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Effective Interventions for Treating Superficial Self Mutilators

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EFFECTIVE INTERVENTIONS

FOR TREATING SUPERFICIAL SELF MUTILATORS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Bachleor of Arts in Social Work.

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Effective Intervention
For Treating Adolescent
Superficial Self-Cutting

Abstract

Self-cutting is the most common form of self-mutilation in adolescents but there is insufficient knowledge as to which treatment methods to reduce self-mutilation are most effective. This exploration into the causes of self-cutting and the treatment interventions, such as Dialectical Behavior Therapy (DBT), compares adolescents who had DBT treatment with those who have used other treatment methods. Research findings indicate that the average age of adolescents in treatment was 15 years old and had been in treatment at least one time prior. Adolescents in DBT treatment showed signs in reducing/stopping self-cutting behavior along with improving communication skills with caregivers. Implications of this study show the need for further research to help educate professionals about the effective treatment for treating adolescent self-cutters.

I. Effective Interventions for Treating Superficial Self Mutilators

A) Self-mutilation is "a direct, socially unacceptable behavior that causes physical injury where the individual is not attempting suicide but is in a psychologically disturbed state"
    1) What is self-mutilation?
        a) Definition
        b) Harm
    2) Self-mutilation can be divided into three categories
        1) Major
        2) Stereotypic
        3) Superficial self-mutilators
            a) Self-cutting
B) Through further theory development, research and clinical practice a better understanding can be gained of the reasons individuals self-cut and more effective ways to begin work toward recovery can be develop
    1) Number of cases social workers has regarding self-mutilation
    2) Risks with clients
    3) Education of worker on topic

II. Main Points

A) Self-cutting is the most common form of self-mutilation
B) Reasons for cutting
    1) To escape from emotional pain
    2) To release tension
    3) To gain control of overwhelming emotions
    4) To physically express pain
C) Reported body parts generally cut and objects used
    1) Arms, hands, thighs, legs, abdomen, breasts, vagina
    2) Kitchen knives, razors, broken glass
D) Underlying Problems
    1) Difference in males and females
E) Effective Intervention
    1) Dialectical Behavior Therapy
    2) Manual-Assisted Cognitive Behavior Therapy
F) Legal and Ethical Considerations
    1) Reporting
    2) Self-mutilators rights
    3) Confidentiality

III. Opposing Points

A) What is self-mutilation?
    1) Definitions
B) Reasons for self-cutting
    1) Manipulate others
    2) Suicidal
    3) Dangerous and harmful
    4) Attention
C) Interventions
    1) Dialectical Behavior Therapy
    2) Manual-Assisted Cognitive Behavior Therapy
D) Legal and Ethical Considerations
    1) Reporting
    2) Duty to warn and protect
    3) Consequences of disclosure
    4) Parents legal right's to access information

IV. Hypothesis

This is the research question generated from the analysis of the main and opposing points. It addresses the "so therefore what does this mean"…issue and is a natural question flowing from Parts II and III.

V. Methodology

A) Sample: type/how selected/number
B) Data gathering: method/tools/variabes
C) Data analysis: application of statistical procedures to derive meaning from the data gathering tool
D) Findings: results of statistical procedures

VI. Conclusion

A) A restatement of what the problem is, what you hypothesize, what you found, and a concluding statement
B) Implications for social work practice, research and policy

Preface

This investigatory paper has been prepared to assist therapists in the determination of level of effectiveness in reducing the level of self-mutilation among self-cutting adolescents through the use of the Dialectical Behavior Therapy (DBT). Adolescents who have undergone DBT therapy will then be looked at to determine its success. It is hoped that DBT will bring about results of great success in regards to decreasing the rate of engaging in self-cutting by adolescents.

Introduction

Self-mutilation can be defined "as a direct, socially unacceptable behavior that causes physical injury where the individual is not attempting suicide but is in a psychologically disturbed state" (Suyemoto, 1995, p.162). This thesis looks closely into dynamics of self-cutting, the interventions offered to self cutters as part of their treatment plan, and identifies the most effective interventions.

Self-mutilation can be divided into three categories: major, stereotypic, and superficial self-mutilation (Lukomski, 2004). Self-cutting is classified as superficial self-mutilation. 63% of individuals who cut themselves experience multiple episodes making self-cutting the most common form of self-mutilation (Lukomski, 2004).

The most frequently reported reasons for cutting include: a) to escape from emotional pain, b) to release tension, c) to gain control of overwhelming emotions, and d) to physically express pain (Lukomski, 2004). The arms and hands are the most frequently cut body parts followed by cutting on the thighs, legs, abdomen, breasts, and vagina with objects such as kitchen knives, razors and broken glass (Himber, 1994).

Research has looked at different intervention methods in an attempt to find the most effective strategies to reduce cutting behaviors yet there has been very little agreement as to which ones seem to be most effective. Several unsuccessful interventions have been found including physical restraint, hypnosis, chemotherapy, "no-cutting" contracts, faith healing, group psychotherapy, relaxation therapy, electroconvulsive therapy, family therapy, and educational therapy (Lukomski, 2004). The most effective intervention to reduce symptoms includes a combination of medication, to help with depression, anxiety and "racing thoughts", along with behavioral therapy. Two effective therapies are Dialectical Behavior Therapy (DBT) and Manual-Assisted Cognitive Behavior Therapy (MACT) (Lukomski, 2004).

The DBT model incorporates skill training in a variety of areas such as mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. The DBT model also utilizes the combination of psychodynamic principles with cognitive behavioral approaches and eastern meditation philosophy (Lumoski, 2004). The Manual-Assisted Cognitive Behavior Therapy is based on DBT techniques. A manual is given to self-mutilators to use at home to decrease the number of incidents of self-mutilation behaviors and to reduce anxiety symptoms (Lumoski, 2004).

It is important for social workers to understand self-mutilators and which interventions work best for a variety of reasons. For every 100,000 individuals seven hundred engage in self-mutilation therefore the chances of a worker having a client who self-mutilates is high. Fifty three percent of a social worker's teen case load includes some form of self-destructive behavior, with 14 to 16 year olds comprising the largest group (Foreschle, 2004). While treating self-mutilators, social workers must be fully

aware of laws and the code of ethics, to determine when "confidentiality must be breached to insure the individual's safety as well as implement strategies to assist self-mutilators" (Foresche, 2004).

Finally, working with an individual who cuts may be disturbing and frustrating to a social worker who does not understand the dynamics of cutting and interventions that best help to reduce or stop the cutting episodes (White, 2004). "Education can serve as a means of preventing the stigma associated with self-injury. Educating staff on the dynamics and purposes of self-cut can help them understand that clients who self-cut are not "crazy"" (White, 2004). Individuals who self-cut often have underlying mental health issues and/or have experienced a trauma that they have not dealt with.

Therefore through further theory development, research, and clinical practice, a better understanding can be gained of the reasons individuals self-cut and more effective ways to begin work towards recovery can be develop (Himber, 1994, 628).

Reasons for self-cutting

There are a variety of behaviors and emotions that lead adolescents to self-cut. Self-cutters see the cutting as a way to release stress, "depression, rejection, hyperactivity, numbness" (Foreschle, 2004, p.2). Life events such as a breakup with significant other or an argument with ones parents may lead to feelings of alienation wit is a common causation of self-cutting (Foreschle, 2004). Adolescents may also turn to self-cutting as a way to deal with peer pressure, conflicts at school, the loss of a parent, sexual abuse, the self-mutilation of another family member, or having observed family violence. Also, "feelings of shame, humiliation, and rage may preempt self-injurious behaviors in these individuals" (Foreschle, 2004, p.2).

Adolescents who have not developed positive ways to cope with intense emotions use self-cutting as a way to escape from their emotions. Self-cutters have described the experience as "an increasing feeling of tension which immediately diminishes after the act of self-cutting" (Lukomski, 2004, p. 92). During a cutting episode the adolescent experiences a feeling of emotional release where the sight of the blood flow is central to the experience (Lukomski, 2004). Cutting is an out of body experience in which the person bypasses the body's defenses and desires pain along with the need to regain control by injuring the body (Foreschle, 2004).

Gender Differences

There is a vast range of underlying problems and risk factors that can lead to an adolescent becoming a self-cutter. The majority of those who self-cut do not begin until after puberty commonly around age 16, though there is a difference between genders (Skegg, 2005). The average age for a female to begin self-cutting is between fifteen and thirty-fieve years old (Suyemoto, 1995). Self-cutting is more common among females than males. Females tend to self-cut more privately to overcome issues associated with the onset of menstruation and previous sexual abuse (Foreschle, 2004). Young females have reported carving the initials of a male into their body as a way to show separation from their families (Foreschle, 2004). Depressed mood and eating disorders are also factors that place females at a higher risk to self-cut.

The average age for males to begin self-cutting is 25-34 years old (Skegg, 2005). Young males have been reported to self-cut "as a passage into manhood and as an attempt to establish self and cultural acceptance" (Foreschle, 2004). Males who self-cut

are at a greater risk for committing suicide (Skegg, 2005) and often have a difficult time developing any form of emotional relationships with women (Froeschle, 2004).

Risk Factors

Men and women who consider themselves to be gay, lesbian, or bisexual orientation are more likely to self-cut than adolescents who consider themselves heterosexual. The risk of self-cutting tends to be greater among homosexual men than homosexual women. Men with bisexual orientation and who have had minor same-sex attraction are also at high risk for self-cutting.

Other risk factors such as marital and socioeconomic status can lead to self-cutting. The risk of self-cutting is 11 times higher for individuals who are separated or divorced when compared to those who are married or single (Skegg, 2005). Adolescents are at greater risk of self-cutting if associated with a low socioeconomic status, low level of education and income, or are living in poverty (Skegg, 2005). Self-cutting admission rates are higher among individuals from areas of socioeconomic deprivation and childhood socioeconomic disadvantages. These factors may predict self-cutting independent of later mental-health problems and stressful life events. (Skegg, 2005).

Childhood experiences and certain family characteristics have also been known to lead to self-cutting in adolescence and early adulthood. Adolescents, who grew up in homes where there was martial discord, are at greater risk to self-cut. Adolescents who come from homes where mothers are poorly educated, victims of domestic violence, and/or are very young are also at risk. Affective disorders, substance abuse and mood disorders may be inherited and lead to a dysfunctional home thus increasing the risk of adolescents becoming self-cutters in the future (Skegg, 2005). “Maladaptive parenting

and childhood maltreatment may increase the risk of self-cutting because these factors lead to severe interpersonal difficulties in adolescence, resulting in difficulty in developing the social skills needed for healthy relationships" (Skegg, 2005, p.1475).

Adverse childhood emotional, physical, and sexual abuse greatly increases the likelihood of adolescents becoming self-cutters in later life. Sexual abuse in childhood is one of the greatest risk factors leading to self-cutting. This may be due to the fact that it increases vulnerability to adolescent mental disorders and to life events (Skegg, 2005). Adolescents who were victims of abuse during their childhood see cutting as a way to express the trauma that is often unspoken referred to as "trauma re-enactment syndrome" (Skegg, 2005, p. 1476).

Neurobiological and genetic abnormalities are associated with adolescents who self-cut and have underlying psychiatric and psychological disturbances (Skegg, 2005). A low concentration of the serotonin metabolite 5-HIAA, has been found in the cerebrospinal fluid of individuals who self-cut. Determining if an adolescent has a low concentration of 5-HIAA can help to predict an individual's risk for self-cutting (Skegg, 2005).

There are several disorders associated with self-cutting such as psychiatric disorders, anxiety disorders, eating disorders, post-traumatic stress disorder, borderline personality disorder, and cluster B personality disorder. Personality disorders are commonly seen in self-cutters, along with depression and substance abuse (Skegg, 2005). When the co-existing disorder is treated along with treatment for self-cutting, the risk to continue the self-cutting decreases.

Effective Interventions

Treatments for self-cutting aim to reduce symptoms which cause an adolescent to self-cut. "The interventions that have been found to be the most effective in symptom reduction generally involve a combination of behavioral therapies and medication" (Lukomski, 2004, p. 4). Adolescents who self-cut are often given medications to treat parallel symptoms of depression, anxiety, and "racing thoughts" (Lukomski, 2004, p. 4). Dialectical Behavior Therapy (DBT) and Manual-Assisted Cognitive Behavior Therapy (MACT) are two of the most successful behavior therapies for working with adolescents who self-cut (Lukomski, 2004, p. 4).

"Treatment strategies in DBT are based on a dialectical philosophy that views reality as an interrelated system, with opposing internal forces and in a state of continuous change" (Miller, 2002, p. 571-572). The main idea of DBT is to accept the adolescents with their flaws while working on changes they need to make such as patients and self-acceptance.

The DBT therapist conducts a behavioral analysis of an "adolescent's self-injurious behavior. There is often some link in the chain that is related to family relationships or attitudes/beliefs within the family" (Miller, 2002, p. 577). The reason for this connection is due to the fact the adolescents often live with, depend on, and are strongly influenced by their families (Miller, 2002). Therefore, the DBT therapists work with adolescents and families to begin to recognize and understand situations from multiple points of view. This helps the adolescents and families to recognize the others understanding and allows them to synthesize their opposing positions (Miller, 2002).

Before DBT therapists begin to establish healthy coping skills with adolescents and families, they need to work through the six levels of validation. Level one is when

the therapist listens to each family members experience without any attempt to change the experience. During level two the therapist reflects on the family's thoughts, feelings, and assumptions. Level three requires the therapist to help the adolescent who self-cuts to communicate their unspoken thoughts and feelings. During level four a better understanding of the events and reasons which cause the adolescent to self-cut is gained by the adolescent and their family. Level five confirms thoughts, feelings and behaviors based on the current context of the adolescent and their family. Finally, during level six called radical genuineness; the therapist removes their self from the therapist role and speaks with the family authentically about the adolescents experience and their experience as a family (Miller, 2002). DBT treatment is successful in working with adolescents who self-cut because it helps them develop skills in areas such as mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance (Lukomski, 2004).

The second treatment type that professionals use when working with adolescents who self-cut is Manual-Assisted Cognitive Behavior Therapy (MACT). MACT techniques are based on those of DBT. Adolescents are given manuals to help develop their coping skills which they work on at home (Lukomski, 2004). MACT therapists believe that what is learned goes beyond a specific solution to a particular problem, and instead involves cognitive and behavioral methods that individuals can use for dealing with types of difficult situations in their lives (Goldfried, 1995). MACT allows the therapist to be seen as more of a teacher or consultant who collaborates with the self-cutting adolescent to increases client functioning (Goldfried, 1995).

Manual-Assisted Cognitive Behavior Therapy teaches relaxation training which involves tensing separate muscle groups for 5-7 seconds. Adolescents are to take notice of the muscles that are tense. They then relax the muscles for 20-30 seconds and focusing on the sensations that one feels when the muscles are relaxed. The relaxation training teaches adolescents to recognize when they feel tension and allows them to work through these thoughts and feelings so as to relax, instead of coping with the tension through as cutting (Goldfried, 1995). MACT has been found to decrease the number of incidents of self-cutting and reduce anxiety symptoms in adolescents (Lukomski, 2004).

Legal and Ethical considerations

Legal and ethical considerations need to be considered when working with adolescents who self-cut. The major concern facing professionals is the idea of confidentiality and when it is that it should be breached. Professionals "must often weigh their legal responsibilities with ethical decisions when dealing with self-mutilators" (Foreschle, 2004, p. 4).

Adolescents who self-cut reported having a comfort in knowing that the conversions and interactions they have with the professional are private and confidential. If the professional were to breach the confidentiality the adolescent may become further alienated due to feeling that they have been betrayed by the professional thus causing more harm to the adolescent. Adolescents who self-cut are more willing to self-disclose once they are aware that what they say to the professional is confidential (Foreschle, 2004). The ethical dilemma tends to be when a professional must decided the difference between "cases of normal identity and those constituting inappropriate behaviors" (Froeschle, 2004. p. 13). Therefore the professional working with the adolescent who

self-cuts often is left with the ethical concern of deciding the client's intent before they are able to develop a plan of action (Froeschle, 2004).

A Bill of Rights for people who self-cut has been established as an attempt to provide better information to medical and mental-health professionals. "The goal of the Bill of Rights is to enable them to more clearly understand the emotions that underlie self-injury and to respond to self-injurious behavior in a way that protects the patient as well as the practitioner" (Martinson, 2001). The Bill of Rights includes ten points: 1) The right to caring, humane medical treatment, 2) The right to participate fully in decisions about emergency psychiatric treatment (so long as no one's life is in immediate danger), 3) The right to body privacy, 4) The right to have the feelings behind the self-injury validated, 5) The right to disclose to whom they choose only what they choose, 6) The right to choose what coping mechanisms they will use, 7) The right to have care providers who do not allow their feelings about self-injury to distort therapy, 8) The right to have the role self-injurer has played as a coping mechanism validated, 9) The right not to be automatically considered a dangerous person simply because of self-inflicted injury, and 10) The right to have self-injury regarded as an attempt to communicate, not manipulate (Martinson, 2001). Professionals who are aware of The Bill of Rights of Self-Cutters can advocated for their clients to ensure they receive the proper services. Having knowledge of the bill of rights can help professionals educate clients as to what to their rights are.

Reasons for self-cutting

Society's view of self-harm has shifted over time to conform to what the norms of society are. Piercings and tattoos, which are today accepted by society, were once

considered forms of self-mutilation (Froeschle, 2004). Though some may be disturbed by piercings of various parts of the face and body, it is no longer considered self-mutilation but simply an adolescent trend (Frosechle, 2004). "In a society full of accepted mutilations, a distinction between accepted body adornments and psychotic mutilations can become blurred (Froeschle, 2004, p.13).

There is often a misunderstanding among professional as to why adolescents self-cut (Froeschle, 2004). Some believe that those who self-cut use it as a way to manipulate other people. In fact those who self-cut tend to hide their injuries and try to present themselves as normal and rarely use it as a form of manipulation. Some believe that self-cutting is a sign of suicide and that those who cut are suicidal. Adolescents who self-cut do so to cope with some form of emotional pain they do not intended to commit suicide. People who do not self-cut tend to view self-cutters as being deviant and dangerous to others as well as themselves. Those who self-cut do it in secret or isolation and do not aim violence at others. A common misconception is that self-cutters are looking for attention. The reality is that those who self-cut are "often humiliated about their scars" and try to keep others from seeing them. (Froeschle, 2004).

Interventions

One way for professionals to approach treatment with adolescents who cut is through Gestalt therapy. Gestalt psychology is concerned with the nature and structure of the perceptual experience (Latner, 1992). Gestalt therapy's central concepts are awareness and finding meaning in the present moment. For the Gestalt therapist, awareness is "an interplay in which both the individual and the environment participate. Each is both active and passive in turn" (Latner, 2002, 84). The present-centered

approach focuses on the significant strains of the philosophical, spiritual, political, scientific and psychological thought (Latner, 1992).

One reason Gestalt therapy may work so well with self-cutters is that studies have shown a strong correlation between individuals who self-cut and those who have experienced childhood sexual abuse (Paul, 2002). The Gestalt present-centered approach is just as interested in "the experience and awareness of remembering as it is in what is remembered" (Latner, 1992).This approach shows that focusing and questioning the events of the past the present moment is unable to be embraced (Latner, 1992).

Another approach a professional can consider when working with adolescents who are self-cutters is Humanistic Therapy. Humanistic Therapy is when you create a climate where the adolescent feels safe and is given praise. (Charnofsky, 2001). The therapy's main focus is on the relationship that is built. There are no techniques used, no manipulation or advice-giving, and no behavior-modifying by choice (Charnofsky, 2001). With this approach the adolescent's freedom of choice is maximized and his or her human potential is validated.

The Humanistic Therapy approach has an operational guide for professionals to follow when working with adolescents. First, the Humanistic therapist must be present and in the moment at all times. They must also be energetic with each adolescent. Second, the therapist must be honest and able to confront the adolescent in a non-threatening manner. The therapist must also encourage responsibility instead of lecturing the adolescent. Third, they must provide a stimulation environment with the use of "a barren external environment to allow a patient to do deep within, to encourage transference uncontaminated by extraneous stimuli (Charnofsky, 2007, p.306). Fourth,

the therapist looks for adolescent code-words. Fifth, they provide a safe environment for the adolescent. To help do this they have the adolescent imagine a familiar safe place while in the room. This helps the adolescent to relax and provides a climate for deeper and safer exploration. Sixth, therapist needs to respect the adolescent's developmental base. Even though Humanistic therapy focuses on the present moment, the adolescent's developmental history needs to be considered because it will help explain the present moment which the adolescent is living in. Seventh, the therapist must respect that affective discharge precedes cognitive restructuring. Humanistic therapists believe "that our thoughts are scrambled because of the affective dissonance, and we can only think straight after blocking emotions are discharged" (Charnofsky, 2007, p.308). Eighth, the therapist must be willing to be vulnerable. Humanistic therapists feel that for the therapy to work both the worker and the adolescent need to be open, self-disclosing and vulnerable. Once this is established the growth and the work begins. Finally, the therapist needs to recognize that all choice is for self-enhancement. "Humanistic therapists honor all of adolescent behavior as chosen, and in fact chosen for perceived, solid personal reasons" (Charnofsky, 2007, p.309).

Legal and ethical dilemmas

During work with a self- cutting adolescent, professionals may be faced with an ethical issue or dilemma regardless of what treatment approach is used. While professionals have a responsibility to the adolescent as their client to keep information between them confidential, they also have a duty to warn and protect others in society from harmful behavior. Therefore it is unclear if a professional is then required to disclose to a parent of a minor who is self-cutting. The problem lies in who the client is

believed to be. Ethically some believe that the adolescent is the client while legally the parent is the client (Froeschle, 2004). "Although parents may have the legal right to know what is going on, it is an ethical responsibility to get the adolescent's permission before sharing anything. The adolescent should be included in as much of the decision making as possible" (Froeschle, 2004, p. 17). The challenge for the professional is to help the adolescent see the importance in sharing information with the parents to develop a therapeutic alliance (Froeschle, 2004). If this alliance can be formed the adolescent will greatly benefit from the treatment.

Hypothesis

Dialectical Behavior Therapy (DBT) and Manual-Assisted Cognitive Behavior Therapy (MACT) are two of the most successful behavior therapies in working with adolescents who self-cut. DBT recognizes the link between adolescents and family relationships. DBT focuses work on both the adolescent and the family to help them recognize the situation from multiple points of view. MCAT focuses on teaching the adolescent relaxation training and the therapist is seen more as a teacher rather than a therapist. Humanistic Therapy is another approach to working with self-cutter where the focus is placed on the relationship that is built. Adolescent who self-cut and have experienced sexual abuse may benefit from Gestalt Therapy to help them begin embracing the present moment.

Therefore it is important to further explore Dialectical Behavior Therapy and the success of adolescents who undergo this treatment for self-cutting. The hypothesis of this thesis is that there will be a greater success rate for adolescents who engage in self-cutting after undergoing Dialectical Behavior Therapy than other treatments.

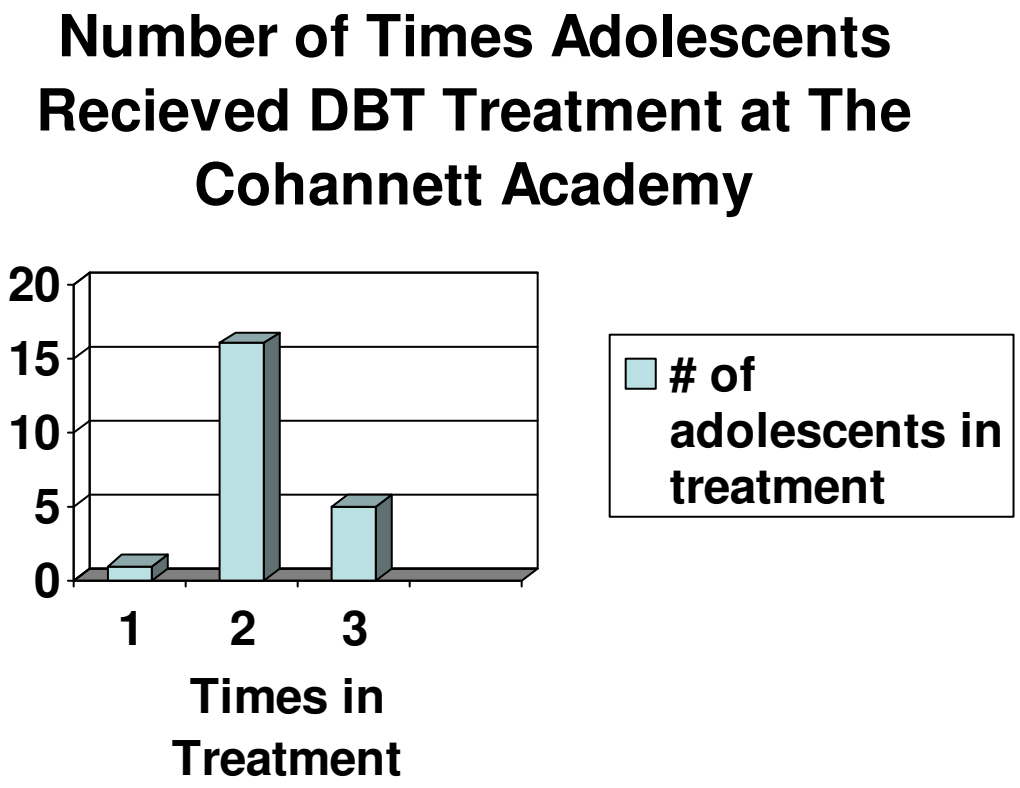
Methodology

Originally the researcher planned to look at 100 adolescent who where in treatment for self-cutting and analyze the effectiveness of the treatment programs. Due to challenges the researcher faced with gaining access to this population a different research method was developed. The researcher posted three blogs on three different internet sites. The blog posting stated that the researcher was looking for feedback from adolescent self-cutters about their experiences with interventions and professionals they have worked with. Only one response was received by the researchers. The response received did not answer the question asked and was from a woman now 34 who self-cut during her adolescence and has recently began cutting again. The responder stated that she has had both positive and negative experience when dealing with professionals due to her self-cutting. The professionals she encountered were primarily doctors in hospitals. The researcher than had to develop another method for conducting research. The focus of the research began to focus on Social Workers who work directly with adolescent self cutters and provide interventions. The researcher began calling hospitals throughout the state of Rhode Island and conduction preliminary interviews over the phone with Social Workers. These interviews allowed the researcher to find Social Workers who worked with adolescent self-cutters and allowed the researcher to gain reference points from Social Workers to other Social Workers.

Preliminary interviews lead the researcher to the DBT treatment program at the Cohannett Academy located at the Taunton State Hospital in Massachusetts. Here the researcher was able to speak with the director of the program and four clinicians who

work with the adolescents in the program. Interviews were than conducted with the director and clinicians.

The DBT treatment program at the Cohannett Academy has been helping adolescents for approximately a year. The range of experience of the four clinicians was two years to ten years. The average age of the twenty-two adolescents that were in the program at the time of the interview was 15 years old. For the majority of the adolescents in this treatment program this was not there first time in treatment. Of the twenty-two adolescents sixteen had already been in treatment at least once. For five of the sixteen this treatment program was their third time in treatment.



When the director was interviewed about the effectiveness of the DBT program she stated that the program has shown signs of decreasing self-cutting behavior for those adolescents in the program. The effectiveness of this treatment program is measured by frequency and severity of cutting and the circumstances before and after the episode (whether the adolescent disclosed the self-cutting and the time frame in which the disclosure occurred).

The director along with one other clinician felt that the DBT program was most effective with the Mental Retarded adolescent self-cutters. They felt this was due to the fact that these patients could be easily redirected and trained as to what to do when they feel the onset for the need to cut.

Two clinicians stated that the majority of adolescent in the treatment program have developed alternative coping skills such as verbally expressing their emotions. One clinician stated that DBT treatment program was still in the beginning stages and he felt it would be difficult to say whether or not the treatment could be called a success. The director along with all four clinicians agreed that the program has helped the adolescent begin to communicate with their caregivers whether it is a parent or not.

Conclusion

Adolescents self-cut as a way to release stress, cope with life events and escape their emotions. Cutting is an out of body experience in which the person bypasses the body's defenses and desires pain along with the need to regain control by injuring the body. Self-cutting is most commonly seen in females and begins after puberty around the age of 16. Factors such as depressed mood or an eating disorder can place a adolescent female at a higher risk for self-cutting. The most significant factor found leading to self

cutting in sexual abuse in childhood. The two most common forms of treatments are Dialectical Behavior Therapy and Manual-Assisted Cognitive Behavior Therapy. This thesis hypothesized that Dialectal Behavior Therapy (DBT) would prove to be most effective when working with adolescent self-cutters. The research conducted showed that DBT was showing signs of effectiveness at the Taunton State Hospital in Massachusetts. Further research would have to been conducted on other DBT programs along with research into other treatment programs to show that DBT is the most effective. Due to limited access to the population in question the researcher was not able to do this. The topic needs to be further explored with more in-depth research.

The conclusion of the thesis shows that adolescent self-cutting is often seen by Social Workers. There is a great deal of literature explaining the issue and the reasons why an adolescent may engage in self-cutting. Yet there has been very little research as to the best way to treat these patients. There has been research conducted on DBT programs for women who self-cut but the focus of these programs is reducing the suicidal tendency of these women not the self-cutting behavior. Many programs the researcher contacted stated they were in the beginning stages of research or were planning to in the near future. The greatest challenge was finding a program that worked primarily with adolescent self-cutters. Many programs have self-cutters in their programs but they often focus on the underlying issues such as sexual abuse not the issue of self-cutting.

Further research will help to educate professionals about the effectiveness of treatments and what treatments work best for adolescents. Further research on treatment programs will be the first step to implementing policies to help these individuals such as issues with paying for treatment (insurance companies want proof a treatment works in

order to pay). Also self-cutters are often stereotyped when receiving medical care. If there was more research to guide professionals with a better understanding of treatment referrals can be made in places such as the Emergency Room and self-cutters could receive better services, sooner. Also if research can show the treatment programs do have effectiveness with adolescent self-cutters more programs can be created to help more individuals.

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