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# Clinical Assessment of Self-Injury: A Practical Guide



**Barent Walsh**

*The Bridge of Central Massachusetts*

In this article, the author provides a practice-friendly guide to the psychological assessment of self-injury, such as self-inflicted cutting, burning, hitting, and excoriation of wounds. The crucial distinction between self-injury and suicide is emphasized. The author presents a structure for the assessment of self-injury that focuses first on the therapeutic relationship, and thereafter on the history and specifics of the behavior, its intrapersonal and interpersonal functions, and its antecedents and consequences. Types of self-injury that are atypical, and especially alarming, are identified. A case example illustrates both the style and content of a thorough assessment. © 2007 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 63: 1057–1068, 2007.

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Self-injury was previously thought to be associated with early-life loss and trauma, related functional impairment (Favazza, 1996, 1998; Walsh & Rosen, 1988), and serious mental disorders such as borderline personality disorder, posttraumatic stress disorder, and major depression (Linehan, 1993; Favazza, 1996; Simeon & Hollander, 2001). However, more recently substantial rates have been reported in high-functioning populations such as Air Force recruits who have completed basic training (Klonsky, Turkheimer, & Oltmanns, 2003) and students at elite universities, who may carry no psychiatric diagnoses at all (Kokaliari, 2004, Whitlock, Eckenrode, & Silverman, 2006).

As self-injury, such as self-inflicted cutting, hitting, burning, and excoriation of wounds, has moved from clinical populations into the general population, there has been an explosion of clinical interest in the phenomena. Unfortunately, relatively little has been written on its formal assessment. This absence is regrettable because any effective treatment of self-injury must begin with a thorough and accurate assessment.

In this article, I differentiate suicide from self-injury, review the functions of self-injury, discuss how to establish a positive relationship with self-injurers, and delineate the myriad of details important in assessing self-injury.

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Correspondence concerning this article should be addressed to: Barent Walsh, The Bridge of Central Massachusetts, 4 Mann Street, Worcester, MA 01602; e-mail: barryw@thebridgecm.org

### Formal Instruments

Only a few instruments have been developed to measure self-injury. These include the Functional Assessment of Self-Mutilation (FASM; Lloyd, Kelly, & Hope, 1997), the Deliberate Self-Harm Inventory (DSHI; Gratz, 2001), the Suicide Attempt Self-Injury Interview (SASII; Linehan, Comtois, Brown, Heard, & Wagner, 2006), and the Self-Injurious Thoughts and Behavior Interview (SITBI; Nock, Holmberg, Photos & Michel, in press). These vary as to the evidence in support of their validity and reliability, and all bear the distinct disadvantage (from a clinical perspective) of having been developed primarily for research purposes. Nonetheless, the instruments can be quite useful in suggesting topics to explore while conducting a clinical assessment.

All four measures contain important elements that will be included in the assessment structure presented here. These entail, among other dimensions, the type(s) of self-injury, age at onset, duration, frequency, use of tool or implement, psychological functions, antecedents and consequences, level of physical damage, need for medical intervention, relation to suicidality, and impact on quality of life (e.g., work, school, relationships).

Of the four instruments listed here, the SASII and the SITBI have the most empirical support for their validity and reliability. They are also the most complete (and thereby lengthy) and, though developed primarily for research purposes, are said to have clinical usefulness. I am not aware of any publications to date that discuss the clinical applications of the SASII or the SITBI.

A limitation of using such instruments in clinical settings is that some clients, particularly adolescents, object to more formal assessment procedures within psychotherapy; not infrequently, such clients complain that they find highly structured interviews or written questionnaires to be off-putting and disempowering. Although a skillful clinician can mitigate such risks, they nonetheless should be kept in mind as an assessment proceeds.

### Understanding the Functions of Self-Injury

Before beginning an assessment, clinicians need to have a basic understanding of the functions of self-injury. At the outset, a key point to understand is that self-injury is generally *not* about suicide. The most common forms of self-injury consist of cutting, scratching, carving, self-hitting, self-burning, excoriation of wounds, picking, and abrading (Simeon & Hollander, 2001; Walsh, 2006). What is important to note from this list is that these methods rarely result in death. Recent statistics from the Centers for Disease Control (CDC; 2002) identify death by suicide as occurring via seven basic methods. These are (a) firearm (56.8%); (b) suffocation, such as hanging (18.6%); (c) poison, such as overdose or carbon monoxide (16.8%); (d) fall, such as jumping from a height (2.4%); (e) cut/pierce (1.4%); (f) drowning (1.1%); and (g) other methods, such as self-immolation or transportation-related deaths (3%). Note that very few people (1.4%) die by means of cutting, the most common form of self-injury. Moreover, for those that do die, the cutting generally involves cutting the neck and severing the carotid artery or jugular vein. Most self-injurers cut the extremities or abdomen, not the neck (Simeon & Hollander, 2001). The other forms of self-injury listed above do not appear on the CDC's list of lethal methods. This argues for self-injury being considered a different form of self-harm than suicidal behavior.

If self-injury is not about suicide, then what is it about? There is considerable evidence that most people self-injure to regulate emotional distress and interpersonal relationships. Self-injury is effective in markedly reducing intense feelings of anxiety, anger, sadness, depression, guilt, shame, or even deadness. Internal emotion regulation is the

most commonly cited reason for self-injuring (Nock & Prinstein, 2004; Klonsky, 2007). A smaller proportion of self-injurers cite interpersonal motivations such as communicating distress to peers or regulating distance in relationships (Nock & Prinstein, 2004; Klonsky, 2007). Walsh (2006) has researched and written extensively about self-injury contagion and has speculated that interpersonal motivations for self-injuring may include a desire to communicate, coerce others, compete with other self-injurers, resolve conflicts, or generate intimacy. Therefore, it is important to note that understanding self-injury requires clinicians to consider both intrapersonal and interpersonal functions.

Self-injury is generally not about suicide; however, some individuals who self-injure do become suicidal. It is important to emphasize that while the behaviors are distinct, both can occur within the same individual. Thus, some individuals may move from the low-lethality methods of self-injury (such as cutting, hitting, excoriation) to the high-lethality methods of suicide (such as firearms, hanging, and overdose) and back again. Clinicians working with self-injurers need to monitor in an ongoing way whether their self-injuring clients are also experiencing suicidal ideation, planning, and behavior. In such cases, the priority is always to respond to the suicidal crisis first.

Individuals from the National Comorbidity Survey who cited suicide as their “reason” for self-injuring (as opposed to the much more common emotion regulation or interpersonal functions) were “more likely to ultimately die by suicide” (Nock & Kessler, 2006, p. 619). Therefore, clinicians need to carefully explore the complex motivations for self-injury in their clients; persons who say they self-injure to die may be at greater risk of subsequent suicide than those who cite the more standard emotion regulation or interpersonal factors.

### Case Illustration

Before discussing the assessment process, I offer a case illustration. This case demonstrates the process of conducting a thorough assessment of self-injury. The client in question will be referred to as Tonya, a White, 20-year-old college student, who has come into treatment for cutting and other problems. At the outset, she concedes that she “has been avoiding therapy for years.” She states that she has been cutting herself and “doing other stuff” since she was about 14 years old. Tonya indicates that she has avoided psychotherapy in the past because she was “pissed off” by the response of her guidance counselor to her self-injury in high school. She said that when he found out she was cutting, he “called an ambulance and tried to get me hospitalized for being suicidal.” She states that her self-injury has never been about suicide. She also says somewhat bitterly that the only other psychotherapist she had ever seen (in her mid-teens), “freaked out about the cutting.” They met a total of two sessions.

These disclosures in the first session make it clear that the therapist will need to proceed cautiously and sensitively if he or she is to avoid another therapeutic failure for this client. So the therapist relates the understanding that self-injury often has little to do with suicide and that there will be no leaping to any such conclusions.

Tonya seems relieved by this reassurance and proceeds to tell more of her story. She says that she began cutting when she was 14 and that the main “trigger” was breaking up with her first boyfriend. She says she’s had a lot of stormy relationships since then and that cutting has usually accompanied such disruptions in her life. She clarifies that she doesn’t cut herself “every day or every week, but from time to time when things get tough.” She states she has cut herself perhaps 100 times over the 7-year period. Asked about level of damage, Tonya clarifies that she has never needed medical attention for her wounds.

When the clinician asks, "What does cutting do for you?" Tonya looks surprised and almost gratified. She responds, "At last someone will actually talk to me about this and not treat me like I'm a psycho and want me to stop it immediately." She then proceeds to say that she cuts herself because it "gets the sadness and anger out," and calms her down so she can function. She goes on to say that one of the reasons she decided "at long last" to come into therapy is that she "hasn't been functioning all that well lately." She indicates that she had been doing poorly in school and is sick of dating negative men, who mistreat her, and are disgusted by her cutting.

Asked about the details of her cutting, she replies that she, "usually makes about 3 or 4 cuts to get relief, but sometimes it takes as many as 20." She adds that she always cut her arms and her legs and nowhere else. Only her closest friends know about her cutting.

In response to follow-up questions about other forms of self-injury, she replies that she has tried burning herself a few times, but "it hurt too much and left ugly scars," so she stopped. She says she also picks at her wound sometimes.

Asked about any history of wanting to end her life, Tonya denies any history of suicidal thinking or behavior. As for other self-harm behaviors, she indicates that sometimes she drinks too much when stressed, and that she occasionally smokes marijuana at parties. She states she does not use other drugs and does not consider herself a "risk taker." She also reports that she is not taking any psychotropic medications.

The first session ends with the client expressing relief that she had finally talked to a therapist about her "cutting problem" and a second appointment is scheduled.

### Assessment of Self-Injury

The assessment structure presented here has two parts: the informal response and assessing the details of self-injury.

#### *Part I: The Informal Response*

As the case illustration of Tonya indicates, it is not unusual that self-injurers encounter professionals who respond clumsily to their self-harm behaviors. Favazza has written that the treatment literature on self-injury "is basically one of countertransference" (1998, p. 265). This statement is hopefully somewhat of an exaggeration; nevertheless, there is little doubt that self-injury can produce extreme reactions in caregivers. Many authors (e.g., Simeon & Hollander, 2001; Walsh, 2006) have discussed the negative reactions of treatment professionals to encountering self-injury in clients, such as shock, disgust, recoil, pejorative judgments, anxiety, fear, anger, and confusion. It is hard to imagine that any of these responses have therapeutic utility.

A key recommendation, then, is that caregivers should respond initially to self-injury with a low-key, dispassionate demeanor (Walsh, 2006). Clients who self-injure are emotionally distressed. They certainly do not benefit from being judged, criticized, or otherwise condemned for their behavior. Responding to self-injury with shock or recoil is also not helpful. Self-injurers are likely to question whether they should reveal additional information to someone who appears alarmed or disconcerted. Also ill-advised are effusive expressions of support; such responses may inadvertently reinforce the behavior. Thus, as a rule, the most helpful strategy is to proceed in a dispassionate way, which is neither reinforcing nor punitive.

In *Skin Game: A Cutter's Memoir*, Kettlewell (1999) recommends that psychotherapists respond to self-injury with "respectful curiosity." As indicated in the case vignette,

posing a respectfully curious question such as, “What does self-injury do for you?” can open the door for direct and open communication about the functions of the behavior. Respectful curiosity conveys the message that “I am interested in your self-injury and want to better understand it and you before we proceed.”

Unfortunately, a common response to self-injury is often an attempt to quickly “contract for safety.” Asking individuals to give up self-injury when it is their best emotion-regulation technique can be both unrealistic and invalidating. Clients may view efforts to contract for safety as an implicit form of condemnation. A more effective strategy is to emphasize that the client learn new skills to regulate emotions as opposed to “forbidding” the behavior of self-injury. The teaching of such skills is discussed at length in other articles within this issue of *Journal of Clinical Psychology: In Session*.

### *Part II: Assessing the Details of Self-Injury*

Once the practitioner has set a low-key, nonjudgmental, respectfully curious tone, he or she can launch into a more detailed assessment. Key topics are provided in Table 1 as a guide for clinicians. Also provided in Figure 1 is a self-injury log designed for clients to complete. The content for the two is complementary. Some clients are able to use the log to complete daily (or weekly) information about self-injury. Information from this log can be an immense help in the assessment and treatment process. Other individuals may find using such a log to be too formal, intrusive, or even traumatizing. In the latter circumstances, any effort to assign the self-injury log as “homework” should be postponed or even abandoned.

The major components of a thorough assessment of self-injury are described in the following sections.

#### *History of Self-Injury*

This portion of the assessment looks at the history of self-injury as to age of onset, types (e.g., cutting, burning, hitting, excoriation), duration of the problem, frequency of the behavior, number of wounds per episode, and level of physical damage. In general, the longer the problem has existed, the greater the challenge to alleviate it. In a clinical sample of adolescents, the longer the course of self-injury, the greater the number of methods, and the absence of physical pain, is associated with making suicide attempts (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Related to this finding is the need to assess the individual for other forms of self-harm, especially suicide, as this problem always takes precedence over self-injury.

Note that in the case example, Tonya was assessed several times as to her history of suicidality and she consistently denied such behavior. This is encouraging information as to prognosis; however, her problem of self-injury has also been persistent (7 years duration) and she has used multiple methods (cutting, burning, excoriation), so these details suggest that she should be assessed for suicidality in an ongoing way. She also has presented with some indications of substance abuse, which should be monitored as well.

#### *Details of Recent Self-Injury*

This portion of the assessment moves from the history of self-injury to recent behavior, such as within the last month or two. The functions of the self-injury are especially important to determine as they have considerable implications for treatment. If the primary

Table 1  
*Key Topics for Assessing  
 Self-Injury*

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I. History of Self-Injury
Age at onset
Type(s) of self-injury
Functions
Wounds per episode
Frequency of episodes
Duration per episode
Duration of the problem
Body area(s)
Extent of physical damage
Other forms of self-harm
II. Details of Recent Self-Injury
Type(s) of self-injury
Functions
Number of wounds
Temporal dimensions
Extent of physical damage
Body area(s)
Pattern to wounds
Use of a tool
Physical location
Social context
III. Antecedents
Historical
Environmental
Biological
Cognitive
Affective
Behavioral
IV. Consequences/Aftermath
Environmental
Biological
Cognitive
Affective
Behavioral
V. Other Details

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function of the self-injury is emotion regulation, then treatment will need to target: (a) reducing emotional triggers, and (b) teaching alternative emotion regulation skills. If the primary functions are interpersonal in nature, social skills training or interpersonal work may be in order. Of course, for many individuals, both aspects apply.

For Tonya, the primary functions of the self-injury have been to reduce “feelings of sadness and anger” and to return to a higher level of functioning (in school). These functions sound primarily intrapersonal in nature, but self-injury is often linked to relationship problems with men, so there may be interpersonal motivations as well.

Other very important details regarding self-injury are the number of wounds per episode and the level of physical damage. In general, the greater the number of wounds per episode indicates a higher level of distress. Tonya says that she usually “only cuts 3 or 4 times to get relief, but sometimes it takes as many as 20.” The therapist will want to explore what circumstances result in lower versus higher numbers of cuts.

Name: \_\_\_\_\_ Week \_\_\_\_\_  
 Of: \_\_\_\_\_

Category	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Antecedents (Events in Environment)							
Antecedents (Biological Elements)							
Antecedents (Thoughts, Feelings, Behaviors)							
# Wounds							
Start Time of SIB Episode							
End Time of SIB Episode							
Extent of Physical Damage- (Length, Width; Were Sutures Obtained?) (If Yes, How Many?)							
Body Area(s)							
Pattern to Wounds- (Yes/No-If Yes, Type)							
Use of Tool- (Yes/No-If Yes, Type)							
Room or Place of SIB							
Alone or With Others During SIB							
Aftermath of SIB (Thoughts, Feelings, Behaviors)							
Aftermath of SIB (Biological Elements)							
Aftermath of SIB (Events in Environment)							
Reactions of Others to Your SIB							
Comments							

Figure 1. Self-injury log.

An especially important detail to assess is level of physical damage. Considerable research has indicated that most incidents of self-injury involve only modest tissue damage that do not require medical intervention (Favazza, 1996, 1998; Simeon & Hollander, 2001; Walsh, 2006). It is rare for individuals to hurt themselves in ways that require suturing or other medical response. When such damage occurs, an emergency mental health evaluation is indicated and protective interventions such as hospitalization may be necessary. Note that Tonya’s level of damage has never required medical intervention. This a reassuring detail for the new therapist.

The SASII (Linehan et al., 2006) offers methods for measuring level of medical treatment and physical condition after the self-harm. For someone wanting more objective measures regarding level of physical damage, the SASII provides a useful framework.

I also recommend looking at the wounds of clients—with their permission, and within the bounds of modesty, as this can provide a great deal of objective information about frequency and level of physical damage. Clients may not always be accurate reporters about their self-injury. Thus, the therapist may ask Tonya to show her wounds (on her arms at least) so that he or she can better assess the extent of the self-injury.

Another topic for exploration is body area. Most self-injurers harm the extremities or abdomen (Favazza, 1996; Simeon & Hollander, 2001). Body areas that are rarely harmed and are particularly alarming are face, eyes, breasts in women, and genitals in either sex. Generally, people who injure these body areas are experiencing either psychotic decompensation or some type of trauma-related behavior (Favazza, 1996; Walsh, 2006). In either case, such individuals should receive an emergency mental health assessment, with hospitalization often indicated.

Another detail to consider is that some self-injurers inflict words, symbols, or other patterns on their bodies. Common examples are words like “hate,” “pain,” a partner’s

name, or an inverted crucifix. It is useful to explore why the self-injurer has chosen to impose this specific content on his or her body. I recommend a nonjudgmental, respectfully curious question such as, "Of all the words (or symbols) you could have carved (or burned) into your body, how did you decide on X?"

Time is also an important dimension to explore. It has multiple elements including duration of the episode, time of day, and gaps between episodes. For many self-injurers, the length of a single episode tends to be quite brief, such as a few minutes. Length of episode points to the amount of time it takes to achieve relief. Longer episodes suggest greater levels of distress, and are thereby more concerning. Time of day is also of interest. For example, many self-injurers harm themselves at bedtime to reduce intense emotions and to get to sleep. Identifying high-risk times of day can be used to practice replacement skills and to alter habituated routines. Also useful is to record the time between episodes. Such information can be used to concretely chart progress and to document a pattern of heightened distress and escalation. Some clients take great satisfaction in setting a "personal best" for time without self-injury.

Assessment can also look at whether the individual uses an implement or tool. Generally, employing a tool such as a razor blade, cigarette, or knife indicates more control and precision than more primitive methods such as punching, scratching, or gouging. There are notable exceptions, however, such as when someone randomly stabs diverse sections of the body. Tonya's preferred method is cutting herself, but the exact implements that she uses are not yet known. The therapist would want to acquire this information over time.

The physical location where the self-injury occurs might also be assessed. Such information is useful in identifying situational antecedents. For example, if a client usually self-injures in a locked bedroom, he or she may want to try not locking the door. Altering established habits or rituals is conducive to behavior change. The assessment with Tonya has yet to identify where or when she tends to self-injure.

Social context is an additional detail of import. Does the self-injury occur alone or with others? Most people self-injure alone, but some teens and young adults cut or burn together. Other individuals may be triggered to self-injure after (or even while) participating in a self-injury chat room or message board (Whitlock, Powers, & Eckenrode, 2006). Therefore, identifying these social reinforcers is a critical part of assessment. In Tonya's case, she appears to self-injure alone. She also discloses her self-injury to only a few trusted friends. Tonya is not one for exhibitionistic behavior, it would appear.

### *Antecedents*

Once the details of the self-injury itself have been assessed, the process moves on to determining the environmental, biological, and psychological antecedents to the behavior. These "triggers" are important in that they can be used to predict future self-injury and become opportunities to practice replacement skills. For example, as with Tonya, if self-injury typically follows a disagreement with a partner, these incidents can be identified as high-risk periods. Such incidents can then be targeted as opportunities to practice replacement skills as opposed to proceeding to the usual self-injurious outcomes.

For many individuals, environmental antecedents include such problems as relationship conflicts or break-ups, or disappointments related to performance at work or school. For other individuals, the precipitants can be daily life experiences that trigger traumatic memories or flashbacks. Linehan and colleagues (2006) provide an extensive list of possible environmental antecedents in their SASII.



Biological elements that influence self-injury vary greatly, including fatigue, insomnia, illness, and intoxication. Use of chemicals such as alcohol and marijuana may play a role in Tonya's self-injury.

There are also the complex biochemical aspects that are being researched in relation to self-injury such as limbic system dysfunction, depleted serotonin levels, problems with the endogenous opioid system, and diminished pain sensitivity (see Simeon & Hollander, 2001).

The psychological assessment of self-injury also looks at the cognitive, affective, and behavioral antecedents: automatic thoughts, intermediate, and core beliefs that may precede self-injury. A common cognition that supports self-injury is that "it works better than anything else" (Walsh, 2006). For many individuals, the detailed assessment of thoughts can elucidate how habituated the process leading to self-injury has become. Stepping back from these automatic thoughts and reexamining their accuracy is a key part of assessment and treatment. For example, a therapist might say, "Yes, self-injury is one way to reduce emotional distress, but what else works well for you?"

As for the affective antecedents, the internal, emotion regulation functions of self-injury have already been referenced repeatedly in this article. Assessment identifies (a) which emotions are managed by self-injury, (b) how the antecedents to these emotions might be reduced as to frequency and intensity, and (c) how these emotions might be managed more effectively using replacement skills.

For Tonya, the primary emotional antecedents to self-injury are said to be sadness and anger. Assessment should start with a careful behavioral analysis of these two emotions, but should also move on to other affective states, so that a thorough map of her distress is obtained.

Behavioral antecedents refer to the actions that lead to self-injurious behavior. These include habits, practices, and even rituals that precede self-harm. Such behavior patterns can become so habituated that it is difficult to interrupt them once the chain is under way. A better strategy may be to identify the earliest links in the chain and redirect to skills practice immediately. For example, subsequent assessment might discover that Tonya uses the same razor over and over again, that she stores it in her dresser drawer, and only uses it behind a locked bedroom door. All of these details could be targeted for intervention. As she experiences a strong urge to retreat to her bedroom to self-injure, she could be encouraged to avoid her bedroom and instead, to practice such skills such relaxing breathing or visualizations.

### *Consequences and Aftermath*

The counterpart to examining the precipitants to self-injury is evaluating the consequences. The subcategories for this dimension are again the environmental, biological, and psychological aspects. The environmental piece involves assessing who becomes aware of the individual's self-injury after the fact. Is the self-injury private or public? Does social reinforcement play a role or is it absent? If the self-injury is reinforced by others, is it intentional or inadvertent? If significant others are reinforcing the behavior, are they amenable to changing their responses? For Tonya, the answers to these questions are not yet known.

The biological aftermath involves how the individual feels physically after the self-harm. Did he or she experience physical pain at the time of the act? What about immediately afterwards? Does it hurt now? Moreover, an odd but important question may be, does the pain feel good or bad? Such questions have not yet been posed to Tonya.

Another biological dimension is whether the self-injurer provides physical aftercare. Does he or she clean the wounds and take care to prevent infection? Is the wound picked at or excoriated? Tonya has indicated that this can be true for her. The psychotherapist will want to assess when and why she excoriates. A critical question that transitions to treatment: Is the client willing to use medicated tape or bandages to cover the wounds and enhance healing?

The cognitive piece looks at the state of mind of self-injurers following the act. Are they remorseful, neutral, or enthusiastic about the self-harm? Those who have little motivation to stop pose a very different clinical challenge than those who are dismayed and urgently want to put an end to the self-harm. Tonya appears motivated to move on from self-injury. She expresses concern that her level of functioning is not where she wants it to be and that she is relieved to finally be seeking professional help.

The assessment also looks at what sort of emotional relief is obtained via the self-injury. Treatment can target skills that will closely match the forms of relief obtained. For example, if a client typically feels invigorated and "hyper" after self-injuring, teaching self-soothing skills as a replacement would be misguided, perhaps irrelevant.

Lastly, behavioral elements at the conclusion of the self-injury sequence need to be assessed for their role in fostering recurrence. For example, does the self-injurer clean and return his or her tool to a hidden spot, to be ready for another day? Does he or she take care to clean up blood so as to be undiscovered? Or is evidence left in open view, all but guaranteeing discovery by others. These aftermath behaviors can also be targeted for change.

### *Other Details*

Another important topic to assess in self-injury is body image (e.g., Muehlenkamp, Swanson, & Brausch, 2005; Walsh, 2006). Some self-injuring individuals may report intense negative thoughts and feelings about their bodies. This bodily hatred can serve to support and facilitate the assaults on the body that are self-injury. Profound body alienation can be associated with childhood experiences of physical and/or sexual abuse, or sustained childhood physical illness (Favazza, 1996, 1998; Walsh, 1988). A thorough assessment of self-injury needs to evaluate whether such aversive experiences have been part of a client's history.

Body image can be assessed using standardized instruments such as Orbach's Body Investment Scale (BIS) cited in Muehlenkamp et al. (2005) and the Body Attitude Scale (BAS) (Walsh, 2006). The challenge of working with body-alienated self-injurers, who are survivors of childhood abuse and/or illness, is often far greater than those without such traumatic histories. The first interview with Tonya gives no indication of trauma or serious body alienation, but it is much too early in the treatment to rule either out.

### Clinical Issues and Summary

In this article, I have provided a clinical structure for assessing self-injury. Of course, any assessment is based on a strong therapeutic relationship. I encourage therapists to employ a low-key, dispassionate demeanor and respectful curiosity to gain the client's trust, establish a spirit of collaboration, and to proceed strategically. With a positive relationship as its foundation, assessment should focus on the history of self-injury, its current manifestations, and especially its functions. The heart of a good assessment is "in the details." Here I have reviewed a myriad of specific characteristics that are often related to the onset, maintenance, and (hopefully) the eventual cessation of self-injurious behavior.

Figure 1 provides a self-injury log to assist clients in participating in the assessment process.

The case of Tonya demonstrates the components of assessment. Tonya is representative of individuals who have an ongoing pattern of self-injury that persists for years. On the positive side, her behavior appears never to have posed risk to life. Instead, she makes clear in the first interview that the primary function of self-injury is to regulate emotions, primarily sadness and anger. Although her behavior appears to have been low lethality self-injury, she nonetheless should be assessed for suicide in an ongoing way, due to the duration of her problem and use of multiple methods. She also should be assessed for body image dysfunction and history of trauma and childhood illness, as these important topics have yet to be addressed. Overall, the prognosis for this client should be considered good as she emphatically denies suicidal intent, her level of physical damage has been modest, and her motivation to work in psychotherapy appears high.

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