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Institutional Responses to Self-Injurious Behavior among Inmates

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Abstract

To date, little research has systematically investigated perceptions of mental health professionals regarding perceived motivations for self-injury among prison inmates. To help fill this gap, descriptive techniques were used to examine self-injurious behavior among inmates from the perspective of correctional mental health professionals. A quantitative survey was used to assess perceptions of mental health staff regarding etiology, motivations, and manifestations of self-injury. A qualitative interview component was used to explicate responses from the survey. Findings indicate that inmate cutting, scratching, opening old wounds, and inserting objects were the most commonly witnessed behaviors. There were indications that self-injury occurred regularly and that a subset of inmates are responsible for recurrent events. Mental health professionals perceived the motivation for inmate self-injury to be both manipulative and a coping mechanism. Professionals described current management strategies and corresponding needs for training and resources.

Keywords: institutional responses; self-injury; self-harm; workplace stress; coping.

Introduction

There is growing professional interest in self-injurious behavior (SIB) among prison and jail inmates. Scholarly articles, professional workshops and conferences, emerging treatment programs, and anecdotes shared by corrections professionals indicate that inmate self-injury is a presence in the workplace that creates a drain on both psychological and material resources in the correctional environment (Berzins & Trestman, 2004; NCJFCJ, 2007; Penn et al., 2003; Thomas et al., 2006; Traver & Rule, 1996). Mental health staff in South Carolina identified SIB as the most pressing problem currently facing the Department of Corrections. In contrast to SIB in community samples, the structural and procedural limitations within correctional settings present unique challenges to providers of mental health services. With a deficiency of research specifically geared toward SIB in correctional settings, we know little about the nature, precipitating conditions, or institutional responses to this phenomenon. Clearly, additional research is needed to forge effective and humane models of practice. The current study examines SIB in prisons from the perspective of correctional mental health professionals—persons central within the institutional response to inmates who self-injure.

Manifestations & Motives for SIB

SIB is defined as “the deliberate destruction or alteration of body tissue without conscience suicidal intent” (Favazza, 1989:137; see also Favazza & Rosenthal, 1993 for discussion). This includes moderate acts such as cutting, scratching,

burning the skin, hitting oneself, hair pulling, reopening of wounds, and bone breaking, as well as severe acts such as eye enucleation, face mutilation, and amputation of limbs, breasts, and genitals. Excluded from this definition are common expressive forms of body modification such as tattooing and piercing (Favazza, 1989). Attempted/completed suicides, although sometimes grouped with self-injury data in previous investigations, are viewed as distinct in etiology and motives and therefore deserving of separate investigation (Borrill et al., 2005; Canadian Centre on Substance Abuse, 2006).

While estimates of the incidence of SIB in correctional settings vary, one study found that 52.9% of mentally disordered inmates had engaged in SIB during their incarceration (Gray et al., 2003). More conservative estimates indicate that 2-4% of the general prison population and 15% of prisoners receiving psychiatric treatment routinely exhibited SIB (Toch, 1975; Young, Justice, & Erdberg, 2006).

SIB places tremendous organizational demands on the correctional system.

Traver and Rule (1996) describe the crisis that follows such behavior as “contagious” to other inmates and staff. SIB incidents also increase the risk of pathogenic blood-borne exposures for other inmates and prison staff. Further, inmates who harm themselves are said to be eight times more likely to harm treatment staff when compared to non-self-injuring inmates (Young, Justice, & Erdberg, 2006).

While the general literature often frames SIB as a coping response to stress (Brown, Comtois, & Linehan, 2002; Deiter, Nicholls, & Pearlman, 2000; Whitlock, Powers, & Eckenrode, 2006), there are indications that correctional professionals

perceive manipulation to be a primary motive for self-injury (Dear et al., 2001; Franklin, 1988). Manipulation is frequently perceived as a negative term in everyday vernacular (e.g., "to control or play upon by artful, unfair, or insidious means especially to one's own advantage;" Merriam-Webster, 2008). As such, individuals who manipulate are expressing personal needs, albeit through nefarious or questionable methods. Given the prison social milieu, disruption of connections to "outside" social and emotional support, and substantial restrictions on inmate behaviors, it is reasonable to expect "at-risk" inmates to have heightened probability of resorting to SIB as a means of expressing or obtaining emotional or physical needs.

Walsh (2006), however, has asserted that interpersonal goals of self-injurers (e.g., manipulation, attention-seeking) are secondary to intrapersonal goals (e.g., anxiety relief, self-castigation). Considering that detrimental effects of imprisonment on physical and psychological health have been widely documented (Toch, 1975), it is important that mental health professionals not lose sight of self-injury's function as a response to stress. To do so may lead to gaps in surveillance with minor wounds being dismissed rather than being viewed as potential precursors to more severe self-injury. To date, no research has systematically investigated perceptions of mental health professionals regarding perceived motivations for SIB in correctional settings.

Institutional Response to SIB

Correctional settings present unique issues in management of self-injury. Within these settings, "standard" clinical approaches to managing self-injury may not be feasible (e.g., encouraging tension-releasing activities such as taking a bath, working in the garden, or hitting golf balls; Deiter, Nicholls, & Pearlman, 2000). Walsh (2006) suggested that interventions should be "positive and nonintrusive" and that "if self-injury is...nonsuicidal, then immediate protective interventions...are usually not necessary" (p.227). Deiter, Nicholls, & Pearlman (2000) caution against use of restraints and seclusion, and Walsh (2006) warns that inappropriate or punitive responses to SIB can have long-term negative repercussions, risking hopelessness, shame, anxiety, and depression, as well as susceptibility to further self-injury.

Further, interventions that address the expressed needs of inmates who self-injure (e.g., transferring the inmate who self-injured to escape a threat) may be perceived as rewarding inappropriate behavior, creating risk for contagion of the behavior among other inmates. Yet, in the correctional environment, certain forms of SIB pose risks to the safety and security of others and place strains on limited resources, thus making the management of SIB especially challenging. There exists little research regarding the range or frequency of particular institutional responses to self-injury or perceptions of correctional staff regarding the effectiveness of different options.

Experiences of Staff Responders

Responding to SIB requires training, patience, and professionalism. Mental health professionals are encouraged to exercise a "low-key, dispassionate demeanor" and "respectful curiosity" when talking to self-injurers, and the early clinical response is said to "set the stage for the remainder of assessment and treatment" (Walsh, 2006, p.271). Mental health providers may experience premature feelings of success and competence when responding to acts of self-injury (Walsh, 2006). That is, the mental health worker may award a measure of sympathy, and the individual who self-injures may promise to cease the behavior. Yet, there are indications in the literature that SIB is a deeply entrenched and compulsive coping mechanism (Taiminen et al., 1998). As such, seemingly unprompted relapses by the self-injurer may increase frustration experienced by mental health staff.

Given the severity of some acts described in the literature on correctional SIB (Green, Knysz, & Tsuang, 2000), one would expect correctional mental health professionals to be at some risk for vicarious traumatization (i.e., the negative impact on the self experienced by helpers who engage with survivors of trauma, accompanied by a commitment to help the survivor; Saakvitne et al., 2000).

Hochschild identified "emotional dissonance" as an internal conflict facing workers who are organizationally mandated to perform responsibilities when their emotional response does not coincide with sincere feelings. This dissonance creates "emotional labor" in which one must "induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in

others” (Hochschild, 1983, p. 7). As a result, such workers tend to experience high levels of psychological exhaustion. Presence of such negative affect among correctional mental health professionals, left unchecked, could create risk of countertransference--transfer of one's own unconscious feelings to the patient (Favazza, 1998). A number of authors have described professional challenges in addressing self-injury in the general population (Alderman, 1997; Farber, 2000; Favazza, 1998; Linehan, 1993), yet we know little about the personal impact of SIB on correctional mental health staff.

Need for Research on Institutional Response

Research on SIB has focused almost exclusively on the phenomenology of the behavior (e.g., diagnoses and traumas of injurers), leaving the role of institutional and staff responses to this behavior largely unexplored. While the experiences of the self-injuring inmate are certainly important, there has been little success transferring this knowledge into practical interventions that reduce rates of SIB, and methods of intervention in correctional settings have only recently emerged (Susan Sampl & Robert Trestman, personal communication, December 7, 2007). Thomas and associates (2006) argue that self-injury must be studied within the sociological milieu in which it occurs. The current study is unique in examining staff perceptions and institutional responses to SIB in correctional settings. Specifically, we examine perceptions of correctional mental health staff regarding the nature and prevalence of SIB among inmates, perceived motivations of inmates who self-injure, strategies employed by staff in managing SIB in the

institution, and the impact of SIB on the institution and correctional mental health staff.

Methods

This research includes a design with both quantitative and qualitative components. Such an approach can limit biases inherent to single-method investigations, and enhances the potential responsiveness of our findings to criminal justice stakeholders with interests in SIB (Denzin, 1989; Patton, 2002). The quantitative component included a survey assessing perceptions of mental health staff regarding SIB etiology, motivations, and manifestations. The qualitative component was designed to further explicate responses from the survey and garner staff input on efficacy of current management strategies. All procedures were reviewed and approved by an Internal Review Board for research involving human subjects.

Participants

Participants were a convenience sample of correctional mental health professionals who attended a regularly scheduled statewide staff meeting ($n = 54$). They represented fourteen different facilities, including all security levels and facilities housing both males (83% of those indicating facility type) and females (17%). Almost all of the professionals were licensed clinicians, with job titles such as licensed clinical counselor, human services coordinator, psychologist, or psychiatrist. There were also several high-level administrators, as well as a few program managers, registered nurses, licensed practical nurses, and social

workers. All fifty-four attendees completed the survey and eighteen provided additional contact information to participate in an individual follow-up phone interview. Two-thirds of interviewees were females.

Quantitative Survey Measures

Survey measures (Appendix A) were created specifically for this study and addressed professionals' perceptions regarding incidents in which inmates intentionally hurt themselves. Participants were asked to respond regarding incidents that they had seen or heard about occurring at their own facility within the past six months. The items assessed: the types of self-injury, number of self-injurious inmates, current strategies used by staff to manage SIB, and perceptions regarding the most common reasons for inmate self-injury. The survey also included open-ended items that addressed barriers to managing inmates' SIB and any additional comments.

Qualitative Follow-Up Interviews

Half-hour, semi-structured follow-up interviews were conducted individually by telephone with survey respondents who confirmed interest on the initial survey form. Prompts addressed: examples of self-injury that occurred at the interviewee's facility; scope and prevalence of self-injury at the facility; perceived motives for self-injury; perceived demographic or offense variation among self-injurers; impacts of self-injury on resources, correctional climate, and staff; methods of staff emotional/psychological coping with SIB; strategies used to address SIB and effectiveness of such strategies; barriers or challenges in

addressing SIB; and resources or policy changes needed to address SIB in correctional facilities.

Analyses

Descriptive statistics on survey items were generated using SPSS statistical software. Open-ended items and phone interviews were analyzed using ATLAS/ti qualitative software and a grounded theory approach (Strauss, 1987). For the current study, qualitative data were used to elucidate quantitative findings by providing examples and insight into dynamics of SIB.

Results

Types, Frequency, & Prevalence of Self-Injury

Table 1 displays types of self-injury that professionals had seen or heard about at their facility in the past six months. Cutting, scratching, opening old wounds, and inserting objects were the most commonly witnessed behaviors. Professionals provided examples in their qualitative accounts, with these sometimes illustrating limitations or overlap within our pre-defined survey categories. They indicated that inmates would cut their arms, legs, neck, and abdomen, sometimes with such severity that intestines were exposed. Inmates would pick at stitches and open old wounds, and some inmates inserted materials into new or re-opened wounds (e.g., paper, socks). Tools used to cut, scratch, or puncture included staples, razors, wire, broken glass, hard plastic, and screws. Staff described frustration in trying to keep such a wide range of objects out of the hands of inmates who self-injure, particularly when some self-injury was encouraged or

facilitated by others in the correctional environment (e.g., inmates or staff providing razors to self-injurers). Professionals also mentioned inmates swallowing objects (e.g., batteries, toothbrushes, ink pens, pencils, silverware) and inserting objects into or using shoe string to constrict their genitals.

We listed attempted suicide in the checklist for inclusiveness, in that this behavior is often confused with self-injury. It was also among most common phenomena professionals had seen or heard about. In qualitative accounts, professionals mentioned attempts involving hanging with sheets or string, swallowing paper, attempted overdose, self-starvation, or attempts to drown in the toilet water.

Professionals mentioned that burns were often self-inflicted with cigarettes or lighters, and that inmates sometimes bit their own lips or inside of their mouth with enough force to require stitches. No professionals had seen or heard about incidents of bone breaking, a type of self-injury mentioned in the literature.

A number of interviewees indicated that women were less likely than men to engage severe acts of self-injury and that women's acts were not as overt (e.g., women tended to use surface cutting and to hide this from others).

Insert Table 1 about here.

Figure 1 displays number of self-injury incidents that the professional had seen or heard about at his or her facility within the past six months. As can be seen, the vast majority of professionals were aware of some incidents, with 75% of mental health professional recalling between 3 and 10 different self-injurious incidents.

Only 4% of mental health respondents could not recall an SIB incident within the previous six months, indicating that SIB is somewhat of a regular occurrence.

Insert Figure 1 about here.

Figure 2 shows perceptions regarding the number of different inmates who self-injured at each professional's facility within the past six months. Again, the bulk of professionals (67%) reported frequencies of different inmates committing acts of SIB to between 3 to 10 different inmates. This suggests the presence of a subset of inmates who repeatedly engage in SIB.

Insert Figure 2 about here.

Perceived Motivations for Self-Injury

Professionals' attributions regarding motivations for inmate self-injury demonstrate overwhelming perceptions that self-injury is used for manipulative purposes, followed by use as a coping mechanism. Qualitative accounts revealed that this was often an attempt to improve one's situation, such as injuring oneself to be transferred out of lock-up or into hospital accommodations, or to obtain a transfer away from harassment or intimidation of other inmates. Some attempts seemed more gratuitous, such as injuring oneself to obtain medications or in order to get the nurse to touch one's penis. Interviewees indicated that some self-injury was used to "send a message," express anger, or inflict hurt directed toward family members, other inmates, or staff whom the inmate felt had wronged him/her. Some SIB was described as "copycat" attempts

after inmates viewed the positive gains of others, and some self-injurers were goaded and given "tools" (e.g., razors) by other inmates or correctional officers.

Examples provided regarding self-injury as coping mechanism included behaviors such self-injuring as a response to the stress of incarceration, to bad news from home (e.g., death of a loved one, divorce), or to separation from children (especially for female inmates). Inmates were described as self-injuring to remove emotional pain, to feel alive or escape emotional numbness, to establish control in the midst of powerlessness, or to animate one's world.

Many professionals noted borderline personality disorder as the predominant underlying psychological condition among self-injurers, and severe psychosis was mentioned less frequently by interviewees.

Insert Table 2 about here.

Behavioral Management Strategies

As can be seen in Table 2, the most common strategy used by professionals to manage self-injury was isolation, followed by psychological counseling, administering first aid, making a report, and confiscating objects used to self-injure. Medication and physical restraints were used less often, but nevertheless used by a substantial number of professionals.

Insert Table 3 about here.

Interviewees indicated that some of these strategies may be used within a tiered response that combined multiple, successive strategies. Immediate response

included taking care of injuries and assessing these to see whether treatment could occur in-house or required transport to a hospital. A common approach then involved placing the inmate in a crisis-intervention cell. The inmate would be in an empty cell, naked or clothed in a paper "suicide" gown, provided only with finger foods. Staff would monitor the inmate at set intervals (e.g., 15-30 minutes), sometimes with the use of cameras. If the inmate showed progress, he or she may be provided with a jumpsuit, a mattress, a toothbrush, or other items.

Several professionals indicated that this approach was effective with malingerers who did not wish to remain under such conditions. However, some professionals felt this approach was not effective for other types of self-injurers, and that this was simply a strategy to "get to the next day" instead promoting real healing.

Some professionals indicated that counseling in individual and group therapy was used in conjunction with or following isolation. Behavioral contracts and medications were sometimes used, with this combination being perceived as more effective. Several professionals mentioned use of restraint chairs, but it was noted that these were not used at some facilities (e.g., women's facility) out of concern that restraint would recapitulate earlier experiences of abuse that the individuals had suffered.

Some professionals expressed a need for intensive in-patient work with self-injurers, but special management units were limited in space and resources to accommodate such need. At least one facility had established a multi-bed "cutter's unit" in one of the dormitories, combining behavioral management with regular individual and group therapy. The unit was described as successful in

preventing the reoccurrence of self-injury among program completers, though no formal evaluation of the program has occurred.

Institutional Impact and Needs

As one might infer, the institutional impact of SIB can be substantial in both monetary and human costs. Our interviewees described numerous tangible expenses associated with self-injury incidents. These included costs for transport to medical facilities via ambulance, costs of medical staff and services, antibiotics to prevent infection, body fluid cleanup and environmental precautions, costs covering staff time for multiple correctional officers to accompany the patient to medical facilities, time devoted to paperwork for intensive incident reports, rescheduled groups and services for staff pulled away from routine duties, and room/equipment costs for a monitored crisis intervention cells. Single incidents could cost tens of thousands of dollars, and some inmates had incurred expenses in the hundreds of thousands.

Human costs include not only the tragedy of self-inflicted injuries and, sometimes, unintentional loss of life, but also the toll that these events may take on well-being of others in the correctional environment. Disrupted routines, security risks, environmental hazards, and witnessed trauma all have potential to impact other inmates and staff. Our professional interviewees described a range of initial reactions to inmate self-injury, including panic, shock, nausea, and anger. Professionals spoke of blaming themselves for inability to stop self-injury, and struggling with frustration, feelings of detachment, and burn-out. Often they

developed methods for dealing with such incidents over time, including vigilance to boundaries between self and the client, showing concern without getting caught up in the inmate's affect, and staying attuned to one's professional responsibilities (e.g., taking precautions) without bearing the onus of the inmate's actions. Professionals contextualized self-injury within the broader issues of inmate mental disorder or distress. Assuring staff supervision and thorough debriefing around traumatic incidents was also helpful in professional coping.

An overarching theme in qualitative data was difficulty addressing the complex psychological and behavioral patterns of self-injurers within rigid and often punitive correctional settings. In such settings, security needs typically override treatment needs, and mental health professionals face significant limitations in time and resources they may devote to treatment of any single inmate. However, with continued incarceration of the mentally ill, there exists dire need for strategies to address self-injury in the correctional environment.

Education and training was foremost among needs cited by interviewees, with interest areas including etiology and motivations behind SIB, screening tools to identify potential self-injurers, assessment to differentiate high- versus low-risk cases, and techniques for risk reduction and intervention. Interviewees also noted that gaining necessary support for the treatment plan among staff uneducated in self-injury is difficult, and that varied types of staff sometimes hold divergent perspectives on the best way to address self-injury (e.g., whether or not to use medication or restraint). Thus, some basic training and team development may be beneficial across medical, mental health, security, and

administrative staff. Other needs included educational supplies for inmate groups on self-injury (e.g., workbooks, DVDs), funds for staff to attend special workshops or conferences on self-injury, physical space and equipment for creation of safe spaces for self-injurers (e.g., metal detectors, cameras), and options for in-patient treatment or diversion to community treatment programs.

Conclusions

Before drawing conclusions, we first recognize limitations of this research. While the mental health professionals self-reported considerable experience in responding to SIB in correctional settings, our small sample of respondents was not selected via a randomized process. As such, we know little about the perceptions of mental health professionals who did not participate in the meeting or who chose not to engage in our follow-up interviews. Because some respondents worked at the same facilities, it is important to note that some respondents may have reported on the same episodes of SIB. Although our study of professionals from across the state may be broadly representative of the entire state, making generalizations to correctional systems in other states is difficult.

The voluntary injury of one's own body tissue is often perceived as irrational, non-utilitarian, and grotesque. Yet, a fuller understanding of processes that drive SIB can provide mental health professionals the opportunity to identify strategies for future interventions. Reflecting the literature (Franklin, 1988; Young, Justice, & Erdberg, 2006), many professionals noted borderline personality disorder as the predominant underlying psychological condition among self-injurers. The

“typical” SIB behavior in this study involved inmates cutting themselves with or without an object or inserting objects into their bodies, and there is evidence of a subset of recidivist’s who engaged in SIB on a regular basis. While these are stereotypical self-injuring behaviors, the qualitative interviews revealed that SIB in corrections can manifest in diverse forms, including the bizarre and deadly.

SIB was perceived as exemplifying motives grounded in both manipulation and coping. Mental health professionals held perceptions that SIBs, in many cases, were self-soothing responses to stress. Unfortunately, this did not protect professionals from experiencing frustration and anger when responding to acts of self-injury. In fact, mental health professionals self-reported a continuum of emotional disengagement from the inmate who self-injures—ranging from increasing personal boundaries to emotional dissonance (e.g., “I just do my job”). These strategies enabled mental health workers to continue responding to acts of self-injury, though provided no long-term solution to reducing SIB in correctional facilities. Behavioral contracts and medications were sometimes used in combination, though the literature casts doubt on effectiveness of contracts (Drew, 2001).

There was consensus among professionals that corrections are currently ill-equipped to adequately treat inmates who self-injure. These mental health professionals unequivocally supported specialized training, equipment, and staffing to respond to acts of self-injury. We hope that our findings can inform educational and resource needs in this area as well as providing direction for future applied research.

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Table 1: Types of self-injury that mental health professionals reported seeing or hearing about at their facility in the past six months.

<u>Behavior</u>	<u>% professionals who reported seeing/hearing</u>
Cutting self with object	87%
Scratching self without an object	67%
Opening old wounds	65%
Inserting objects into body or under skin	65%
Attempted suicide	63%
Head banging	43%
Burning or branding self	15%
Biting self	11%
Pulling own hair	6%
Bone breaking	0%

Figure 1: Number of self-injury incidents that the professional reported seeing or hearing about at their facility in the past six months.

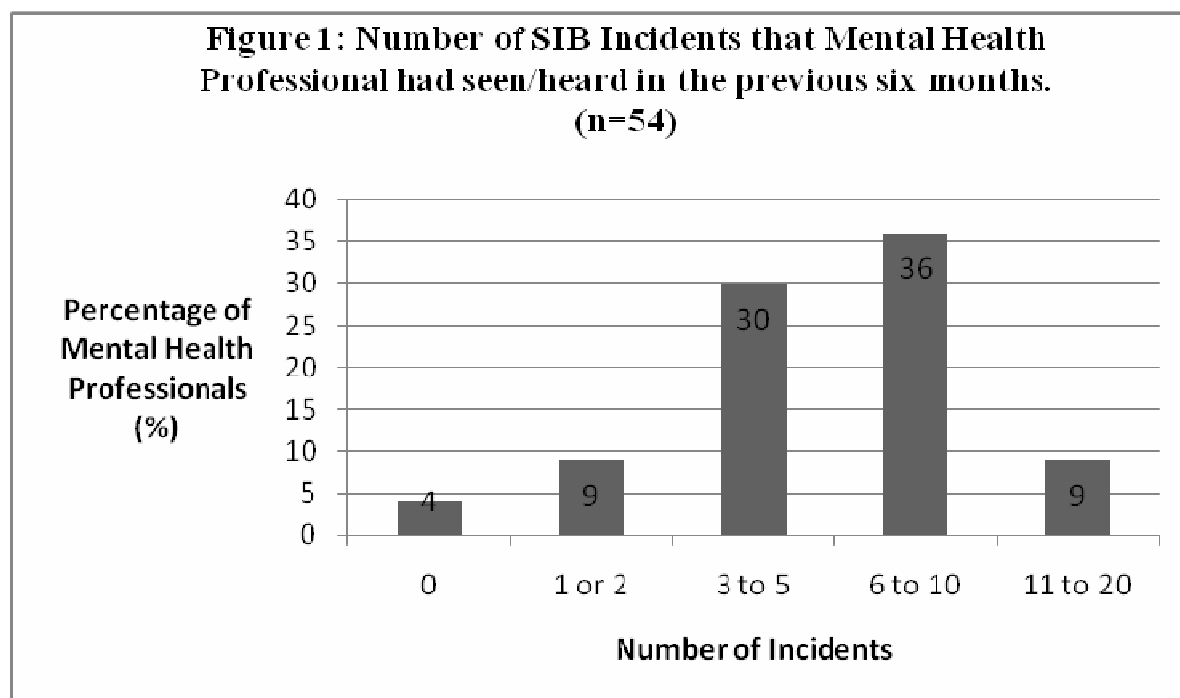


Figure 2: Perceptions regarding the number of different inmates who self-injured at each professional's facility within the past six months.

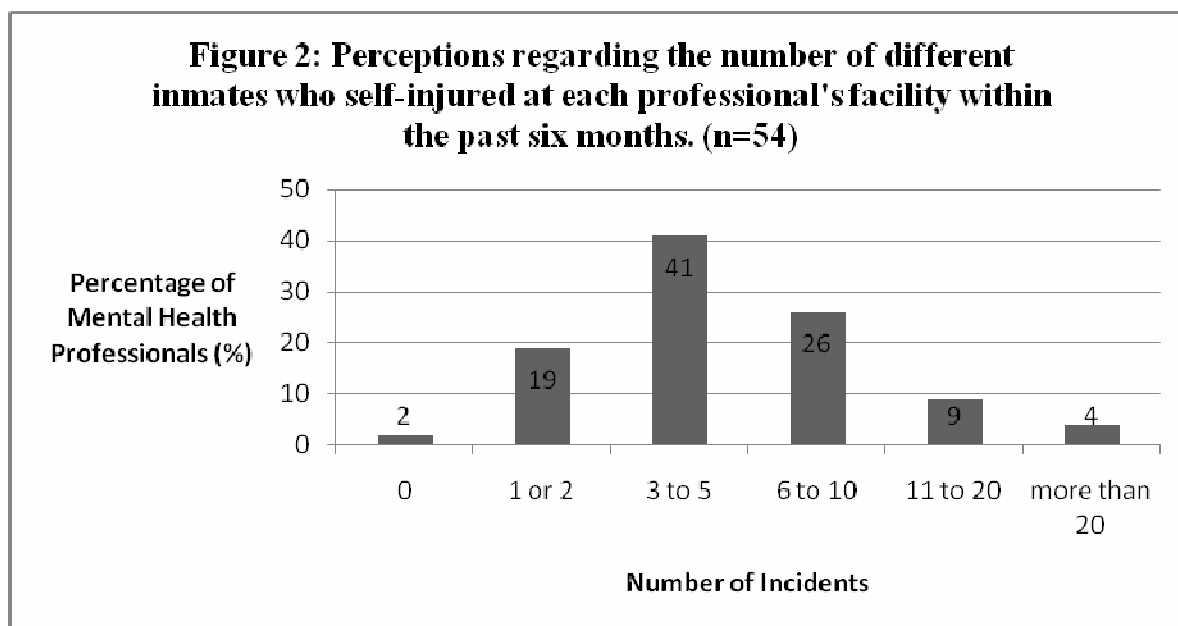


Table 2: Perceptions of mental health professionals about reasons that inmates self-injure.

<u>Reason that inmates self-injure</u>	<u>% professionals</u>
To get special treatment or different placement in facility	91%
To cope with stress	85%
To attempt suicide	33%
To intimidate other people	28%
Due to delusions or severe mental disorder	22%

Table 3: Types of strategies that mental health professionals reported using most often to manage self-injury.

<u>Response</u>	<u>% professionals who reported using</u>
Isolate inmate	78%
Administer psychological counseling	69%
Report to appropriate authority/provider	57%
Administer first aid / transport to health care unit	57%
Confiscate objects used to self-injure	52%
Administer psychiatric medications	46%
Restrain inmate	24%
Do nothing	2%

Appendix A: Survey items

We are a team of researchers studying self-injury among inmates. By “self-injury,” we mean inmates hurting themselves on purpose.

In the past six months what types of self-injury have you seen or heard about at your facility (check all that apply):

- ☐ Burning or branding self
- ☐ Cutting self with an object
- ☐ Scratching self (without an object)
- ☐ Biting self
- ☐ Pulling own hair
- ☐ Head banging
- ☐ Opening old wounds
- ☐ Inserting objects into their body or under skin
- ☐ Bone breaking
- ☐ Attempted suicide
- ☐ Other (please describe) _____

About how many different incidents of self-injury did you see or hear about in the past six months:

- ☐ 0
- ☐ 1 or 2
- ☐ 3 to 5
- ☐ 6 to 10
- ☐ 11 to 20
- ☐ More than 20

About how many different inmates did you see or hear about that self-injured in the past six months:

- ☐ 0
- ☐ 1 or 2
- ☐ 3 to 5
- ☐ 6 to 10
- ☐ 11 to 20
- ☐ More than 20

Given what you know about the incidents, about what percentage of incidents required medical attention:

- ☐ Less than 10%
- ☐ 10 to 20%
- ☐ 21 to 50%
- ☐ 51 to 75%
- ☐ Over 75%

What types of strategies do you use most often to manage self-injury behavior (check all that apply):

- ☐ Do nothing
- ☐ Report to appropriate authority/provider
- ☐ Confiscate objects used to self-injure
- ☐ Isolate inmate
- ☐ Restrain inmate
- ☐ Administer first aid or transport to health care unit
- ☐ Administer psychological counseling
- ☐ Administer psychiatric medications
- ☐ Other (please describe) _____

What do you think are the most common reasons that inmates self-injure (check all that apply):

- ☐ To cope with stress
- ☐ To intimidate other people
- ☐ To get special treatment or different placement in facility
- ☐ To attempt suicide
- ☐ Due to delusions or severe mental disorder
- ☐ Other (please describe) _____

What are the biggest challenges for you in managing self-injury at your facility?

Is there anything else you would like to tell us about self-injury among inmates?

May we contact you to discuss self injury in your facility? If so, please provide your contact information below.