TITLE: Self-Injurious Behaviors: Assessment and Diagnosis
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ABSTRACT

This article examines the diagnosis and assessment of self-injurious behaviors. A classification model for conceptualizing self-injury is discussed, and the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision; American Psychiatric Association, 2000) diagnoses associated with self-injury are addressed. Assessment questions and issues to consider when assessing clients who self-injure are provided.

Public interest in self-injurious behaviors (SIB) has increased rapidly in recent years. The media and popular literature have begun to address the issue of SIB, and counselors have had an increasing number of clients presenting with SIB. Minor forms of self-injury, such as hair twisting and fingernail biting, are common among the general population. Most cultures also have forms of culturally approved and sanctioned SIB (Favazza, 1996). For example, in Western culture, ear-piercing, tattooing, various forms of body piercing, and plastic surgery are becoming more commonplace.

In the clinical literature, there are many varied definitions indicating what constitutes SIB. For the purposes of this article, SIB is defined as a volitional act to harm one’s body without any intention to die as a result of the behavior (Simeon & Favazza, 2001; Yarura-Tobias, Neziroglu, & Kaplan, 1995).

There seems to be an upward trend in the incidence of SIB. Earlier estimates indicated that 1% of the general population self-injured (Lester, 1972), and 3% to 5% of psychiatric populations engaged in SIB (Ballinger, 1971; Phillips & Muzaffer, 1961). More recent estimates indicate that approximately 4% of the general population and 21% of the clinical populations without mental retardation or a developmental disability engage in SIB (Briere & Gil, 1998). More specifically, SIB is seen in 13% to 53% of patients diagnosed with Tourette’s syndrome (Robertson, 1989; Robertson, Trimble, & Lees, 1989), in 3% to 46% of the population diagnosed with mental retardation or a developmental disability (Bodfish, Crawford, & Powell, 1995; Winchel & Stanley, 1991), and in 75% of hospital patients diagnosed with borderline personality disorder (BPD; Clarkin, Widiger, & Frances, 1983).

Despite an ostensible increase in and discussion of SIB, little is known about the etiology, course, diagnosis, assessment, and appropriate treatment interventions associated with SIB. Many counselors have had little, if any, exposure in managing issues associated with client SIB.

This article focuses on forms of SIB as described in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision [DSM-IV-TR]; American Psychiatric Association [APA], 2000). Self-injury has long been recognized as being related to many mental disorders. The current DSM-IV-TR diagnoses that are most related to SIB are stereotypic movement disorder with self-injurious behavior, trichotillomania, impulse-control disorder not otherwise specified (NOS), and BPD.

It is important for counselors to be able to diagnose and assess SIB accurately for several reasons. First, a thorough assessment of SIB is needed to select appropriate diagnoses and to determine the severity and potential degree of danger of such behaviors. Second, the appropriate diagnosis of SIB is critical for a clear understanding of the client's SIB dynamics and the eventual selection of effective interventions.

Education on SIB has been shown to increase health care professionals' ability to assess and manage clients who self-injure (Crawford, Turnbull, & Wessely, 1997). To
encourage accurate client diagnosis, this article provides an introduction to the diagnosis and assessment of SIB. A recently updated classification system that can facilitate counselor conceptualization of client SIB is discussed, along with the DSM-IV-TR diagnoses associated with SIB. Finally, questions and issues to consider in assessing SIB are addressed. After reading this article, counselors should feel more comfortable with diagnostic and assessment issues as well as special considerations when in the initial stages of working with clients who engage in SIB.

CLASSIFICATION AND DIAGNOSIS OF SIB

Classification of SIB

As stated, SIB is varied and complex and spans the DSMIV-TR diagnostic categories. Recently, Simeon and Favazza (2001) expanded on an earlier model (Favazza & Rosenthal, 1990, 1993) and developed a classification system for organizing and categorizing SIB. Each of the four categories corresponds to, and tends to be more prevalent with, various DSM-IV-TR mental disorders. The four-category classification of SIB is as follows: Stereotypic SIB, Major SIB, Compulsive SIB, and Impulsive SIB.

Stereotypic SIB generally includes behaviors such as head banging, self-hitting and face slapping, lip and hand chewing, self-biting, and hair pulling behaviors most typically seen in individuals with organic mental disorders such as mental retardation and developmental delay. In these cases, SIB has typically been conceptualized as organically based, biologically driven behaviors. The pattern of these injurious behaviors is fixed and highly repetitive, causing a range of mild to severe tissue damage. Disorders associated with this type of SIB include Tourette's syndrome, Lesch-Nyhan syndrome, autism, temporal lobe epilepsy, mental retardation, and Cornelia-de-Lange.

Major SIB includes more severe or potentially life-threatening injuries such as castration, eye enucleation, and limb amputation. These extremely intrusive behaviors are obviously very isolated and generally occur when a person is suffering from a severe psychosis, intoxication, or a severe character disorder. Self-injurious behaviors of psychotic people differ from the other forms of SIB in that the person injures in response to profound disorders of perception or thought and does not recognize the irrationality of the behavior (Conn & Lion, 1983). The SIB is not of the stereotyped repetitive type but is composed of discrete acts that are often bizarre or drastic and that have personalized, symbolic meaning to the person (Conn & Lion, 1983). People who are psychotic and self-injure may do so in response to command hallucinations or delusions, particularly religiously theme-related delusions. In psychotic-related SIB, the organ system or body part that is injured is almost always associated with a delusional belief (Clark, 1981). Reports of autocastration, autoamputation of digits and limbs, self-enucleation, abdominal self-surgery, removal of the tongue, amputation of the ear, and autcannibalism have been described in the literature (Conn & Lion, 1983). Compared with other persons who self-injure, people who engage in psychotic-related SIB report no pain and often experience calm before, during, and after the injury occurs.

Compulsive SIB consists of repetitive hair pulling, skin picking, and nail biting of a mild to moderate severity. Compulsive SIB is consistent with the DSM-IV-TR diagnoses trichotillomania and stereotypic movement disorder with self-injurious behaviors. People engaging in this type of SIB are compelled to execute the impulse but may wish to resist it, with varying levels of success. An increasing anxiety with subsequent tension release is commonly described with compulsive SIB, similar to obsessive-compulsive disorder (OCD) dynamics. However, some people with compulsive SIB report that the behaviors occur automatically, without any conscious urge (Simeon & Favazza, 2001).
Impulsive SIB consists of skin cutting, burning, and self-hitting of a mild to moderate severity. These behaviors tend to be isolated or habitual. It has been noted that there are two types of Impulsive SIB—episodic and repetitive (Favazza, 1996). Episodic self-injury is self-injury that occurs only a limited number of times throughout a person’s life. Repetitive types are more associated with reoccurring self-injury that has an almost addictive quality and is incorporated into a person’s life and personality and should be classified under the impulse-control disorders NOS category of the DSM-IV-TR (Favazza & Simeon, 1995). Impulsive types of self-injury are more sporadic, are externally triggered, and are associated more with BPD; antisocial, dependent, and histrionic personality disorders; eating disorders; posttraumatic stress disorder (PTSD); and dissociative disorders (Briere & Gil, 1998; Dallam, 1997; Ferreira, Cunha, Pimenta, & Costa, 1998; Simeon & Favazza, 2001).

Although impulsive SIB is often associated with personality disorder diagnoses, people engaging in these behaviors constitute such a large group that it is impossible to make a singular etiological formulation (Favazza & Conterio, 1998). Typically, impulsive SIB is established early in adolescence and often develops into a chronic behavior in adulthood. Impulsive SIB can be seen as pathological on one hand and as a self-help strategy on the other hand. Although it is easy to see how SIB is destructive, it is also helpful in that it can provide relief from unpleasant experiences and may prevent temporary psychotic episodes and suicidal acts. Research on impulsive SIB indicates that it often prevents people from experiencing symptoms such as depersonalization, severe anxiety, intense anger, depression, hallucinations, perceived external and internal flaws, racing thoughts and rapidly fluctuating emotions, boredom and stimulus deprivation, and feelings such as loneliness, emptiness, and insecurity (Favazza & Conterio, 1998). Impulsive SIB is often associated with childhood sexual abuse and subsequent PTSD reactions (Ghaziuddin, Tsai, Naylor, & Ghaziuddin, 1992; Langbehn & Pfohl, 1993; Zweig-Frank, Paris, & Guzdar, 1994). Some writers have even called for the inclusion in the DSM-IV-TR of a disparate diagnosis for people who engage in SIB—“Deliberate Self-Harm Syndrome” (Pattison & Kahan, 1983) or “Repetitive Self-Harm Syndrome” (Favazza & Rosenthal, 1993).

The aforementioned classification of SIB can be helpful in providing clues as to the DSM-IV-TR diagnostic category with which the SIB may be consistent. For example, a counselor could use this taxonomy in considering a person presenting with an isolated incident of extremely intrusive SIB and surmise that the person may have a diagnosable psychotic disorder versus a personality disorder. Another example would be a client presenting with repetitive hair pulling who reports that she tries to resist this behavior. This would be indicative of compulsive SIB and would lead to a trichotillomania diagnosis. Ultimately, this classification system is a tool to use in considering and selecting appropriate DSM-IV-TR diagnosis and thus effective interventions.

Diagnoses Related to SIB

The DSM-IV-TR diagnoses associated with SIB vary from Axis I to Axis II diagnoses, and they vary from diagnoses in childhood and adolescence (i.e., stereotypic movement disorder) to disorders diagnosed in adulthood (i.e., BPD). It is important to note, however, that SIB has been associated with many more diagnoses than those that are stated explicitly in the DSM-IV-TR. In fact, people who engage in SIB have been reported as being diagnosed with mood disorders such as major depression and dysthymia, dissociative identity disorder, anxiety disorders such as OCD, substance abuse disorders, adjustment disorders, schizophrenia, personality disorders, and eating disorders (Brittlebank et al., 1990; Darche, 1990; Dulit, Fyer,

The following four diagnoses are explored in more detail in relation to SIB because they either explicitly mention self-injury as a diagnostic criterion or they are directly applicable to SIB (i.e., impulse-control disorder, stereotypic movement disorder with self-injurious behavior, trichotillomania, impulse-control disorder NOS, and BPD.

Stereotypic movement disorder with self-injurious behavior. This disorder would best be classified as a stereotypic form of SIB or possibly a compulsive SIB if the behavior is ritualized (Simeon & Favazza, 2001). This is a disorder categorized under the other disorders of infancy, childhood, or adolescence in the DSM-IV-TR. This disorder consists of behaviors that are "repetitive, often seemingly driven, and nonfunctional" (APA, 2000, p. 134). Examples of behaviors associated with this diagnosis are head banging, self-biting, skin picking, or hitting various parts of one's body. Mental retardation does not necessarily need to be present, but it is often associated with this diagnosis.

Because of the high incidence of stereotypical behaviors in the population with mental retardation, the DSM-IV-TR (APA, 2000, p. 134) states that this diagnosis should only be given if the behavior is of sufficient severity to become a focus of treatment. In addition, the DSM-IV-TR (APA, 2000, p. 134) states that the SIB should not be accounted for by another disorder such as a pervasive developmental disorder (e.g., autism), OCD, or trichotillomania.

There are many theories concerning the etiology of SIB related to stereotypic movement disorder. One theory is that the self-injury serves as a form of self-stimulation and helps to either regulate overstimulation and decrease arousal or serves as a means to increase stimulation and arousal (Favazza & Rosenthal, 1993; Roanyczyk, Lockshin, & O'Connor, 1992). Other etiological explanations include a behavioral hypothesis, which states that the behavior of the person who self-injures is reinforced by caretakers or that the self-injury serves as a means to escape unpleasant stimuli (Roanyczyk et al., 1992). Other explanations of SIB in this population include psychodynamic and biological theories (Roanyczyk et al., 1992; Symons & Thompson, 1997).

Trichotillomania. This disorder would best be classified as a compulsive form of SIB (Simeon & Favazza, 2001). Trichotillomania was first introduced into the DSM in its 3rd edition as one of the disorders associated with impulse-control disorder NOS. The current DSM-IV-TR (APA, 2000, p. 677) includes it as a distinct disorder under disorders of impulse control. The primary features of trichotillomania are recurrent hair pulling, a noticeable loss of hair, and clinically significant distress or functional impairment as a result of the hair pulling. Although most hair pulling occurs from the scalp region, hair pulling from the eyebrows, eyelashes, beard, and the pubic area also occur (Cohen, Stein, & Simeon, 1995; Stein, Christenson, & Hollander, 1999). In addition, hair pulling may be limited to single areas of the body or may involve many areas of the body. This is an impulse control disorder classified by increasing tension immediately prior to, and the gratification or relief during, the recurrent hair-pulling behaviors. It has been described as being related to OCD. In one sample of patients with trichotillomania, 15 had a lifetime history of OCD and 18 had OCD-related symptoms (Christenson, Mackenzie, & Mitchell, 1991).

Impulse-control disorder NOS. This "not otherwise specified" diagnosis under the impulse control category is a catchall for any impulse-control-related disorders that are not explicitly identified elsewhere (e.g., pathological gambling, pyromania). As the name implies, this diagnosis would best be classified as an impulsive form of SIB (Simeon
One of the criteria for meeting this diagnosis is having and following through on irresistible urges and experiencing subsequent relief. This is a similar dynamic to trichotillomania, which is also an impulse control disorder. When self-injury is not better accounted for by the trichotillomania diagnosis or another diagnosis, but is impulsive and repetitive and fits the dyscontrol criteria regarding irresistible urge and subsequent relief, this diagnostic category can be applied. This diagnosis is very similar to the proposed “Deliberate Self-Harm Syndrome” (Pattison & Kahan, 1983) or “Repetitive Self-Harm Syndrome” (Favazza & Rosenthal, 1993).

BPD. This disorder would best be classified as an impulsive form of SIB (Simeon & Favazza, 2001). One of the nine criteria for this personality disorder diagnosis is “recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior” (APA, 2000, p. 710). However, self-injury by itself is neither necessary nor sufficient to establish a BPD diagnosis.

Although there is variability in the underlying dynamic of impulsive SIB in BPD clients, the typical progression involves the person experiencing a precipitating event such as rejection, escalating dysphoria, an attempt to forestall the self-injury, a self-injury event, and a subsequent tension release (Grossman & Siever, 2001). The dysphoria is often described by clients as being a feeling of fear, shame, anger, loneliness, and panic. Many clients describe dissociative experiences, such as feeling numb, empty, and dead, immediately prior to the self-injury (Grossman & Siever, 2001). The states and motivations for engaging in impulsive, BPD-related SIB include the following:

- releasing unbearable mounting tension; discharging rage directed at hated parts of the self, real or internalized others, or both; self-punishment; attempting to feel alive again by lifting depersonalization and emotional deadness; regaining a sense of control and omnipotence; self-soothing; reconfirming self-boundaries; communicating with or controlling others; experiencing sexual excitement euphoria or titillation; relieving intolerable aloneness alienation, hopelessness, or despair; combating any desperate affects or thoughts; and expressing conflictual dissociative states. (Simeon & Favazza, 2001, p. 17)

As can be seen, the motivations for SIB are varied and complex. Clients may report a variety of motivations for self-injury.

A discussion of SIB and BPD would not be complete without mentioning the significance of past abuse and trauma. Although most traumatized individuals do not self-injure, a majority of people who engage in impulsive self-injurious behavior have histories of trauma and abuse, with instances ranging from 62 (Favazza & Conterio, 1989) to 79 (van der Kolk, Perry, & Herman, 1991). Counselors should not assume clients to be abused secondary to SIB, but the possibility of a past abuse history should be explored.

Because personality disorder diagnoses are very stigmatizing, care should also be taken to avoid an unnecessary BPD diagnosis. Many are quick to apply a BPD diagnosis at the mention of self-injury. However, in one recent study of participants in an inpatient hospital setting, only 48 of a sample of self-injurers met the DSM-IV-TR criteria for BPD, and when self-injury was excluded as a factor, only 28 of the sample met the criteria (Herbertz, Sass, & Favazza, 1997). Thus, impulsive SIB does not necessarily indicate that a client meets the criteria for BPD.

ASSESSMENT OF SIB AND IMPLICATIONS FOR COUNSELING PRACTICE

Even if a client does not present with ostensible SIB, it has been suggested that an assessment of SIB be incorporated into any initial evaluation or diagnostic assessment. General questions (e.g., “Have you ever physically hurt yourself in any
way?" can be used to inquire not only about past suicidal behaviors but also about SIB history (Simeon & Favazza, 2001). If a client does note a history of SIB, a thorough assessment of the behaviors is necessary. The first step in assessing client SIB is to thoroughly determine the frequency, duration, and onset of the SIB and the antecedents and consequences of the SIB. Although measures have been developed to assess for the severity (see Iwata, Pace, Kissel, Nau, & Farber, 1990) and the frequency and severity (see Brasic et al., 1997) of repetitive stereotypical and compulsive SIB concurrent with mental retardation, autism, neuroacanthocytosis, and Tourette’s syndrome, no formal assessments have been developed to assess for impulsive or major SIB. Because no formal assessment measures have been developed to assess for SIB, a thorough informal assessment during the diagnostic interview is necessary.

When assessing SIB, an understanding of the functions, dynamics, and severity of the SIB is needed. Given the wide variety of explanations, correlates, and functions of SIB (Suyemoto, 1998), counselors need to be careful not to presuppose the etiology or function of client SIB but must consider each individual to be unique. In other words, it is important to try and understand the behaviors from the client’s reality and perspective: What do the behaviors mean to the client? For what reasons does the client believe he or she engages in these behaviors?

Some of the issues to consider inquiring about during an initial interview are as follows (Simeon & Favazza, 2001): age of onset, course of the behavior, longest period free of behavior, lifetime and current frequency of SIB, change of behavior over time, medical complications (e.g., stitches, surgeries, infections, corrective surgeries), emotional states when injuring, triggers leading to the SIB, immediate and more long-term aftermath of injuring, impulsivity of SIB, dystonicity (a wish to stop oneself), resistance (effort to stop oneself), control (success in stopping oneself), use of substances before and after the behaviors, past interventions to stop behavior, and family history of SIB.

In addition, to facilitate client safety, issues related to suicide should be addressed and a standard suicide assessment (e.g., assessment of depression, helplessness, and hopelessness, suicidal ideation, plan and intent, preparation and access to a means, past attempts, social support, family history of suicide, recent stressors) should be implemented. It is important to note that suicide and SIB are not necessarily related (see Pattison & Kahan, 1983). Indeed, SIB should only be thought of as suicidal if the client indicates intent to die (Simeon & Favazza, 2001). However, the issue of suicidal ideation is complicated, and one can have suicidal ideation and self-injure and not be considered suicidal (Simeon & Favazza, 2001). In fact, 28 to 41 of people report suicidal ideation while self-injuring (Gardner & Gardner, 1975; Pattison & Kahan, 1983). Welch (2001) reviewed 20 studies that examined parasuicide (i.e., attempted but failed suicide) and stated that it is difficult to study this area because parasuicide and deliberate self-harm without intent to die are often blurred together. Support for the idea that suicidal behaviors and self-injury are disparate is found in Stone’s (1990) research indicating that, over a 15-year follow-up time period, a history of suicide attempts was a better predictor of future suicide than was SIB. In summary, there is a link between suicide and SIB, but the nature and extent of this link is still under investigation. Thus suicidal intentions should always be assessed for, but clients need not be considered suicidal unless they express intent to die (Simeon & Favazza, 2001).

Shneidman (1985) noted dimensions that can be considered in delineating between suicide and SIB. Most relevant is the author’s contrast between the stimulus, purpose, goals, emotions, and attitudes of suicidal versus self-injury-related behaviors: Suicide stimulus (unendurable psychological pain) and the self-injury stimulus (intermittent
psychological pain), the suicide purpose (seeking a solution to an overbearing problems) and the self-injury purpose (achieving short-term alleviation), the suicidal goal (cessation of consciousness) and the self-injury goal (alteration of consciousness), the suicide emotion (hopelessness/helplessness) and the self-injury emotion (alienation), and the suicide internal attitude (ambivalence) as opposed to the self-injury attitude (resignation; Shneidman, 1985, p. 216).

In assessing a client's SIB, it is also important to consider the severity of current as well as possible medical complications secondary to the SIB. If there is any concern that the client has infections or is engaging in self-injury of a severe and chronic nature (e.g., insertion of metal objects under skin, possible infections secondary to recurrent cutting), the client should be referred immediately to a physician for an assessment. Clients who engage in milder forms of SIB should be referred for a medical evaluation and instructed not to share blades with other people who self-injure so as to prevent disease transmission (Dallam, 1997).

It is also important during an initial interview to explore all aspects of the client’s life: recent life experiences, past traumas, current life stressors, and so forth. Current life stressors may be indicative of triggers for impulsive SIB, and past traumas and abuse are possible indicators of current SIB dynamics. It is also helpful to have the client self-monitor SIB during the course of the week that follows the initial session to better map the frequency, triggers, cues, and reducers of the SIB. The following list summarizes these assessment issues and provides the general steps to take in assessing a client’s self-injury:

* Conduct a detailed mental status exam, paying particular attention to the presence of psychotic symptoms, intoxication, dissociative states, and cognitive functioning.
* Inquire about the frequency, duration, and onset of the SIB as well as the antecedents and consequences of the SIB. Ask about the first, last, most severe, and most typical incidents of SIB.
* Conduct an evaluation and, based on mental status and knowledge of the client’s SIB-related dynamics, determine which DSM-IV-TR diagnosis best fits the client’s behaviors; rule out any additional psychiatric diagnoses or additional self-damaging behaviors.
* Rule out sociocultural variables to determine if the SIB has any special meaning within the client’s subculture or religion.
* Assess for suicidal ideation, plan, and intent as well as risk factors of suicide.
* Inquire about medical complications associated with SIB and determine if the client currently needs medical attention for injuries.

SPECIAL CONSIDERATIONS WHEN WORKING WITH SIB

Contextual, Cultural, and Gender Issues Associated With SIB

Self-injury has existed throughout human history; thus, behaviors alone, considered outside of social context, do not constitute self-injury per se. Favazza (1996) reported that self-injury is described in the Bible, and that self-cutting involving religious and cultural beliefs has been practiced throughout human history. Favazza noted that cave drawings from 20,000 years ago depicted finger amputations that occurred during religious rituals.

The continuum of self-harming behaviors is determined by social norms, individual intentions, the psychological dynamics of the incident, and how the injury affects the self (Connors, 1996). For example, although piercing one’s skin can constitute self-injury, in Western culture it provides a means for wearing earrings—a culturally sanctioned activity. The same behavior in a different culture might be part of a ritual or initiation rite. When assessing SIB, it is important to consider the person’s religious, cultural, and sub-cultural context in determining what is and is not normal.
Gender issues may also be related to rates of self-injury. Regarding stereotypic movement disorder, there are indicators that head banging is more prevalent in boys and men (3:1 ratio) and self-biting is more common in girls and women (APA, 2000). It is commonly stated that girls and women are more likely to engage in impulsive self-injury than are boys and men (Suyemoto, 1998; Suyemoto & Kountz, 2000). However, Briere and Gil (1998), using a community sample, found no gender differences regarding compulsive and impulsive SIB. The common belief that women are more likely to engage in these types of SIB may be related to researchers’ use of help-seeking clinical populations, persons diagnosed with BPD, and sexual abuse and incest survivor populations-samples that are more likely to comprise women. Compulsive SIB such as trichotillomania seems to be much more common in girls and women, but this may be due to cultural and gender-based attitudes regarding appearance, with girls and women seeking out support secondary to hair loss and concerns about their appearance (APA, 2000).

Counselors’ Personal Reactions to SIB

Those who write about self-injury frequently address the issue of counselors’ need to manage countertransference toward clients who self-injure. Issues such as the time and emotional investment required in working with this population, the strong reactions of counselors to self-injury, and the limits these reactions place on counselors’ ability to work with clients have been noted (Zila & Kiselica, 2001). Data gathered from 117 mental health professionals indicated that self-injury was identified as the most distressing client behavior encountered in clinical practice and was the behavior that the professionals found most traumatizing to encounter (Gamble, Pearlman, Lucca, & Allen, 1994, as cited in Deiter & Pearlman, 1998). In many intervention settings, such as hospitals, group homes, and residential treatment, SIB is conceptualized as being manipulative or “attention seeking” (Simeon & Favazza, 2001). Mental health care providers often feel frustrated with SIB and want to attempt to control the client by forcing him or her to stop engaging in SIB. It is important that the counselor constantly monitor his or her own reactions to SIB in an attempt to be self-aware, open to, and respectful of clients. Self-awareness along with ongoing consultation and supervision will best ensure that counselors maintain an objective perspective when working with this population (Deiter & Pearlman, 1998).

CONCLUSION

Counselors are encouraged to conduct a thorough assessment of client behavior and experiences and to develop knowledge of diagnostic issues associated with SIB. It is important that counselors carefully consider all aspects of SIB in concert with the client’s past and current life context to avoid misdiagnosis or the use of unnecessary personality disorder diagnoses.

The assessment and diagnosis of SIB requires counselors to possess general counseling skills and abilities as well as specialized skills and abilities relative to this population. Knowledge of how to adequately assess SIB and choose an appropriate DSM-IV-TR diagnosis is necessary for the counselor to communicate with other professionals and to determine appropriate interventions and treatment recommendations. An accurate diagnosis developed early in the counseling process will contribute to the client getting the appropriate interventions as soon as possible, thus facilitating client safety.

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