with this behavior.

Materials: "Yes" Bingo cards and some kind of marker to cover the spaces (i.e. one inch by one inch pieces of paper). Flipchart or marker board to promote participation among group members.

Warm-up activity: "Yes" Bingo (see attached example forms). This game is similar to regular bingo, but there is a slight twist. Each player has a card in front of them and the word "yes" is in place of the "free" space. Each card has a grid with twenty-four questions. The object of the game is to look at your card, pick a question and choose someone in the group whom you think will answer "yes" to that question. If the person you chose answered "yes" to your question, then you get to cover that question on your card and it is the next person's turn. If the person answers "no" then it is the next person's turn. You can win by getting a line in a diagonal, horizontal, vertical, etc.; the same way you win in regular bingo, it just depends on what the group leader and/or group decides. This activity is good to begin a new group with because it helps loosen up participants and follow-up questions can be asked to get to know the participants further. The game will assist in discovering commonalities among the group.

Activity Idea: Introduction to self-harm

Instruction for activity: Go over what self-harm is, types of self harm, risk factors that increase the chance of self-harming, and reasons people self-harm. (See attached handout for specific information regarding these questions).

Follow-up: Discuss the information presented today. The feelings that today's topic elicited, questions that arose from today's session, etc. Specific questions may include: What information did you find helpful? Why? Did any of the information surprise you? Can any of you relate to the information that was provided to you today? Hearing what some of the risk factors were, what feelings were you experiencing? What thoughts were running through your head during this group? Can you identify with any of the reasons that were noted for engaging in self-harming behaviors? What questions do you think are still unanswered, etc?

Reference:

Remund, T.L., & Keever,A.J. (2004). *Yes bingo*. Unpublished manuscript.

"YES" BINGO

Do you have a nickname?	Do you like to drink soda/pop?	Do you like having your picture taken?	Do you like cream in your coffee?	Do you do your own laundry?
Can you fly a kite?	Do you know how to sew?	Do you have any children?	Have you ever been to Seattle?	Do you know what your "sign" is?
Do you like Italian food?	Do you have a tattoo?	YES	Were you are Beatles fan?	Have you ever lived in California?
Do you get mad easily?	Did you get married in a church?	Do you like antique things?	Do you know who the president of the U.S. is?	Do you like to talk on the phone?
Do you know who Fred Astaire's dance partner was?	Have you ever been to Chicago?	Do you like the sunshine?	Do you like to play cards?	Have you ever been in a helicopter?

"YES" BINGO

Have you been to the Grand Canyon?	Can you name a famous movie dog?	Do you brush your teeth at least twice a day?	Did you go to Sunday school as a child?	Do you own a hat?
Do you like lemon meringue pie?	Have you ridden in a limousine?	Are you outgoing?	Do you know how many inches are in one foot?	Do you like blueberries?
Do you know how to use a microwave oven?	Do you like Jazz music?	YES	Have you swum in the ocean?	Have you ever gone sledding (in the snow)?
Have you laughed today?	Have you ever had poison ivy?	Do you like washing dishes?	Have you smoked a pipe?	Do you like to watch old movies?
Do you know how to whistle?	Have you ever had your fortune read?	Have you ever eaten pickled pigs feet?	Have you been to the circus?	Can you do the Tango?

"YES" BINGO

Do you have grandchildren?	Did you ever own a dog?	Are you shy?	Have you ever walked in your sleep?	Can you name a famous baseball player?
Have you ever had poison ivy?	Do you like to eat popcorn when you go to the movies?	Have you ever been camping?	Have you ever milked a cow?	Can you name one of Santa's reindeer?
Have you said something nice to someone today?	Have you ever lived in California?	YES	Have you ever flown in an airplane?	Do you believe in love at first sight?
Have you ever gone bowling?	Did you ever get to ride on a hay wagon?	Do you like to watch TV?	Are you afraid of snakes?	Do you have any children?
Do you like tomatoes?	Have you ever been in the military?	Did you get married in a church?	Do you know how to whistle?	Have you been to New York City?

Teaching guide for group facilitator

This handout is for the facilitator and is designed as a guide for the discussion regarding information on self-harm. This may be used both as an informational tool as well as an instrument to promote discussion from the group members. Encourage questions and comments for optimal clarification and understanding.

Introduction to Self-Harm

Types of self-harm:

- Self-harm, self-injury, and self-mutilation are often used interchangeably.
- Some researchers have categorized self-mutilation as a form of self-injury. Self-injury is characterized as: any sort of self-harm that involves inflicting injury or pain on one's own body. In addition to self-mutilation, examples of self-injury include: hair pulling, picking the skin, excessive or dangerous use of mind-altering substances such as alcohol, and eating disorders.
- Pathological self-mutilation is defined as: the deliberate alteration or destruction of body tissue without conscious suicidal intent. A common example of self-mutilating behavior is cutting the skin with a knife or razor until pain is felt or blood has been drawn. Burning the skin with an iron, or more commonly with the ignited end of a cigarette, is also a form of self-mutilation. (Suyemoto and MacDonald, 1995)

Risk Factors:

- Risk factors are associated with self-harming behaviors in adolescents. These factors may be different for each individual, some individuals may have mutiple risk factors, while others may have only one. Risk factors can affect an individual from childhood through adulthood. Common risk factors for those who self-harm include: physical, mental, and/or sexual abuse; Axis I disorders and Axis II disorders; childhood trauma; family history of violence, suicide, etc; lack of effective coping skills; peer pressure/conflict; and poor parenting, i.e. neglect, abandonment, etc. (Dallam, 1997; Derouin & Bravender, 2004; Miller, 1999; King et al., 1995)

Reasons people self-harm:

- Some reasons for these self-mutilating behaviors include: feeling overwhelmed with emotional pain; self punishment (for selfishness, anger, sexual impulses, and for feelings of self-loathing); increase anxiety; decrease control; punish loved ones (inability to effectively deal with stress); alleviate feelings of loneliness and alienation; and attention seeking. Adolescents may exhibit self-harming behaviors in order to allow the physical pain to reduce the emotional pain and provide themselves with a sense of control. (Dallam, 1997 and Whotton, 2002)

Week 2: ***Coping Skills***

Purpose: Identify alternatives, develop insight and promote positive peer pressure for healthy handling of feelings versus self-harm.

Materials: Board, marker, "Tic-Tac-Cope" questions and answer sheet. Optional—offer prizes to encourage appropriate expression.

Warm-up activity: A volunteer helps with this activity by writing on the board. The group brainstorms words and phrases related to coping with self-harm. The volunteer writes the related words and/or phrase on the board and the group gives ideas of what each letter can stand for.

Example phrase: **S-E-L-F H-A-RM**

S = Suicide is not an option
E= Express feelings safely
L = Love yourself unconditionally
F = Find supportive people
H = Help each other stay safe
A = Accept what cannot be changed
R = Reach out to others who are hurting
M = Make a contract for safety with yourself and others

Activity Idea : Tic-Tac-Cope

Instructions for activity:

Variation 1.

1. "Game Show Host" draws Tic-Tac-Toe grid on the board. Two teams sit facing each other with "Host" at the board in the front. At the bottom of the board, note all players' names under 'X' or 'O' and keep score (number of games won by each team).
2. "Host" asks alternate teams the questions; a correct answer warrants an 'X' or 'O'; teammates should collaborate on answers and some questions require two or more people to respond. If they answer incorrectly, the opposition tries. Continue until one team wins or all spaces are filed. If a tie occurs, the next question is the tie-breaker. Whichever team answers correctly first, wins.
3. Erase the board, appoint another "Host," and continue until all questions have been answered.
4. When the activity is completed discuss what everyone 'won' in terms of coping skills. If tangible awards are available, winners get first choice of prizes; the opponents select from the remaining prizes.

Variation 2.

1. Distribute question sheets about 20 minutes before the game. The teams go to separate areas to discuss and/or writes answers, then use their 'cheat sheets' during the game.

Variation 3.

1. Individuals, dyads, or teams—choose from the following activities:

a. Make "No Self-Harm" posters using drawings, stick figures, cartoons, and symbols; display posters on the walls.
b. Compose poetry and/or songs promoting self-care and share with the group.
c. Create 'infomercials', monologues, or skits to convince 'viewers' to act safely in stressful situations. (Example: role-play partners breaking up; the jilted lover thinks about cutting his/her wrist, and then calls a support person instead).
d. Select a term and compose helpful messages

Examples: **A** = A strong feeling
C = Cop-out
N = Never stuff anger
U = Understand feelings
G = Get your feelings out safely
T = Think about options
E = Everyone feels mad at times
R = Recognize early warning signs of anger, depression, and cravings.

Follow-up: Discuss the value of a support group for safety wherein people pledge to tell group members, (and staff), immediately when impulses occur or at the first 'warning signs' of anger and/or depression in self or others. Encourage daily 'success stories' about times they felt like cutting, purging, or other destructive acts, but used coping skills instead. Consider graphs showing the number of 'safe' days (each draws and/or records their own progress).

Reference:

Butler, C.A. (2001). Tic-tac-cope. *100 interactive activities for mental health and substance abuse recovery* (pp. 103-105). Plainview, NY: Wellness Reproductions and Publishing, Inc.

TIC-TAC-COPE

QUESTIONS

1. Give 3 examples of self-harm.
2. Name 3 emotions that cause some people to think about self-harm.
3. Name 3 consequences of self-harm.
4. What is the major drawback of self-harm?
5. What is a 'quick-fix'?
6. What are at least 3 examples of 'quick-fixes'?
7. What is not helpful about 'quick-fixes'?
8. What is more helpful than 'quick-fixes'?
9. What is peer pressure?
10. Tell a time you felt pressure to do something harmful.
11. Tell a time someone influenced you to do something helpful to yourself.
12. What is a support group?
13. Why can people with similar problems help each other effectively?
14. How could you help a person who wants to hurt himself/herself?
15. What are at least 2 healthy ways to let out your feelings of sadness or anger?
16. What are early warning signs of anger?
17. What are 2 early warning signs of depression?
18. How might medications help people who hurt themselves?
19. How might individual therapy help?
20. How might family therapy help?
21. Who is responsible or who causes someone to harm himself/herself?
22. Yes or No – can we control what others say or do?
23. What or who can we control?

TIC-TAC-COPE

ANSWER SHEET

1. **Give 3 examples of self-harm.**
   Cutting, suicide attempts, purging, starving, drugs, alcohol and others
2. **Name 3 emotions that cause some people to think about self-harm.**
   Anger, depression, craving excitement, guilt, low esteem and others
3. **Name 3 consequences of self-harm.** *Scars, being hospitalized, health problems, death*
4. **What is the major drawback of self-harm?** *We do not solve the problem that led to it – we still have the anger, depression or conflict with someone*
5. **What is a 'quick-fix'?** *Something that seems to give relief at the moment*
6. **What are at least 3 examples of 'quick-fixes'?** *Cutting, punching walls, banging heads, drinking, drugs and others*
7. **What is not helpful about 'quick-fixes'?** *They do not last*
8. **What is more helpful than 'quick-fixes'?**
   Facing and solving problems, prescribed medication, therapy, coping skills and others
9. **What is peer pressure?** *People similar to ourselves or our friends influencing us*
10. **Tell a time you felt pressure to do something harmful.**
    At least 2 people on the team must share
11. **Tell a time someone influenced you to do something helpful to yourself.**
    At least 2 people on the team must share
12. **What is a support group?** *People with same problems help each other.*
13. **Why can people with similar problems help each other effectively?**
    First-hand experience, accessibility
14. **How could you help a person who wants to hurt himself/herself?** *Listen, suggest ways to deal with the problem and tell the family, therapist or the police if they are in danger*
15. **What are at least 2 healthy ways to let out your feelings of sadness or anger?**
    Talk, draw, write and others
16. **What are early warning signs of anger?** (At least 2 people share)
    Clenched fists, rapid breathing and heartbeat, red face
17. **What are 2 early warning signs of depression?**
    Sleep more or less, eat more or less, very tired or restless, teary eyed, isolated
18. **How might medications help people who hurt themselves?** *Stabilize a chemical imbalance*
19. **How might individual therapy help?**
    Find out what's really bugging them and ways to handle problems
20. **How might family therapy help?** *Solve problems, open communication*
21. **Who is responsible or who causes someone to harm him/herself?** *Himself/herself*
22. **Yes or No – can we control what others say or do?** *No*
23. **What or who can we control?** *Our own reactions*

Week 3: ***Self-Esteem***

Purpose: To increase self-esteem by acknowledging and accepting positive qualities regarding oneself. Positive affirmations can be created by using the alphabet as an outline. Acknowledging one's own positive qualities can be a powerful tool in boosting self-esteem.

Materials: A-Z worksheet, writing utensils, bowl, paper.

Warm-up: Have each participant and the group leader write their name on a small piece of paper. Fold the papers and place them in a bowl. Each person takes turns taking a piece of paper out of the bowl. Each person will think of something positive to say about the person whose name they have drawn.

Activity Idea: I will like myself A-Z!

Instructions for activity:

Variation 1.

1. Instruct each group member to complete the handout using the following format: "I will like myself because I am…"
2. After each letter, a phrase or word beginning with that letter (or sound, if you like) should follow to complete the sentence. (i.e. R—receptive to new ideas; X—exceptional in drawing cartoons).

Variation 2.

1. Distribute the handouts and ask each group member to put his/her name at the top of the page.
2. Collect and redistribute handouts so that everyone has someone else's paper.
3. Instruct members to insert one adjective or phrase after one letter of the alphabet, describing something positive about that individual.
4. Encourage each group member to put one positive comment on each of his/her peers' handouts, continuing to pass them around until 26 comments are on each sheet and all handouts are returned to the owner.

Follow-up: Invite each participant to read his/her handout aloud to the group. Process benefits of positive affirmations and impact on self-esteem.

References:

Korb, K.L., Azok, S., & Leutenberg, E.A. (1989). I will like myself a-z! *Life management skills: Reproducible activity handouts created for facilitators* (pp.35). Beachwood, OH: Wellness Reproductions, Inc.

I will like myself A to Z!

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

h. _____

io _____

J. _____

K. _____

L. _____

M. _____

n. _____

O. _____

P. _____

Q. _____

R. _____

S. _____

t. _____

U. _____

V. _____

W. _____

X. exceptional

y. _____

Z. _____

Week 4: ***Anger Management***

Purpose: This lesson plan is designed to teach anger management and conflict resolution through the "I-Message" communication technique and other group activities.

- To help group members see that conflict can become a positive situation
- To help group members widen their vocabularies in reference to emotions
- To enable group members to describe anger and its effects on them
- To transition group members from inappropriate action when angry to more constructive behavior
- To give group members options with which they can cope with their anger
- To give group members communication tools to aid them in relationships

Materials Needed: Board, marker, paper, writing utensils, and bowl for the warm-up activity. Paper cup, grocery bag, and tape for the main activity.

Warm-up: This is an activity to identify sources of agitation in order to express feelings more appropriately. The participants in the group write their pet peeves anonymously on slips of paper (some of these pet peeves may relate to peers, which is okay). Put the slips of paper into a bowl. Each person takes a turn reading one, writing it on the board, and the group brainstorms ideas to more effectively handle the person and/or peer.

Activity Idea: Managing Anger

Instructions for activity:

1. Begin the lesson by working with the group to compile a list of feelings: negative in one column, positive in another. You'll be referring to this list later.
2. Explain that today, the topic will be what happens when people get angry, and what they do as well as not do.
3. Ask the group to reflect on the last time that they were angry. Ask them to focus on where that anger came from. Do the angry feelings have synonyms, such as frustration, rage, disappointment, etc.?
4. Ask them to share, as best they can, what happened to them when they got angry. Examples: went to sleep, yelled at their dog, confronted someone, cried, punched a wall, irritated, flight or fight, etc.
5. Pair the participants up and ask them now to share what they felt like when someone was angry at/with them. How did you know the other person was angry? What did they do in reaction to the other person's anger? Have each pair give a brief summary to the group. Record the main ideas on the blackboard.
6. Ask each pair to join with another pair. Ask the new foursomes to discuss if there's any one correct way to handle anger. Report back to the class. Record on the blackboard.

7. This is a good time to talk about inappropriate venues of venting anger, such as physical fighting, punching walls, etc. Keep in mind that often a physical fight is admired within certain peer groups, and often children are instructed by their parents and peers to only take so much before standing up for themselves physically. Listen and divert to more positive options, rather than challenging the method. Punching a wall and other physical manifestations of anger, if repeated constantly, is a mental health issue. The actual physical pain is a catharsis for the internal pain that the participant has no idea how to handle. Explain that this lesson is to help them have more options available to them when they feel trapped by their anger.
8. Explain that a game "Blowing Off Steam" is now in order to lighten up a very difficult discussion:
    - Use the table, the paper cup, grocery bag, and tape.
    - Have 6-8 participants sit around the table. Place the cup at one end of the table. Tape the grocery bag at the other end. On command, the group must attempt to blow the cup into the grocery bag with no physical touching--only air power.
    - Have them do it several times, until they've worked out a technique to do it quickly, and with much less frustration.
    - When finished, ask them why they think this game was chosen. Ask them if they were frustrated at all and if so, how did they go beyond that feeling.
    - Explain that the next part of the group is to offer alternative ways of dealing with anger.
9. Go back to the list on the board and highlight anger management techniques that the group members view as productive. Examples include: going into room and listening to music, separating yourself to a quiet place, talking to a friend or adult, talking in a calm way to the person you're angry with, going for a walk, talking to your dog, etc.
10. Explain the "I-Message" in the following way, perhaps written on the blackboard or an easel:

    I feel _____ (be specific)

    When you _____
    (give details of the behavior or circumstances)

    Because _____
    (this is the hard one: the "why")

11. Optional: Pair up group participants to do role-plays in front of the class using either real or fictitious disputes. Give each pair a little rehearsal time to define the dispute. Explain that this is only the beginning of a conversation. They should understand that when they're a little clearer of exactly why they're angry, the other person will also have a clearer picture.

Additional Ideas:

- Other topics for discussion:
    - What is compromise?
    - When are you truly happy with compromise? What's the recipe? Must the other person lose, so I can win?
    - When someone apologizes, do you accept it?
- A relaxation group may be a good group to follow-up this group. Relaxation techniques are excellent tools for dealing with anxiety and anger:
    - Deep Breathing
    - Tense and Release various muscles. Example: clench fist and tighten entire arm, then let drop relaxed
    - Visualize a quiet place

Follow-up: Discuss these areas:

- Conflict can become a positive situation
- Describe anger and its effects on them
- Transitioning from inappropriate action when angry to more constructive behavior
- Options with which they can cope with their anger
- Communication tools to aid them in relationships

References:

Butler, C.A. (2001). Don't let them push your buttons: pet peeves. *100 interactive activities for mental health and substance abuse recovery.* (pp. 5). Plainview, NY: Wellness Reproductions and Publishing, LLC.

Nagel-Smith, T. *Managing Anger.* (n.d.) Retrieved November 1, 2004 from In the Mix Educators website: http://www.pbs.org/inthemix/educators/lessons/schoolviol3/

Week 5: ***Stress Management***

Purpose: To categorize concerns as past, present, and future; to differentiate what can and cannot be done; to productively handle stressors.

Materials: Board, marker, calendar, "Past, Present, and Future" worksheet; pencils and blank paper for variation 2.

Warm-up activity: A volunteer holds up a calendar and asks, "What do calendars show?" Another volunteer divides board into three vertical columns and labels them Past, Present, Future. Explain, "Worries fall into these categories. "Past" means yesterday and before, "Future" means tomorrow and after and "Present" means today."

Activity Idea: Past, Present, and Future

Instructions for activity:

Variation 1.

1. Participants brainstorm as a volunteer lists problems in "Past" column. Examples: prior abuse, guilt, arrests, financial losses, broken relationships, death of loved ones, poor grades or job performance.
2. Another volunteer lists as peers brainstorm "Future" items. Examples: bills, potential illness or injury (self and loved ones), fears of school or work failure, anticipated family feuds or relationship break-ups, possible relapse (worsened symptoms of mental illness and/or substance abuse).
3. Another volunteer lists under "Present" *only* immediate concerns. Examples: homelessness, current abuse, ongoing conflicts, today's school or work demands. Ask, "Which list is shortest?" (Present) "Why?" (Most stress relates to the past or future).
4. Ask, "Can we change the past?" (no) "Can we control the future?" (no) "What *can* we control?" (*Today's* thoughts and actions).
5. Participants take turns going to the board, selecting a *Present* stressor and discussing what *can* be done *today*. Examples: calling shelters for homeless people or victims of abuse; asking a teacher or boss how we can improve; reviewing and role-paying conflict resolution techniques; and making an appointment for family or relationship counseling.
6. Take turns selecting *Past* worries and discussing what *can* be done *today*. Examples: participate in therapy addressing abuse, guilt, grief, and loss; decide that resentment hurts us more than the person we resent; decide to forgive self and others; find out *whether* and *how* we can repair financial, legal, school, work or relationship problems; plan ways to avoid repeating mistakes. *After doing what can be done today, let it go!*
7. Take turns selecting *Future* concerns and discussing what *can* be done *today*. Examples: develop a budget; make calls about financial aid, employment, credit counseling, utility assistance, food stamps; make doctor appointments; do preventive maintenance on vehicles, home, and equipment; develop a study schedule; request tutoring; ask for a work performance review and

develop a plan for improving or advancing; develop a relapse prevention plan encompassing medication, therapy, support groups, written assignments, exercise, nutrition, rest, appropriate socialization and other components. After doing what can be done today, let it go!

Variation 2.

1. People write stressors on slips of paper anonymously. Collect them and put them in a container. Take turns writing them on the board under "Past, Present, or Future" and discuss what *can* be done *today*.

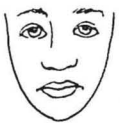
Follow-up: Each shares his/her major stressor, the group brainstorms and the participant receives feedback about all s/he can do today.

Reference:

Butler, C.A. (2001). Past, present and future. *100 interactive activities for mental health and substance abuse recovery* (pp. 273-274). Plainview, NY: Wellness Reproductions and Publishing, LLC.

PAST, PRESENT AND FUTURE

WORKSHEET

PAST STRESSORS	PRESENT STRESSORS	FUTURE STRESSORS
1. I was mean to someone. 	1. No food. 	1. Worry I'll get cancer. 
2.	2.	2. Afraid I'll fail a test.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.
Things I <u>can</u> do TODAY about the past.	**Things I <u>can</u> do TODAY about the present.**	**Things I <u>can</u> do TODAY about the future.**
1. Apologize and make appointment for Anger Management Class.	1. Call Food Stamp Agency, Emergency Food Kitchen, and/or Shelters and tell social worker.	1. Make doctor appointment.
2.	2.	2. Make study schedule and stick to it.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.
I did what I can do today – Now I will Let It Go!	*I did what I can do today – Now I will Let It Go!*	*I did what I can do today – Now I will Let It Go!*

Week 6: ***Developing Effective Communication & Assertiveness Skills***

Purpose: To increase an awareness of verbal, nonverbal, one-way, and two-way communication as well as promote open communication in general. Open communication involves verbal, nonverbal, and two-way communication, together these provide the clearest picture to the receiver. Effective communication promotes improved personal and professional relationships.

Materials: Clipboard, "Just Do It" checklist, pencils, handout (see attached form), and blank paper.

Warm-up activity: This activity gets the group members who act tired or shy to move and mingle. For this activity, each participant receives the 'Just Do It' checklist, a clipboard, and a pencil. Move the tables/chairs to one side of the room, so there is free space for everyone to move about the room. Each participant is to complete as many of the listed actions on the checklist as possible in the allotted time the therapist gives the group (i.e. 10 minutes). Some actions may require role-play; those who assist with role-plays initial each other's sheets. They are not to pair-up but do different actions with different people.

Activity Idea: Communication Building Blocks

Instructions for activity:

Variation 1.

1. Photocopy one handout (attached page with the twelve designs).
    a. Optional—each design may be cut into individual pieces and mounted on an index card for easier (or random) selection of designs.
2. Distribute blank paper and pencils to the group members.
3. Ask for a volunteer, and instruct him/her (without showing the handout/cards to others) to…
    a. Choose one shape (or select one card).
    b. Describe it to the group using *verbal cues only,* so the others can accurately draw it on their papers. Use one-way communication only. Do not allow questions/comments from the group. Do not use nonverbal cues (hand motions, body gestures, etc).
4. Encourage group members to show their drawings to the describer to compare their copies with the original.
5. Continue the activity by instructing volunteer #2 to describe a different shape *verbally,* but this time *including nonverbal cues as well.* Use one-way communication only.
6. Encourage group members to first draw then show their drawings to the describer to compare their copies with the original.
7. Continue the activity by instructing volunteer #3 to describe a third shape *verbally*, and *nonverbally, allowing for two-way communication* with the group members.

Variation 2.

1. Photocopy one page and make cards using each of the twelve designs.
2. Encourage group members to describe their shapes to the rest of the group. They can choose to describe them…
    a. Verbally, with no nonverbal cues.
    b. Verbally and nonverbally, allowing no questions.
    c. Verbally and nonverbally, encouraging questions.

Follow-up: Process the group by discussing members' reactions and responses to the exercise(s), emphasizing the benefits of open communication in general as well as verbal, nonverbal, and two-way communication. Also discuss the warm-up activity, what was beneficial, etc. Have each participant state a positive action s/he needs to 'just do'.

References:

Butler, C.A. (2001). Just do it. *100 interactive activities for mental health and substance abuse recovery* (pp. 25, 27). Plainview, NY: Wellness Reproductions and Publishing, LLC.

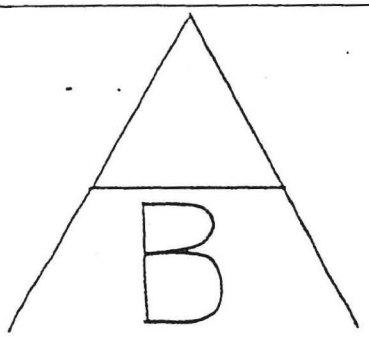
Korb, K.L., Azok, S., & Leutenberg, E.A. (1989). Communication building blocks *Life management skills: Reproducible activity handouts created for facilitators* (pp.14). Beachwood, OH: Wellness Reproductions, Inc.

Just Do It!

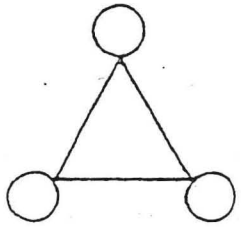
CHECKLIST

ACTIONS	WITNESS INITIALS
Receive and refuse and invitation.	
Make a request.	
Express fear.	
Express anger (assertively, not aggressively).	
Introduce yourself.	
Give a compliment.	
Receive a compliment.	
State a decision without justifying it.	
Express love.	
Ask to borrow something.	
Receive constructive criticism.	
Give constructive criticism.	
Say "No" to a request.	
Start a conversation.	
Receive an invitation and accept.	
Express annoyance. (Use an "I" statement)	
Express an opinion	
Say "I don't know" without apologizing.	
Admit a mistake and accept the consequences.	
Say something positive about yourself.	

COMMUNICATION BUILDING BLOCKS



1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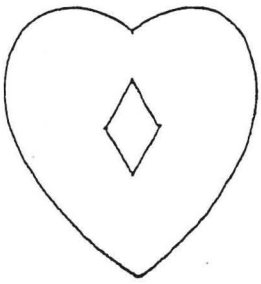
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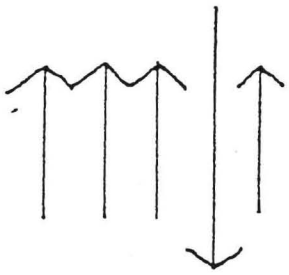
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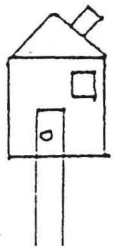
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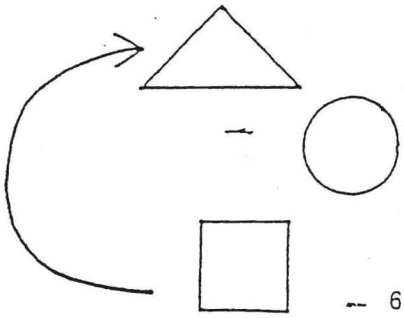
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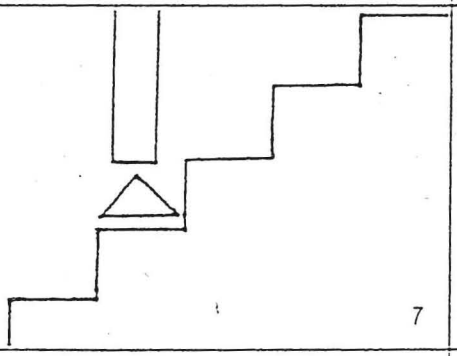
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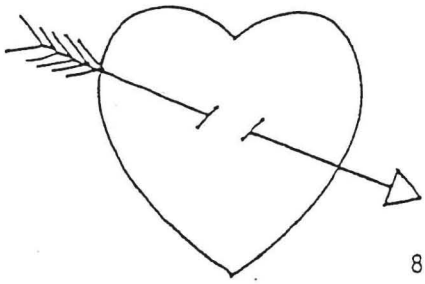
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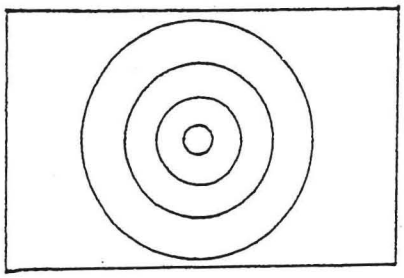
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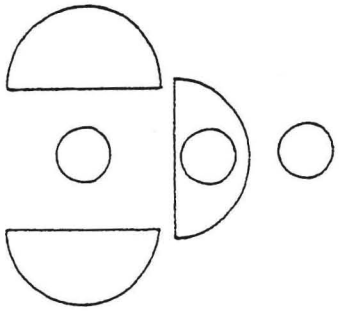
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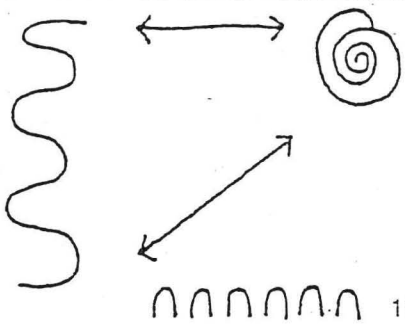
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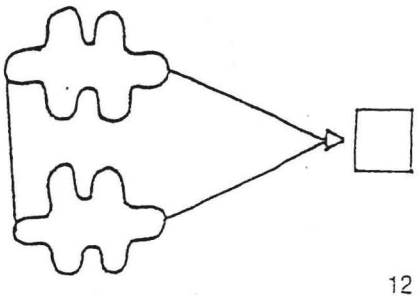
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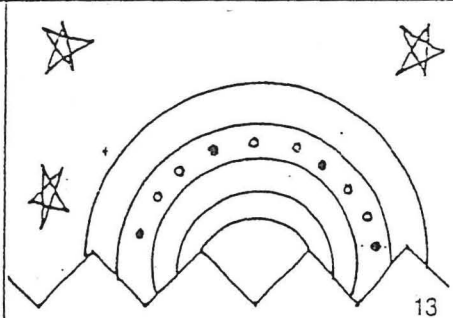
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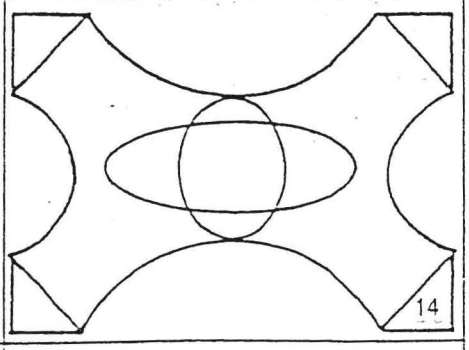
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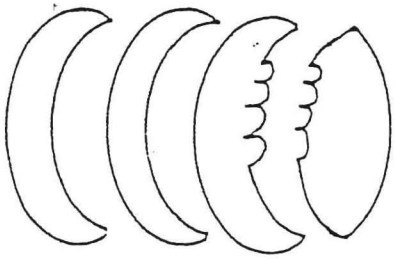
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Week 7: ***Nutrition and Exercise***

Purpose: To recognize the importance of a healthy/balanced diet as well as the significant role exercise plays in the functioning of the body.

Materials: Paper, writing utensils, handout containing the food pyramid and information on vitamins.

Warm-up activity: Have everyone write down what they ate/drank yesterday and today as well as what, if any, physical activity they have engaged in. When everyone is done writing, put papers aside and continue with the day's main activity. In the follow-up discussion, talk about everyone's current diet and exercise plans and if/how it could be adjusted for a healthier lifestyle.

Activity Idea: Discussion on nutrition, exercise and plan a meal as a group.

1. Introduce and discuss the food pyramid. Emphasize the importance of eating healthy and having a balance of all food groups as well as limiting excessive sugars, fats, etc. from one's daily diet.
2. Discuss essential vitamins necessary in one's daily diet and which foods are good sources of these vitamins.
3. Have the group participants' brainstorm and plan a nutritiously balanced meal including all of the food groups.
    - Optional extra group: Have the group members prepare the meal during an additional group session.
4. Discuss importance of daily physical exercise in one's life and how it correlates with eating healthy. Discuss various forms of exercise options and how exercise currently benefits us as well as benefits us in the future.

Follow-up: Re-cap the important ideas discussed. Discuss the papers from the warm-up activity. Have each participant state two ideas s/he is taking with them from this group session and how they will implement the new ideas into their everyday life.

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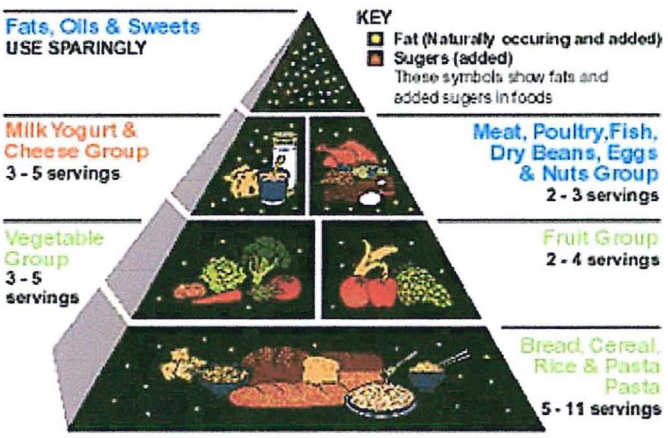
Food Pyramid

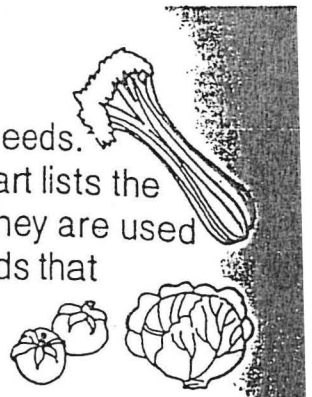


When choosing a healthy diet, follow the Food Pyramid guidelines developed by USDA and HHS. Simply select the suggested number of servings from the five basic food groups above. These groups are:

1. bread, cereal, pasta, and rice (5-11 servings)
2. vegetables (3-5 servings)
3. fruits (2-4 servings)
4. milk, yogurt and cheese (3-5 servings)
5. meat, poultry, fish, dry beans, eggs, and nuts (2-3 servings)

A sixth group (fats, oils and sweets) consists mostly of items that are pleasing to the palate, but high in fat and/or calories; these should be eaten in moderation or intake should be limited.

VITAMINS



NOTE Like minerals, vitamins are nutrients that help the body to use other nutrients. Vitamins are found in almost all foods. Eating a variety of foods from the four basic food groups provides all the necessary vitamins your body needs.

The following chart lists the main vitamins, how they are used by the body, and foods that provide them.

VITAMIN	HOW USED BY THE BODY	SOURCES
A	Healthy skin, good vision at night, strong bones	Dark green and yellow vegetables, yellow fruits, butter, cheese, milk, liver
B_1	Helps body get energy from food, increases appetite, healthy nervous system	Eggs, yeast, potatoes, pork, grains
B_2	Healthy skin, helps body get energy from food	Fish, eggs, liver, milk and other dairy products
B_3	Healthy skin and nervous system, helps body get energy from food	Eggs, fish, wheat germ, liver
B_6	Helps body use protein	Fish, liver, vegetables, grains
B_{12}	Growth, helps produce red blood cells	Liver, milk, eggs, meat
C	Healthy gums, protects body against infection, helps wounds heal	Oranges, lemons, grapefruit, tomatoes, broccoli, green peppers, strawberries, potatoes
D	Strong bones and teeth, helps body use calcium	Milk, egg yolks, liver, fish oils, butter
E	Helps blood carry oxygen	Vegetable oils, wheat germ
K	Helps blood clot	Broccoli, spinach, lettuce, cabbage

ACTIVITY

1. How is vitamin C used by the body? _____

_____

2. What foods are good sources of vitamin A? _____

_____

3. What vitamins are found in milk? _____

_____

4. What vitamins help to keep the skin healthy? _____

_____

5. What vitamin helps the body to use protein? _____

Week 8: ***Support Systems and Community Resources***

Purpose: To identify the resources and support systems that are available to the participants in the community and in their own lives (friends, family, teachers, churches, etc).

Materials: Phonebook, pamphlets from various community resources, and a reference list of resources for the group members to take with them.

Warm-up activity: Conduct a brief discussion: Ask if anyone in the group has ever elicited community resources/supports before. Discuss what they liked, disliked, what would be beneficial to have available to them. Ask if there are any questions or concerns regarding other areas they may want more support from. For example, areas such as leisure, employment, friends, and social opportunities.

Activity Idea: Introduce and discuss resources and supports available to use.

1. Have group members identify support systems in their lives and share with other members.
2. Have the group members brainstorm ideas of possible supports in the community. Share ideas that have worked for themselves or for people they know.
3. Share ideas of resources/supports that were not beneficial. Discuss why not.
4. Identify community resources that are available using the phonebook or pamphlets from community resources.

Follow-up: Re-cap ideas/supports that have worked in the past as well as new ones to try. Each participant makes a plan as to how they will utilize the resources and supports they think may be beneficial.

Therapist's Copy of
Outcome Criteria Survey for Survival Skills Group

A survey will be given to all members in group treatment at three different points: prior to the start of the 8 week group, at the completion of the 8 week group, and 3 months post-treatment. The therapist will document changes in patterns and frequency of self-mutilation as well as look at sustained skill development to discover effectiveness of the group protocol.

Questions Prior to Beginning of Treatment:

1. How many times per week do you self-harm?

2. Why do you engage in self-harming behaviors?

3. What types of self-harm do you engage in? Check all that apply.
   _____Cutting,
   _____Burning
   _____Biting
   _____Starving self
   _____Other (explain)

4. Have you ever received therapy services to help you in dealing with your self-harming behaviors?

5. What are your goals for treatment?

6. On a scale of 1 to 10, rate your current abilities to effectively deal with situations that lead to engagement in self-harming behaviors (10 = most effective and 1 = least effective).

Questions after Completion of Treatment:

1. How many times per week do you self-harm?

2. What types of self-harm do you engage in?

3. What strategies/skills have been useful in effectively dealing with situations that lead to engagement in self-harming behaviors?

4. Describe you progress toward meeting the goals you identified for treatment.

5. What strategies/resources would assist you in continuing to work on your goals?

Questions at 3 Months Post-Treatment:

1. How many times a week do you self-harm?
2. What types of self-harm are you engaging in?
3. Have you had to seek any medical attention for a self-harm episode since outpatient treatment ended?
4. If yes for question 3, what were the stressors that caused this episode?
5. What treatment did you receive?
6. What services are you currently using to help you deal with your self-harming behavior? Such as occupational therapy, psychiatry, social work etc.
7. Describe your ability to control your self-harm? What alternatives are you using?
8. What ideas for treatment could have better prepared you for dealing with your illness?

Survey for Survival Skills Group

This is a survey that helps give the therapist a better understanding of where you are coming from in order to assist you in this group. Please take the time to fill this out prior to beginning this group.

Questions Prior to Beginning of Treatment:

1. How many times per week do you self-harm?

2. Why do you engage in self-harming behaviors?

3. What types of self-harm do you engage in? Check all that apply.
   _____Cutting,
   _____Burning
   _____Biting
   _____Starving self
   _____Other (explain)

4. Have you ever received therapy services to help you in dealing with your self-harming behaviors?

5. What are your goals for treatment?

6. On a scale of 1 to 10, rate your current abilities to effectively deal with situations that lead to engagement in self-harming behaviors (10 = most effective and 1 representing least effective).

Survey for Survival Skills Group

Now that you have completed this eight week treatment group, please take the time to answer these questions in order to determine how/if this group was beneficial to you.

Questions after Completion of Treatment:

1. How many times per week do you self-harm?

2. What types of self-harm do you engage in?

3. What strategies/skills have been useful in effectively dealing with situations that lead to engagement in self-harming behaviors?

4. Describe you progress toward meeting the goals you identified for treatment.

5. What strategies/resources would assist you in continuing to work on your goals?

Survey for Survival Skills Group

It has been three months since the completion of the eight week treatment group you attended. Please take the time to answer these questions to let the therapist know what has and has not worked for you. Your feedback is greatly appreciated and helps in developing and providing effective treatment to you as well as to other individual's in need.

Questions at 3 Months Post-Treatment:

1. How many times a week do you self-harm?

2. What types of self-harm are you engaging in?

3. Have you had to seek any medical attention for a self-harm episode since outpatient treatment ended?

4. If yes for question 3, what were the stressors that caused this episode?

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7. Describe your ability to control your self-harm? What alternatives are you using?

8. What ideas for treatment could have better prepared you for dealing with your illness?

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