GAVIN PUBLISHERS

Journal Psychiatry and Cognitive Behaviour

Johnson R. J Psychiatry CognBehav 1: JPCB-102.

DOI: 10.29011/2574-7762.000002

Review Article

Training Psychologists Risk Assessment and Theory-driven Paradigmsfor Culturally Diverse Non-Suicidal Self-Injury Forensic Patients: DSM-5 Implications

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Citation: Johnson R (2016) Training Psychologists Risk Assessment and Theory-driven Paradigmsfor Culturally Diverse Non-Suicidal Self-Injury Forensic Patients: DSM-5 Implications. J Psychiatry CognBehav 1: 102. DOI: 10.29011/2574-7762.000002

Received Date: 7 December, 2016; **Accepted Date:** 27 December, 2016; **Published Date:** 3 January 2017.

Abstract

Non-suicidal Self-Injury (NSSI) has risen as a behavioral concern in recent years. To date, however, the focus has primarily been directed at epidemiological issues. This paper aims to bridge this gap in understanding, through addressing definitions, rates, and functions of self-injury before advancing a discussion on ethically-informed strategies for working with diverse NSSI forensic clients. The article includes ethnoracial and cross-cultural factors, risk assessment, psychology training and supervision, use of the DSM-5, CoginitiveBehaviorTherapy, and Positive Psychology.

Keywords: Counseling Theory; DSM-5; NSSI; Risk Assessment

Training Psychologists Risk Assessment and Theory-driven Paradigms for Working with Diverse NSSI Forensic Clients: DSM-5 Implications. Significant evidence suggests Non-Suicidal Self-Injury (NSSI) is a worldwide behavior. NSSI is defined as self-inflicted damage to one's own body tissue performed in the absence of suicidal intent [1].This behavior is an enduring and perhaps irreversible psychological condition. Arguably, the impairment and mental health needs for these NSSI individuals are greater than those of other patients, and because of this, achieving high quality, culturally responsive care is filled with complexities. Culturally responsive assessment, diagnosis, and treatment of diverse NSSI clients requires conditional decision-making. The underlying psychopathology must be identified through a recognized diagnostic framework like the DSM-5 before attempting to define appropriate actions via traditional psychological treatment theories taught in graduate school. Complicating the assessment, diagnostic, and treatment process even more is the personal meaning of the patient's NSSI often best understood from a biopsychosociocultural perspective [2].

A forensic risk assessment helps decipher the level or rating assigned a patient based on a psychologist's assessment of concern. Crisis and violence intervention are wisely folded under the umbrella of forensic risk assessment No substantial attempts have been made to collectively examine NSSI issues (e.g., risk assessment, psychological treatment theory, and ethnoracial factors). Given the complex nature of NSSI cases and current cost containment concerns, it is logical to optimize the delivery of services to these diverse patients. Psychology education for NSSI clients must be driven by the best available evidence-based approaches. NSSI patients are likely to have an exhaustive list of unmet psychological needs [3,4] . Growing empirical evidence suggests an inadequacy of care for patients with NSSI. A lack of awareness during formal education and continuing training of clinicians contributes to this shortcoming [5]. Treatment is often complicated by insufficiently trained clinical supervisors, who struggle to guide their students [5].

Psychology training points are underscored by the release of the DSM-5, the most universally used diagnostic and treatment reference. It generates new education and supervision issues for NSSI. The significant mental health needs of NSSI patients, coupled with enduring deficits in clinical education, highlight the need for additional investigation [6]. Supervision must help supervisees adapt to the moment-to-moment changes of NSSI patients, or risk severe injury and death if changes are not addressed. Forensically-

relevant risk assessment challenges for psychologists working with NSSI patients are examined, followed by ethnoracial and cultural factors that affect treatment. Psychology training and supervision of assessments is examined. Two psychological treatment theories as well as ethical and legal considerations for this population are discussed. Finally, implications for future NSSI research, clinical supervision, and training are highlighted.

Risk-assessment Factors for Psychologists ork-ing with NSSI Patients

Clinical and forensic risk assessment issues associated with NSSI patients pose a number of practice challenges for psychologists. A risk assessment designates a rating of concern that should guide a psychologist as to the urgency of interventions. Considerable biopsychosociocultural complexity within the inherent risk probabilities for NSSI patients requires competent assessment and decision-making regarding their mental health service delivery [7]. Reflexive safety vigilance for NSSI patients is essential compared to other diagnosis groups. Safety vigilance must be coupled with ongoing theoretically basedassessment and interventions [8]. When relied on using a dimensional guide, the suggested NSSI risk assessment factors listed below have implications for case management, prevention, and risk-reduction strategies. These factors are not equivalent and they do serve to fill information gaps for clinical decision-making as it pertains to NSSI behaviors, especially ones that deviate from clinical hunches [9]. The incorporation of the following six risk assessment factors of NSSI can be useful in creating a standardized NSSI risk assessment:NSSI Statistics.The estimated NSSI prevalence is 5.9% for the U.S. adult population and about 17% of young adults report a history of one or more NSSI behaviors. Forensically, NSSI patients often come to mental health professionals when their self-injurious behavior is mistakenly assessed as an imminent threat to their safety.

Suicide Assessment

The assessment and prevention of suicide is a daunting task when working with NSSI patients. There is frequently no suicidal intent behind NSSI, rather it is part of an unrelenting desire to reduce distressing affect, inflict self-punishment, and/or to warn others of distress. The suicide rate has consistently increased and is the third leading cause of death for those in the age group of 15 to 24 [10,11]. Welfel (2006) [12] reported 71% of clinicians and 20% of trainees encountered at least one actively suicidal client during their professional life. It is not easy to differentiate between self-injurious behavior and a suicide attempt [4,13,14]. Some clinicians argue self-harm or parasuicidal behavior is directly related to suicidal ideation, even if the patient reports suicide was not their intent. A wide range of methods and the varying patterns of NSSI behavior (i.e., single episode, weeks, months, and years) all complicate both the assessment and treatment. Assessing for intent is the most important challenge in the clinical evaluation of NSSI patients [13]. Clinicians should be cognizant of several questions while evaluating NSSI clients: Is the patient a reliable historian? Were there lethal means? How do we assign a risk level for the patient? Is there a co-occurring disorder present? What is the pattern of NSSI behavior? Such questions can provide valuable data.

Cross-national diagnostic assessment data for self-injury is insufficient, and little guidance is available from counseling theory prescriptions or related ethical codes. The psychologist must gauge decision making and ponder what actionable interventions are required [15]. Timely suicide interventions necessitate recognition of co-morbid emotional and other behavioral issues [16]. Assessment must identify which variables are protective, as opposed to factors that point to increased suicide risk. Contacts with legal authorities during mental health pickups do not afford extensive time or immediate availability of reliable information needed for decisions on safety.

Evidenced-Based Assessment

Beyond determining suicide risk, an evidence-based assessment of NSSI requires combining knowledge of research and the informed application of psychological treatment theories. Evidence-based assessment informs the understanding of etiology, development, and phenomenology of NSSI. The selection of information gathering techniques must be supported by reliability, validity, and ethnoracial utility. Perhaps the most validated intervention studied for adolescents with NSSI is the “therapeutic assessment.” In this case, efforts have been made to assess or use differential diagnostic processes (e.g., self-injurious acts that are non-suicidal) that would assist in more precise treatment for these patients. This is particularly relevant due to a paucity of treatments for this group.

The psychologist must determine whether a self-injury patient has the requisite minimal ability to function without posing a serious threat to the individual’s safety. Forensically, an evidenced-based assessment result that exceeds a predetermined threshold may convince an expert that an SI patient cannot make appropriate safety judgments. The assessment focuses on the SI patient’s ability to make a clear and convincing case for self-care. Even with evidenced-based assessments, the ability to address the forensic referral question may not be completely reliable.

Transdisciplinary Approach

This is a means of exchanging behavioral information from diverse disciplines, altering disciplines, and integrating interventions as opposed to a silo-oriented multidisciplinary strategy [17]. NSSI clinical and forensic issues can occur on a continuum from negative affect to suicidal ideation to imminent risk of dying due to self-injurious behavior. All of these transdisciplinary efforts are aimed at an evidence-based therapeutic goal. The list of NSSI risk

factors requires coordinated solutions using healthcare providers from various disciplines. Working transdisciplinarily can reduce duplication, working at cross-purposes, and a patient's feeling overwhelmed. Forensically, this approach can promote better risk assessment. This is especially true of forensic patients with co-occurring disorders diagnosed with the DSM-5 [18,19].

Each of the aforementioned empirically based factors impact risk perceptions for NSSIpatients. However, these same NSSI risk assessment factors do not exempt psychologists from recognizing other concerns through their ongoing evaluation [20]. Culturally responsive counseling theories may be crucial toward understanding the diversity among self-injurers.

DSM-5

The DSM-5 is not the definitive authority for the complex and diverse diagnostic dilemmas presented by NSSI clients [21]. Its NSSI criteria are heavily weighted by data gathered in the U.S. and Canada [14]. Also, NSSI psychopathology is disproportionately more prevalent in adolescents and young adults. NSSI was not listed as a disorder in the DSM-IV or ICD-10, nor is it a component of any current anxious or depressive syndrome. These nosological shortcomings and DSM-5 status are psychopathologically relevant for training and supervision of psychologists. Since the DSM-5 is the primary reference for diagnosis and treatment planning courses, status may be problematic for education and supervision. These limits must be offset by use of other professional sources. Forensically, clinicians may find Walsh's (2007) [8] work useful in crafting a risk assessment framework (i.e., ethical duty to protect from impulsive self-destructiveness). The forensic decision-making process may also be informed by research finding those who self-injure want to free themselves from an unending negativeaffect instead of enduring it to have low distress tolerance and emotional instability [13].

Biopsychosocial Cultural Approach

This approach (Johnson, 2013; Klonsky, May, & Glen 2013; Johnson 2013a; Johnson, 2012) [14] is required because of a blend of biological, psychological, social, and cultural factors thatcontribute to self-injury risk. These SI variations may be observed through the developmental stage, ethnoracial status, gender, LGBTQIA status, international location, and economic standing of the client. Biopsychosociocultural issues become a critical matter because they seamlessly flow through SI patient's intrusive symptoms, avoidances system, negative emotions and cognition. The core elements are the avoidance or escape of negative affect [22,23].

Ethnoracial and Diversity Factors in NSSI Clients

Many different components comprise an individual's cultural identity, but we will focus on the specific cultural factors of race/ethnicity, gender, sexual orientation and age, and how NSSI presents itself within these populations. In 2009, the U.S. juvenile population was 77% White, 16% Black, 5% Asian Pacific Islander, and 1% American Indian. The 2009 arrest rates for juveniles disproportionately involved minorities: 47% Whites, 51%, Blacks, 1% Asian, and 1% American Indian [24]. In 2011, Black and Hispanic adults were also imprisoned at higher rates than Whites [25].

Caucasians have higher rates than non-Caucasians in psychiatric, forensic, andcommunity samples [26]. However, Borrill et al. (2003) [27] found Black and Multi-racial females with substance dependence had higher rates of NSSI than Caucasians [28]. Data from 5,691 undergraduate students in the Midwest showed Caucasians and those identifying as Multiracial were at especially high risk for a history of NSSI [9]. New findings suggest Multiracial people are at a higher risk for engaging in NSSI, highlighting a need for research.

Gender

The literature presents mixed results, but since there is an elevated risk for both genders in forensic settings, it is essential for mental health counselors to learn about the differences between genders in relation to types, functions, and locations to better serve this population.

Types of NSSI

Smith & Kaminski (2011) found the most common types of NSSI in inmates of both sexes were: Scratching with an object (95.7%), cutting with an object (94.3%), head banging (84.8%), scratching without an object (82.2%), opening old wounds (81.3%), and inserting objects (70.9%) [28]. Whitlock et al. (2011) [29] compared gender and NSSI behavior in a college sample of 14,372, and found women scratched and cut moreand men punched objects to inflict pain. A study of 7,126 Kansas high school students, found similar results with the female population and found males banged their heads, burned themselves and punched things [30].

Functions

Some differences were identified among the reasons male and female college students gave for engaging in NSSI. Women were more likely to use it to help regulate mood, because they had experienced an overwhelming urge and hoped someone would notice. Men engaged in NSSI to feel a sense of stimulation, release anger, or were under the influence of substances [29]. Emotion regulation is a big reason why prisoners reported engaging in NSSI. Offenders reported emotional release, including anger, as a motive [28].

Locations

Evidence shows males and females may differ in the bodily locations they choose to self-injure. In a college sample, Whitlock et al. (2011) [29] found women were more likely to report injury

to their arms, wrists, calves, and ankles; whereas men were 2.1 times more likely to report injury to their hands. Sornberger et al. (2012) [30] had similar results, adding that males were more likely to injure their chest, genitals and face.

Sexual Orientation/Identity

Sexual identity/orientation is a cultural component shown to be a risk factor for NSSI in men and women. Due to sexual minorities exhibiting higher risk for NSSI, those working with forensic populations should be on high alert, especially since it is reported that LGBTQIA youths are over represented in the juvenile justice system. In the general population the LGBTQIA youth population is between 2-10%, but of youth who are incarcerated the LGBTQ population may be up to 15%.

Age

Understanding how age affects likelihood and prevalence rates for NSSI can help practitioners identify individuals at risk. The typical age of onset for NSSI is 13-14 [6]. Studies of adolescent samples show high lifetime NSSI prevalence rates ranging from 12% to 47%, and lifetime NSSI prevalence rates with college-aged students are estimated at 17% to 38% [29]. In psychiatric hospital settings prevalence rates for adolescents who engage in NSSI are estimated to range from 40-80% [26].

These prevalence rates for NSSI and younger populations are important to note because about 61% of the sentenced prison population in 2011 was 39 or younger and the estimated number of juvenile arrests in 2009 was 1.9 million [24]. A majority of those incarcerated fall into these higher risk age groups. Furthermore, 75% of lifetime incidences of NSSI for a sample of youth occurred in prison, and up to 24% of young offenders engaged in NSSI while in custody [28].

Psychology Training and Supervision of Assessments for NSSI

There are several formal instruments developed to measure NSSI behavior. However, the plethora of formal assessment instruments causes difficulties when comparing research. Muehlenkamp, Claes, Havertape and Plener (2012) compared current research nationally and internationally to determine NSSI prevalence rates and found it was a difficult because of the differences in assessments being used. These difficulties led them to push for a possible gold standard assessment process. It would be appropriate to make this push within clinical settings, but many formal instruments that measure self-injury were developed for research purposes, with scarce data on their clinical applications.

Walsh (2007) [8] warns “a limitation of using such instruments in clinical settings is that some clients, particularly adolescents, object to more formal assessment procedures within psychotherapy.” Adolescent clients find highly structured interviews or written questionnaires “to be off-putting and disempowering” [8].

Given the high incidence of NSSI in forensic settings, there is a need to assess for NSSI and suicide risk upon admission to correctional settings. But there is no standardized assessment for determining NSSI risk[28,31]. There should be such an assessment to ensure the safety of these individuals.

Use of the DSM-5 in a Refreshed Mental Health Diagnostic Frontier

Despite the National Institute of Mental Health (NIMH) withdrawal of support, the DSM-5 is the diagnostic tool most widely used by mental health counselors. Supervisors at practicum sites must adjust diagnostic training practices with supervisees to coincide with the changes. Views on SI differ within the field. The American Counseling Association (ACA) code of ethics calls for mandatory reporting when a patient discloses behavior indicating serious harm, whereas the NSSI criteria in DSM-5 specify the behavior must inflict only involuntary commitment. This conflict suggests a more aggressive response that may create less autonomy for an NSSI client. Furthermore, all counseling programs are required to modify their curriculums to accommodate the new diagnostic frontier presented by the DSM-5.The historic restructuring included in the DSM-5 should change well-entrenched diagnostic practices that cut across several disciplines, requiring psychologists to develop requisite clinical and forensic skills. Research concludes understanding of NSSI and competency of response among correctional staff is 44 % [28]. With a legitimized diagnosis, NSSI may be seen as what it truly is -- a very complex disorder. The new diagnosis may be the impetus for proper education and training, creating a better environment for both prison staff and inmates alike.

Five forensically-relevant benefits emerge from NSSI inclusion in the DSM-5. Standardized definition and criteria facilitate uniform comparison of components like prevalence rates, functions, treatments, and risks-to be used by providers and researchers. There is DSM-5 criteria for NSSI that states, “the injury will lead to only mild or moderate physical harm”. Self-mutilation, parasuicide, deliberate self-harm, self-injury, and non-suicidal self-injury are detailed with definitions and criteria.

Second, efforts to optimize NSSI client safety must begin with training. Psychologytraining provides a platform to infuse the knowledge, technical skills and dispositions relevant to client safety [32]. Teaching clinical decision making could reduce diagnostic error that can result in inappropriate or absent interventions. Third, a competent reasoning skill set is the primary goal related to using the DSM-5. The complexity of NSSI issues poses a major challenge for experienced clinicians. Properly treating NSSI patients requires the ability to render a differential diagnosis as well as a comprehensive blend of forensic competencies. Fourth, the DSM-5 signals a sea change for psychologists. Forensically, psy-

chologists must understand how to manage the information that is specifically relevant to NSSI patients. This may be at least partially achieved by remaining current and appropriately applying their knowledge within a specified legal context (e.g., civil commitment, risk assessment).

Finally, although the DSM-5 signals another step toward merging with ICD-10(APA, 2013), the new NSSI diagnosis may not translate internationally. Mullenkamp, Claes, Havertape, and Plener, (2012) stated reasons for possible cultural and international biases, "the DSM-5 is proposing a non-suicidal self-injury disorder that is largely based on data collected from the U.S. and Canada." The data may not be relevant in other countries.

Toward culturally responsive psychological theoretical paradigms for NSSI

Therapeutic logic fuels the operational context needed for psychologists to address a host of issues. None of the core techniques historically taught in graduate programs were specifically designed for NSSI. The core tenets of these approaches can serve as a framework for orchestrating the much-needed clinical case conceptualization and culturally responsive ways of conducting treatment. Phenomenologically, the foundational assumptions of psychologicaltheories permeate the patient's experience of treatment and can generate more desirable outcomes when the theories have ethnoracial salience. The core of the model must have constructs or techniques, that can make a clear and convincing argument for the theory being culturally-responsive. Success occurs on an ethnoracial level by explaining divergent meanings of the NSSI behavior that could theoretically function as a force towards sustainable therapeutic change [33]. Regardless of the theory, the psychopathology of NSSI must always be kept in mind.

The disparate NSSI meanings represent seminal clinical issues that must be conceptualized by theory to achieve culturally responsive treatment. It is beyond the scope of this paper to review an exhaustive list of the psychological treatment theories. To promote scholarship, two approaches, Cognitive Behavioral Therapy and Positive Psychology, are reviewed.

CBT and NSSI

CBT was selected because it has an extensive research base [34]. CBT focuses on changing negative feelings, thoughts, and severe distress that interfere with functioning. SI may present a cognitively-based preoccupation that can last for hours [35]. Clinically, CBT begins with a culturally-responsive collaborative relationship component [36]. This helps a psychologists identify or assess for cultural features of a cognitive schema that can plague clients. Schemas function as a structured set of psychologically-relevant representations of their world view. The same cultural schema can function in two ways simultaneously. First, culture can support a variety of treatment issues relevant for addressing the underlying negative affect and omnipresent SI preoccupation. Second, culture can contain features of traumatization (e.g., historical trauma). CBT uses a variety of techniques like cognitive restructuring that is proceeded by a culturally-relevant assessment that identifies unwanted cognitions. CBT addresses issues related to psychological recrudescence by using relapse prevention techniques that facilitate change after treatment.

Positive Psychology and NSSI

Positive Psychology (PP) is based on theory research and practical treatment. PP starts with a focus on psychological functioning, human potential, and well-being [37]. In a nutshell, PP focuses on the strengths of the NSSI patient instead of psychopathology, to encourage clinical change. Strengths of the NSSI patient's character can affect the unwanted experiences and traits. The power of the "positive" in PP functions as an underlying counseling tenet required during the pursuit of happiness [38]. NSSI patients are often preloaded with a laundry list of negative emotions. PP's therapeutic aim is set on developing positive emotions. Through the PP model, psychopathology associated with NSSI patients is muted by interpersonal skills, courage, optimism, and future-mindedness.

Conclusions

This paper outlined a critical review and synthesis of the complex experiences and clinical reality for these patients. It described the common biopsychosociocultural themes associated with the assessment and treatment of NSSI patients that have unique personal meanings for them. In terms of supervision, despite the cumulative effect of increased education and awareness about NSSI, this type of psychopathology and a life course of threatening situations is expected to continue occurring. Supervisors working with NSSI cases require skills beyond the common foundational and specialized competencies required in psychologyeducation. These competencies are obtained through a specified sequence of education and training involving didactic and experiential participation, and involve NSSI patients. Research has improved the understanding of the complexities confronted by NSSI patients, but more is needed on strengthening extra-therapeutic support resources that help reduce risks for NSSI patients.

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