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Calendar of Events

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and cost outcomes, where significant, medium-sized effects have been found across a range of studies. Positive clinical and youth functioning outcomes, however, have been less consistently shown, and where significant, effects have been found to be small (Suter & Bruns, 2009).

Finding more positive results for residential, family, and cost outcomes is perhaps not surprising, given that wraparound is an intensive care coordination process that is explicitly focused on keeping children in their home communities with their families or other caregivers. Wraparound’s principles and practice model stress the importance of supporting caregivers and families so that they, in turn, can support their children. The perspectives of caregivers—and older children—are prioritized in the planning process to ensure that the service and support strategies that are included in the plan are those that the family feels are most likely to be effective and feasible. Furthermore, in creating the care plan, a wraparound team actively considers the multiple levels of a child’s social ecology (family, friends, and neighbors; providers; systems; community) and identifies service and support strategies that fit within the family’s context and culture (Bruns et al., 2010; Walker & Matarese, 2011; Walker et al., 2008).

By mobilizing and coordinating a holistic range of services and supports that tie to families’ priority needs, wraparound has been quite successful in stabilizing children’s living situations, keeping children in their homes—or in “home-like” community settings—and avoiding costly out-of-home placements (Bruns, 2008; Bruns & Suter, 2010; Bruns, Walker et al., 2010. Indeed, a recently completed 10-state Medicaid demonstration project found that wraparound cost substantially less than institutional and other alternatives, with an average per capita saving of $20,000 to $40,000 (Urdapilleta et al., 2011).

Given its greater emphasis on collaboration and holistic, individualized supports as opposed to the structured clinical procedures more typical of evidence-based clinical treatment, it may also come as no surprise that wraparound tends to have a much more modest (though still positive) effect on youth clinical and functional outcomes (Bruns, 2010; Bruns, Walker et al., 2010). Indeed, a recent small-scale, NIMH-funded randomized trial found that in the absence of connection to research-based clinical supports, clinical and functioning outcomes in wraparound were no better than usual care (Bruns et al., in revision; Bruns, Walker et al., 2010). Such research results and real-world experiences have inspired many wraparound and systems-of-care proponents to ask how better clinical and functional progress in youths might be promoted through thoughtful application of research-based practices.

Strengths and Limitations of Evidence-Based Practices

Communities have become aware of the fact that “evidence-based practices” (EBPs) have the potential to produce better outcomes than treatment as usual, and many providers have explored adopting manualized empirically supported programs (MESTs) for use in community
settings (Weisz & Kazdin, 2010; Weisz et al., 2012). However, EBPs, in general, and MESTs, in particular, may struggle with a complementary problem to that of wraparound—that is, extensive support for their clinical efficacy but less clarity regarding their “real-world” effectiveness, feasibility, and cost/benefit ratio (Chorpita, Rotheram-Borus et al., 2011). Among other challenges, providers do not have favorable attitudes about many manualized treatments, often perceiving them as inflexible, burdensome, and inattentive to issues of therapeutic alliance and clinical judgment (Addis & Krasnow, 2000; Borntrager et al., 2009; Chorpita et al., 2007).

Manualized EBPs may challenge existing system and organizational infrastructure because they require multiple fidelity monitoring, billing, and claims procedures, each unique to the specific MEST (Chorpita et al., 2007). Moreover, MESTs are not available for all child disorders and do not incorporate a coordinating infrastructure for how to navigate between protocols to deal with multiple and complex disorders. In addition, many MESTs are expensive to implement, requiring training and retraining by the treatment developer (often in their home town). Finally, as described by Chorpita, Becker, and Daleiden (2007), training in EBPs often represents a “replacement paradigm,” whereby providers are asked to substitute (rather than complement) their existing skills and strategies by shelving their existing approaches, even those that are based on evidence of effectiveness.

Even where community providers have adopted MESTs and made them available to wraparound teams, manualized EBPs often do not represent a good fit with either the family’s expressed needs or the philosophy embedded in the wraparound process (Walker & Bruns, 2006). The service and support strategies provided through wraparound are intended to be highly flexible and individualized, so that they match family needs, preferences, and perceptions of utility as described above. The wraparound team monitors services in an ongoing way to ensure that families are engaged and that outcomes are improving. If a service is not meeting these expectations, then the team adjusts the service or replaces it with an alternate strategy. In contrast, manualized EBPs usually emphasize adherence to specific protocols that are not to be altered. Thus, the wraparound team (and by extension, the family and youth) lose the power to individualize and optimize the treatment so that it focuses on family-prioritized outcomes and needs.

The structure of MESTs can also make it difficult for wraparound teams to coordinate multiple treatments for children with complex needs, raising the real possibility of overburdening the youth and family with assessments and treatment demands or overburdening practitioners and systems with managing multiple, unique EBP approaches. Finally, some EBPs operate out of a philosophical framework that is not compatible with wraparound. For example, fidelity to an MEST may require that the child/family not be involved with other services, thus precluding collaboration with a wraparound team. For other EBPs, there is a fundamental philosophical dissonance with wraparound. For instance, EBPs may be expert-driven in a way that does not by generating options and tracking practice and progress for each youth using strategies grounded in the experimental literature, knowledge on clinical theory, and local knowledge from measurement of youth outcomes and local norms (Daleiden & Chorpita, 2005). Thus, treatment is coordinated based on evidence for effects of psychosocial interventions while also being flexible, modularized, and capable of midcourse corrections when interference or changes in treatment priority arise, or when multiple youth needs demand a more individualized and tailored approach.

**Applying a Knowledge Management Approach to EBP**

One of the cornerstones of using a knowledge management approach to implementing research-based services is recognition that among the many hundreds of interventions that exist for youths’ problems, there are a relatively small number of treatment components. These components—sometimes referred to as “common elements” of EBP (Barth et al., 2011; Chorpita et al., 2005a)—are essentially the smaller pieces that make up interventions. Put another way, many interventions can be conceived fundamentally as different ways of repackaging the same components or elements (Chorpita et al., 2005a, 2005b). In fact, much of the codified knowledge represented in manualized evidence-based interventions represents subtle variations of many of the same elements or components, such as cognitive restructuring, psychoeducation, praise, rewards, or modeling. In a recent published example of the commonality of intervention components, Chorpita and Daleiden (2009) reviewed 322 randomized trials of treatments for the most common problem areas of youths, including depression, anxiety, and disruptive behaviors. Coding of the components of these studies found that 41 common practice elements could be “distilled” from the 615 manualized protocols reviewed.

Of course, the power of this type of component analysis is not just in the scientific

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**On the surface, the complementary nature of the limitations of wraparound and EBPs seemingly points to an opportunity to leverage the strengths of both through their coordinated application.**

Applying a Relevant EBP Paradigm to Wraparound

Recognizing the difficulties that have arisen in attempts to reconcile wraparound and EBP, researchers have been searching for a way to combine the strengths of the two approaches in a synergistic manner (Weisz et al., 2006). On the surface, the complementary nature of the limitations of wraparound and EBPs seemingly points to an opportunity to leverage the strengths of both through their coordinated application. This has traditionally not been easy, however, given the philosophical and structural challenges noted above.

More recently, some applications of EBP have taken a more individualized approach that aligns with the wraparound philosophy. Instead of strict implementation of one or more manualized treatments, these applications are based on quality improvement models and flexible application of the evidence for “what works” in child and family treatments. Such knowledge-management approaches to EBP flexibly inform practice by generating options and tracking practice and progress for each youth using strategies grounded in the experimental literature, knowledge on clinical theory, and local knowledge from measurement of youth outcomes and local norms (Daleiden & Chorpita, 2005). Thus, treatment is coordinated based on evidence for effects of psychosocial interventions while also being flexible, modularized, and capable of midcourse corrections when interference or changes in treatment priority arise, or when multiple youth needs demand a more individualized and tailored approach.
discovery of these commonalities, but in their application to children and families. Chorpita and Daleiden (2009) hypothesized that it should be possible to determine which specific components drawn from evidence-based protocols would best fit the needs of a particular child. With tools to help review the applicability of the components to the characteristics of the youth in care and to guide the assembly of components into individualized service episodes, the clinician or team may select from among these components and implement them while monitoring the child’s responses. If desired outcomes are not being achieved, the clinician or team might attempt systematic adaptations, such as implementing different components (Chorpita et al., 2008).

**For all its strengths, the wraparound practice model does not provide explicit guidance for how to incorporate evidence-based clinical content into plans of care.**

With this approach, treatment teams would not be limited to the specific components in the specific sequence of a specific EBP but would, instead, have the flexibility to individualize the treatment to a considerable extent through a process of informed choice. In the context of wraparound, the team would be able to collaborate more meaningfully and effectively with a clinician to ensure that clinical treatment would be responsive to family needs, goals, and preferences, or a facilitator could even work with the team (which may or may not include a clinician) to review relevant options from a range of research-based elements. With this information at hand, the facilitator could help the youth, family, and other team members consider which options might be best aligned with the strengths, needs, and preferences of the youth and family.

This leads, of course, to the question of how to use information about the elements of empirically supported practices in a way that makes strategizing and decision making for a system or a specific child more informed—and thus more amenable to making promising decisions, actions, and treatments. To support better child- or team-level decision making, an interventionist or team can match the characteristics of a youth who is the focus of treatment to elements that are included in treatments found through research to have been effective for similar youths (with respect to problem area, age, gender, race, and treatment setting). When provided with training and supportive tools to do this “matching” work efficiently, the provider, team, and/or youth and family stand to benefit from this “modularized” way of applying the evidence. For example, a provider can learn a set of skills to deliver common elements of treatment with fidelity that allows for emulation of many manualized treatments. Once learned, she or he can also then apply the components flexibly as youths’ needs shift or barriers arise to initial treatment. At a system level, this approach provides significant “coverage” to meet a range of youths’ problem areas without having to impose expectations of multiple manualized treatments, with their multiple and overlapping training, contractual, and strategies. The Practitioner Guides present two-page reviews of the steps to implement the common treatment practices and processes in a way that reflects the research literature. (see an example in Figure 1). The Practitioner Guides can be used flexibly by a range of practitioners to enhance their skills (if they are well versed in the treatment) or to structure the care they provide (if they are relatively unfamiliar). These guides may also be used to help a wraparound facilitator understand the nature of treatment that is expected from a clinician to whom the team has referred a youth, or to help a natural support, mentor, behavioral aide, or family member support a treatment (e.g., rehearse cognitive or behavioral strategies in the community).

An additional challenge in applying the flexible, components-based approach is how to accurately and efficiently monitor how the child is responding, so that the clinical approach can be adjusted as needed. In the MAP system, the Clinical Dashboard serves this role by monitoring the youth’s progress and process. The MAP Dashboard presents progress (such as toward a goal or as assessed by a standardized measure) in one pane, and process (e.g., the treatment components that were implemented) in another pane, both along the same axis of time (see Figure 2). Monitoring and feedback of information on progress has been found to be one of the most critical factors in effective health and mental health treatment (Kawamoto et al., 2005; Lambert & Hawkins, 2001). In wraparound, the outcomes-based principle demands that needs be prioritized and that progress toward meeting needs and achieving outcomes be measured and reviewed by the team as a way of continually adjusting as required. However, such efforts are often not undertaken by wraparound teams or staff (Bruns et al., 2004; Bruns, Walker et al., 2010). A standardized means for doing so, such as through a consistent yet individualized Dashboard, would be likely to promote positive teamwork and outcomes in wraparound.

**How Can We Best Incorporate Evidence-Based Clinical Content Into Care Coordination?**

With nearly 20 years of research and widespread implementation of the wraparound process behind us, the field of children’s mental health is seeking potential solutions to the widely observed concern that, for all its strengths, the wraparound practice model does not provide explicit...
Figure 1: Example of Practice Guide From the Managing and Adapting Practice (MAP) System

Practitioner Guide

Attending

Objectives:
- to increase the amount of positive attention provided to the child, even if the child has misbehaved at other times during the day
- to teach the caregiver to attend to positive behaviors
- to promote the child’s sense of self-worth

Steps:

- **Provide rationale**
  - Emphasize the importance of providing positive attention to the child.
  - Elicit the caregiver’s opinion about how attention affects behavior and people’s motivation to do a good job.
  - Have the caregiver describe his or her best and worst “managers” and the caregiver’s motivation to work for each.
  - Lead the caregiver to recognize that how he or she was treated affected the caregiver’s desire to work.
  - Discuss how the child’s behavior may be affected by the caregiver’s behavior towards the child and how the child’s desire to behave can be increased by improving the caregiver-child relationship.

- **Set aside one-on-one time for caregiver and child**
  - Encourage the caregiver to set aside a block of time (e.g., 10 minutes) each day devoted to joining the child in an activity the child has chosen.

- **Teach caregiver to provide positive and descriptive commentary**
  - Show the caregiver how to demonstrate sincere interest in the child’s activities while they are playing.
  - Instruct the caregiver to provide enthusiastic descriptive (e.g., “You are drawing a tree”) and/or positive (e.g., “I like the way you stacked the blocks”) commentary and praise regarding the child’s behavior.

- **Encourage caregiver to engage in child’s activity**
  - Suggest that the caregiver become actively involved in the play activity by imitating the child’s behavior in order to demonstrate approval.

- **Restrict criticism, questions, and commands**
  - It is important that the child lead the activity; that is, the caregiver should refrain from making suggestions, asking questions, and criticizing the child.
  - Allow the child to use his or her imagination (e.g., coloring the green or making up new rules to a game) without caregiver input about the “correct” way to do things.

- **Anticipate difficulties**
  - When the procedure is initially implemented, the child may engage in negative behavior that characterizes the usual caregiver-child interaction. When this occurs, the caregiver should:
    - consistently ignore negative behavior by looking away;
    - refrain from scolding the child so as to avoid providing negative attention for misbehavior;
    - end one-to-one time if disruptive behavior continues or is dangerous.
  - Over time, however, it is expected that consistent positive attending will result in decreased negative behavior and increased positive caregiver-child interactions.
Figure 2: Example of a Wraparound-Specific Dashboard From the Managing and Adapting Practice (MAP) System

Progress and Practice Monitoring Tool

Age (in years): 10.7

Case ID: Wraparound Practice Illustration

Gender: Female
Ethnicity: Asian

Progress Measures:
- Left Scale
  - Goal #1: CANS Natural Support
  - Goal #2: CANS Res. Stability
  - WiFi
- Right Scale

CANS Functioning
CANS Needs

Orientation: Services - Family
Orientation: Legal/Ethical - Family
Assess: Crisis - Family
Assess: Crisis - Team
Intervene: Crisis Response
Assess: SNCV - Family
Document: Summary Prep
Team: Select and Orient
Team: Ground Rules
Document: Summary Reprise
Team: Mission
Team: Prioritize Needs/Goals
Team: Select Goals/Outcomes
Team: Select Strategies
Team: Assign Actions
Team: Determine Risks
Document: Safety Plan Prep
Document: Plan Prep
Intervene: Practice #1 (MAP)
Intervene: Practice #2 (MAP)
Intervene: Practice #3 (MAP)
Intervene: Practice #4 (MAP)
Monitor: Progress
Team: Evaluate Success
Team: Celebrate Success
Team: Revise Strategies
Monitor: Team Satisfied/Engaged
Intervene: Team Cohesion/Trust
Document: Plan Reprise
Team: Transition Plan
Team: Crisis Plan
Team: Transition Members
Document: Team Summary Prep
Team: Celebrate Commencement
Check-in: Family

Days Since First Event

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guidance for how best to incorporate evidence-based clinical content into plans of care. One solution to this problem would be to promote system-level efforts to identify relevant manualized EBPs that should also be available to wraparound clients and to install these EBPs in the system. Given the hundreds of randomized trials in the literature on these MESTs, this option holds promise for achieving positive clinical effects. However, as described above, there is a range of effectiveness barriers to installing even one MEST, such as costs, the need for provider retraining, poor provider attitudes, and poor fit to the complex needs of the youths in care. Installing multiple MESTs as a potential solution to the problem of a lack of availability of EBPs is likely to result in a great deal of complexity, which Rogers (2003) cites as a primary barrier to implementing innovative practices.

The alternative, proposed in this article, is to introduce a clinical model that incorporates knowledge of all EBPs in an individualized manner and that does not just align with the wraparound principles but actually reinforces them. With respect to research evidence, this option has obvious weaknesses, with only one randomized trial (Weisz et al., 2012) and a statewide open trial (Daleiden et al., 2006) showing the promise of modular protocols for implementing evidence-based practices. The strengths of this option are more positive provider attitudes (Borntreger et al., 2009), greater compatibility with organizational and system contexts (Palinkas et al., 2009), and a more collaborative and individualized approach that holds promise for enhancing critical aspects of the wraparound process, such as team-based planning, creative brainstorming, and purposeful use of natural and community supports (Chorpita et al., 2008, 2011; Daleiden & Chorpita, 2005).

What would this clinical model look like? As described above, the knowledge management framework of MAP provides an appealing method for enhancing wraparound with empirically supported practices. The pursuit of more effective wraparound via application of the knowledge management framework of MAP is supported not only by the distillation of research, but by the translation of this information into a system (PracticeWise) that can be used to support the workforce to mobilize this information in ways that fit with workers’ roles in helping youths and families. Options for how this would be achieved, however, remain to be developed and tested. As one option, the MAP approach could simply be used by clinicians who will therefore become more effective at treating children and youths as well as more effective members of wraparound teams. Or “Wrap and MAP” could be administered in a coordinated way whereby wraparound staff and teams are themselves trained to use the MAP concepts and tools to better manage available knowledge (research evidence as well as local and child-specific evidence) to generate more and better options for the plan of care.

The PracticeWise system supports training, coaching, and certification of a range of roles, including therapists, agency supervisors, and professionals who can train others in their agency or system on use of the system (PracticeWise, 2010). The developers of MAP and the co-directors of the National Wraparound Initiative (NWI; www.nwi.pdx.edu) are currently working to develop and test a clear approach to training and supporting the wraparound workforce on the knowledge management framework promoted by MAP, and the tools of PracticeWise, while maintaining adherence to the principles and practices of wraparound teamwork.

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Are outcomes enhanced?

Information about patient progress in supervision:


Cultural exchange and the implementation of evidence-based practices: T wo case studies. 


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Non-Suicidal Self-Injury in Adolescent and Young Adult Populations: A Look at the Literature

by Heidi Beckenbach*

Rates of non-suicidal self-injury (NSSI) are increasing, especially in the adolescent and college age populations (Nock & Favazza, 2009). Statistics (as cited in Nock & Favazza, 2009, p. 15) show that those reporting a lifetime history of NSSI include:

• Approximately 7.7% of preadolescents (Hilt et al., 2008);
• 13.9% to 21.4% of adolescents and young adults (Muehlenkamp & Gutierrez, 2004; Ross & Heath, 2002; Zoroglu et al., 2003); and
• 4% of adults (Briere & Gil, 1998; Kloner et al., 2003).

Jacobson and Gould (2007; as cited in Healey et al., 2010) report that the typical age of onset of NSSI behaviors occurs between the ages of 12 and 14.

Due to this increase in NSSI behaviors in the adolescent and young adult populations, it is important that mental health providers become knowledgeable about the characteristics often associated with this behavior. This article reviews the literature in order to educate providers about NSSI, specifically discussing NSSI:

• Definitions/criteria;
• Types;
• Risk factors;
• Functions;
• Assessment needs; and
• Treatment options.

It also seeks to inform those working with this population about ethical and legal issues and how to safeguard against ethical/legal breaches.

Definition of NSSI

The term “non-suicidal self-injury” has also been referred to as “parasuicide,” “self-mutilation,” “deliberate self-harm,” “self-cutting,” etc. Within the research and literature on the subject, there are also varying definitions as to what self-injury is.

Kakhnovets and colleagues (2010, p. 309) define self-injurious behavior (SIB) as: any behavior that seeks out pain and/or blood on one’s own body tissue without conscious suicidal intent.

Simeon, Favazza, and Hollander (2001; as cited in Healey et al., 2010, p. 324) refer to NSSI as:

the deliberate, socially unacceptable destruction of one’s own body tissue without intent to die.

The numerous names and variations in definitions of NSSI have held back communication and research among professionals, creating a lack of cohesion within the field. Currently, NSSI is being proposed for inclusion in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V). Wilkinson & Goodyer (2011, p. 104) support the inclusion and feel it will be helpful in improving communication, in reducing problems due to the lack of diagnostic specificity, and in improving research on etiology, treatment, and outcome. Due to the positive implications and possible future inclusion for an NSSI disorder in the DSM-V, this paper will base its definition for NSSI on the new criteria exhibited in Figure 1, as proposed by the American Psychiatric Association (2010).

Types of NSSI

Based on the new proposed definition of NSSI, examples of client behaviors that may fit within NSSI criteria include:

• Cutting;
• Lacerating;
• Burning;
• Stabbing;
• Skin picking;
• Excessive rubbing;
• Scratching;
• Hitting;
• Interfering with wound healing; and
• Inserting objects under the skin.

NSSI behaviors do not include socially sanctioned forms of bodily alterations such as tattooing and piercing.

Risk Factors Associated With NSSI

Healey et al. (2010, p. 325) define risk factors as “those behaviors, symptoms, or diagnoses empirically associated with self-injury with regard to client actions as well as clinical judgment and perceptions.” Mental health providers need to be aware of risk factors associated with NSSI because they may act as clues for purpose, motiva-

NSSI is described as “the deliberate, socially unacceptable destruction of one’s own body tissue without intent to die.”

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Figure 1: Proposed Revision for DSM-V

<table>
<thead>
<tr>
<th>V 01 Non-Suicidal Self-Injury</th>
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<tbody>
<tr>
<td>A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body, of a sort likely to induce bleeding or bruising or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), for purposes not socially sanctioned (e.g., body piercing, tattooing, etc.), but performed with the expectation that the injury will lead to only minor or moderate physical harm. The absence of suicidal intent is either reported by the patient or can be inferred by frequent use of methods that the patient knows, by experience, not to have lethal potential. (When uncertain, code with NOS 2.) The behavior is not of a common and trivial nature, such as picking at a wound or nail biting.</td>
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<tr>
<td>B. The intentional injury is associated with at least 2 of the following:</td>
</tr>
<tr>
<td>1. Negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.</td>
</tr>
<tr>
<td>2. Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to resist.</td>
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<td>3. The urge to engage in self-injury occurs frequently, although it might not be acted upon.</td>
</tr>
<tr>
<td>4. The activity is engaged in with a purpose; this might be relief from a negative feeling/cognitive state or interpersonal difficulty or induction of a positive feeling state. The patient anticipates these will occur either during or immediately following the self-injury.</td>
</tr>
<tr>
<td>C. The behavior and its consequences cause clinically significant distress or impairment in interpersonal, academic, or other important areas of functioning.</td>
</tr>
<tr>
<td>D. The behavior does not occur exclusively during states of psychosis, delirium, or intoxication. In individuals with a developmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior cannot be accounted for by another mental or medical disorder (i.e., psychotic disorder, pervasive developmental disorder, mental retardation, Lesch-Nyhan Syndrome).</td>
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Non-Suicidal Self-Injury Disorder, Not Otherwise Specified (NOS), Type 1, Subthreshold

The patient meets all criteria for NSSI disorder but has injured himself or herself fewer than 5 times in the past 12 months. This can include individuals who, despite a low frequency of behavior, frequently think about performing the act.

Non-Suicidal Self-Injury Disorder, Not Otherwise Specified (NOS), Type 2, Intent Uncertain

The patient meets criteria for NSSI but insists that in addition to thoughts expressed in B4, he/she also intended to commit suicide.


- High levels of negative affect;
- Hostility; and
- Feelings of dysphoria and loneliness (Bennum & Phil, 1983; Darche, 1990; Favazza, 1998; Guertin et al., 2001; Linehan, 1993, as cited in Kakhnovets et al., 2010).

Common symptoms of individuals who engage in NSSI are:
- Somatic problems;
- Emotional inexpressivity; and
- Distress resulting from trauma (Gratz, 2004; Hilt et al., 2008; Marx & Sloan, 2002; as cited in Healey et al., 2010, p. 325).

Results from Kerr & Muehlenkamp’s (2010) study on NSSI and female college students indicate that negative emotional lability, unstable relationships, and a poor or distorted sense of identity may be core symptoms for this population. Because self-concept of self-injurers is a unique risk factor for this population (Kerr & Muehlenkamp, 2010, p. 299), treatment should be directed toward techniques that help focus on and combat distorted cognitions of the self.

Functions Behind NSSI Expression

In order to help NSSI clients, providers should assess the function behind expressions of the behavior. If we understand the reasons behind NSSI behavior, we can often substitute more appropriate coping skills for the behavior to obtain similar results for the client. Briere & Gil (1998; as cited in Kakhnovets et al., 2010, p. 311) found that the most common reasons for using NSSI behavior are to:
- Self-punish;
- Distract from painful feelings;
- Reduce anger; and
- Feel a sense of self-control.

NSSI is also linked to a need for emotional regulation and control of present experiences. Gratz (2007; as cited in Healey et al., 2010, p. 325) believes that individuals may use NSSI to “internally regulate emotions by using the behavior to stop, start, or limit feelings.”

Proposed Models of NSSI Functionality

In an effort to understand the functions behind NSSI behaviors, many leaders in the field have developed models of NSSI functionality.

The Four-Function Model. Nock & Prinstein (2004, 2005; as cited in Nock & Cha, 2009, pp. 66–67) proposed a four-function model (FFM) of NSSI to help explain reasons for the behavior. The model includes functions that differ along two dichotomous dimensions—positive reinforcement and negative reinforcement—as well as contingencies that can be automatic (i.e., intrapersonal) or social (i.e., interpersonal). Figure 2 provides a schematic representation of this model:
- The first function proposed in the model is automatic negative reinforcement (ANR). This occurs when NSSI is engaged in order to escape from a negative affective or cognitive state.
- The second function is automatic positive reinforcement (APR). In APR, NSSI is used to generate a feeling (often used to counteract feelings of numbness).
- The third function is social positive reinforcement (SPR). In SPR, NSSI is used to get attention or to manipulate resources in the environment.
- The fourth function refers to social negative reinforcement (SNR). In SNR, NSSI is used to remove an interpersonal demand of some kind.

The Biological Model. In addition to functional models based on automatic/social and positive/negative reinforcements, there are biological models that help to explain NSSI. Stanley and colleagues (2008) have proposed a homeostasis model of self-injury, as shown in Figure 3, which adds the influence of biological factors as another reason why individuals engage in NSSI. This biological model proposes that individuals who self-injure may have chronically lower levels of endogenous opioids, resulting from chronic and severe
trauma. These severe traumas may have resulted in a permanent deficiency state or habituation to higher levels of endogenous opioids. Thus, engaging in self-injury may be used as an attempt to restore levels of endogenous opioids to a homeostatic level. Other biological components that may have a hand in the expression of NSSI are dysregulations in serotogenic neurotransmission, abnormalities in the dopaminergic system, and abnormalities in the hypothalamic-pituitary-adrenal (HPA) stress system.

The Biopsychosocial Model for Self-Injury. Another model, which incorporates five different functions and motivations for NSSI behavior is Walsh’s (2006) biopsychosocial model for self-injury. In this model, NSSI functionality is looked at with regard to five interrelated dimensions:

1. Environmental;
2. Biological;
3. Cognitive;
4. Affective; and
5. Behavioral.

Walsh (2006, p. 57) believes that “for the large majority of individuals, all five dimensions play a role in the emergence and recurrence of self-injury.” These five different dimensions and examples of each are illustrated in Figure 4. The roles that the five different dimensions play for each client vary; because of this variation, providers have to assess and treat the needs of each client individually.

Assessment Needs

The three models of NSSI discussed in the previous section (four-function model, biological model, and biopsychosocial model) explain what aspects of an individual’s life may influence, trigger, and maintain NSSI behavior. These models also serve as helpful reminders of what is important to consider in treating this population—specifically, functions for engaging in NSSI, which include factors related to biology, environment, social arenas, cognitive patterns, affective dysregulation, and behavioral components.

Another factor that should be assessed is where on the body the client self-injures. The two most common areas for self-injury are the arms and the legs. Walsh (2006) feels that the body areas most clients choose for NSSI involve a dual purpose of both symbolic meaning and practical utility. It is important to continually assess where on the body NSSI occurs because when a client shifts to another area of the body, it can indicate a psychological shift (e.g., exacerbation of distress and trauma. These severe traumas may have resulted in a permanent deficiency state or habituation to higher levels of endogenous opioids. Thus, engaging in self-injury may be used as an attempt to restore levels of endogenous opioids to a homeostatic level. Other biological components that may have a hand in the expression of NSSI are dysregulations in serotogenic neurotransmission, abnormalities in the dopaminergic system, and abnormalities in the hypothalamic-pituitary-adrenal (HPA) stress system.

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possibly an emergency requiring inpatient care; Walsh, 2006, p. 88). Walsh’s experiences with this population have led him to believe that NSSI on four specific areas of the body can be a cause for special concern—that is, face, eyes, breast (in females), and genitals (in either gender). He feels that:

In general, when persons injure the face, eyes, breasts, or genitals, an emergency psychiatric evaluation should be considered. The level of distress accompanying such behavior is often considerable, meriting protective intervention and close supervision (Walsh, 2006, p. 89).

Whitlock (2010) has developed a list of key components to assess if NSSI is detected. This needs for assessment list includes:

- Immediate risk of infection;
- Presence of comorbid mental health conditions; and
- The extent of informal and formal support systems for the client.

Assessment of NSSI severity is also necessary because:

In general, lifetime frequency of NSSI in combination with the number of methods used and the likelihood that the methods used will cause severe tissue damage (i.e., cutting, burning, bone breaking, etc.) is directly and positively correlated with risk of other adverse outcomes, such as suicide-related behaviors and global psychological distress. High severity cases (high lifetime frequency, injury in the past 6 months, use of forms likely to inflict high tissue damage, and/or use of multiple forms) warrant thorough assessment of existing therapeutic support and referral if found inadequate or lacking (Whitlock, 2010, p. 3).

Hoffman & Kress (2010, p. 343–344) have also created a list of assessment recommendations with risk management considerations included. Like Whitlock, they advocate for severity assessment, adding that the counselor should decipher when the behavior began, whether the client has ever abstained from the behavior, and its current frequency. Other concerns include:

- Whether the client is sharing cutting tools;
- If he or she is caring for wounds properly;
- If there have been medical complications as a result of NSSI;
- If the client has developed a higher pain tolerance;
- Whether others are aware of the behavior; and
- If the client is engaging in other high-risk behaviors.

### Treatment Options

Based on risk factors, functions, motivations, and research, the current and most promising treatment for NSSI is cognitively and behaviorally based. According to Nock, Prinstein, and Serba (2010, p. 49), NSSI is typically conceptualized as serving an affect-regulation function. Their study found that NSSI also serves a cognitive regulation function because it is often used to distract individuals from unwanted negative thoughts. Because the functions behind NSSI are often largely for affect and cognitive regulation, the combination of cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) techniques may be helpful in reducing NSSI behavior.

In CBT, Beck (1995, p. 1) explains that: [The cognitive model] proposes that distorted or dysfunctional thinking (which influences the patient’s mood and behavior) is common to all psychological disturbances. Realistic evaluation and modification of thinking produce an improvement in mood and behavior.

This theory can easily be applied to NSSI clients because many issues related to their behavior are associated with negative thoughts and beliefs, as well as with faulty coping skills. Kerr and Muehlenkamp (2010, pp. 301–302), in their study of self-injuring female college students, proposed that interventions focusing on modifying cognitive distortions, especially ones related to self-concept, would be a valuable treatment target. Uses of CBT interventions such as thought records, thought stopping, identification of triggers, and psychoeducation may be helpful in identifying and modifying client’s distortions about themselves and NSSI behaviors.
DBT was originally developed by Marsha M. Linehan, Ph.D., as a treatment for suicidal patients, specifically those with borderline personality disorders. Koerner and Dimeff (2007, pp. 1–9) explain that DBT considers suicidal behavior to be a form of maladaptive problem solving and uses CBT techniques as well as skills training and validation to reduce negative behaviors, thoughts, and feelings. DBT skills-training modules include emotion-regulation skills, distress-tolerance skills, interpersonal-effectiveness skills, and mindfulness skills. All of these interventions can prove helpful when working with NSSI clients because they focus on affect regulation for change, and affect is a main background function for many clients who self-injure.

Most research on NSSI treatment is on individual therapy, but group therapy has also shown promising results in working with adolescents who engage in NSSI, especially within a multimodal approach. Burns et al. (2005; as cited in Wilkinson, 2011, pp. 124–125) reviewed 10 different studies that involved a comparison of treatment modalities for adolescents (e.g., psychotherapy, intensive outreach, family problem solving) The evidence pointed to group therapy as the only specific therapy relevant to NSSI, with the potential to provide immediate and long-term benefits. Group therapy as the only specific therapy relevant to NSSI, considering social contagion and the possibility of social contagion, self-injury contagion is defined as when (1) acts of self-injury occur in two or more persons within the same group within 24 hours, or (2) acts of self-injury occur within a group of statistically significant clusters (Walsh & Rosen, 1985; as cited in Richardson et al., 2012). Due to the risk of self-injury contagion, Richardson et al. (2012, p. 129) created a list of prevention methods based on the current literature; these are:

1. Building clinical understanding through training and research on how social contagion may affect adolescents;
2. Working with clients who engage in NSSI to help them become aware of the possibility of social contagion;
3. Asking clients who self-injure to cover up scars, wounds, and bandages, which can be triggering;
4. Prohibiting graphic detail about NSSI when group therapy begins;
5. Incorporating strengths-based strategies into treatment to encourage healthy coping behaviors;
6. Assessing client Internet use, especially exposure to self-injury imagery;
7. Determining the appropriate level of treatment and avoiding unnecessary hospitalizations that may trigger NSSI in vulnerable clients; and
8. Instructing group members to share stories of healing and healthy coping behaviors to both decrease the opportunity for contagion and inspire altruistic motives.

### Ethical/Legal Issues

Currently, the law does not address the duty to protect clients who engage in NSSI, as it does with regard to suicidal behaviors (Vesper, 1996; Walsh 2008; as cited in Hoffman & Kress, 2010, p. 346). Even though it is not specifically addressed, it is still important to assess for suicide risk throughout the course of treatment when working with NSSI clients. The relation between self-injury, suicidal ideation, and suicide is complex. Kerr & Muehlenkamp (2010, p. 302) note that there is a significantly higher prevalence of suicidality among women with a history of NSSI than among men and suggest that NSSI may be a risk factor for suicide, especially for someone with a co-occurring disorder. Hoffman & Kress (2010, p. 346) discuss how:

Individuals may be more capable of engaging in lethal suicide attempts because of the history of SI [self-injury]; engaging in SI may desensitize them to the act of physical harm and possibly suicide. It is important to note, however, that suicidal ideation is more prevalent among those who have a history of suicide attempts than those who engage in SI alone.

Simeon & Favazza (2001; as cited in Hoffman & Kress, 2010, p. 346) found that it is possible for an individual to have suicidal ideation and engage in NSSI but not be considered suicidal because he/she uses self-injury as a means of coping with the ideation. The research on the complex relationship between NSSI, suicidal ideation, and suicide suggests that throughout assessment and treatment, providers must always consider the risk factors involved in working with this population. Figure 5 provides a decision tree that can be used in assessing for risk.

Treating NSSI adolescents can be very tricky because of the age of the client and the legal versus ethical disparities with regard to breaching confidentiality. Causing harm to oneself or to someone else is one of the main limitations to confidentiality, and NSSI usually falls into this category. The problem is that this breach of confidentiality may trigger the client to shut down or further act out, causing additional harm to the client. The American Counseling

### Figure 5: Self-Injury Risk Assessment and Evaluation

<table>
<thead>
<tr>
<th>Suicide Risk Factors</th>
<th>No: Lower risk; continue to assess</th>
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<td></td>
<td>• Write a suicide prevention plan and resource tree;</td>
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<td>• Hospitalization if needed.</td>
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<td>No: Lower risk; continue to assess</td>
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Association (2005, p. 8) Code of Ethics code B5.2.b. Responsibility to Parents and Legal Guardians states that:

Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship. . . . Counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.

This code aids providers in their decision-making process because it promotes an inclusion of the adolescent in the process. Best practice in this situation involves a cooperative approach between client and counselor in deciding how to disclose this behavior to their caregivers. It is hoped that the cooperation and the client’s ability to actively engage in his or her own decision-making process will alleviate the negativity associated with the counselor’s need to break confidentiality. When in doubt, it is important to remember that anytime a counselor does decide to withhold information from a parent, the counselor must assume responsibility if that withheld information later leads to injuries for the client (Remley & Herlihy, 2010).

**Summary and Recommendations**

The current elevated trend of NSSI in adolescent and young adult populations is alarming. In order to help individuals suffering with NSSI, it is important to tailor assessment and treatment to the specific needs of the clients. When working with clients who engage in NSSI, providers should be well informed about the behavior—specifically, the types, functions, methods, assessment needs, treatment options, and legal/ethical issues that may arise. The more prepared mental health worker are, the better they will be able to guide their clients toward recovery. It is hoped that in the future, more research can be performed on NSSI adolescents, their specific needs, and the best ways providers can facilitate positive growth in treatment.

**References**


Clinical Use of the DSM-5 in a Multi-Method Assessment of Native American Familial Adaptation and Resiliency

by Ronn Johnson and Max Edgar*

A New Body of Knowledge

Logan Wright, co-founder of the Society of Pediatric Psychology and the first Native American president of the American Psychological Association, authored a seminal paper on the role of the pediatric psychologist in 1967. His forceful recommendations for the future of pediatric psychology involved the “construction of a new body of knowledge.” One such body of knowledge would be the inclusion of Native Americans in studies of adaptation and resiliency using a multi-method family assessment including the Diagnostic and Statistical Manual of Mental Disorders (DSM). Even more than 30 years later, a search of PsychINFO and MEDLINE databases from 1950 to December 2008 reveals fewer than 20 investigations examining treatment of African-American, Asian-American, or Hispanic/Latino populations, and virtually nothing on Native Americans or children.

Few groups have had to reconstruct themselves in response to multigenerational oppression and trauma as frequently as have Native Americans. Violence in the form of genocide, health crises as byproducts of contact with Europeans, forced assimilation and mandatory attendance in boarding schools, and involuntary relocation of tribal populations has resulted in a loss of many Native American cultures and customs (Duran & Duran, 1995; Duran et al., 1998; Fast, 2002; Walters et al., 2003; Zahran et al., 2004). In addition, Native American and Native Alaskan communities continue to experience discrimination and disempowerment in interactions with the dominant cultural group (Morissette, 1994). In response to these experiences, Native Americans have developed important family adaptation and resiliency (AR) factors. These factors can be understood diagnostically through the structured clinical judgment making framework of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR, APA 2000). Just as there are levels of psychopathology, there are levels of adaptation and resiliency within the family. For Native American families, diagnostic assessment should assume the existence of an underlying culturally relevant coping system specific to Native American families operating in the aftermath of traumatic events. The family may display a need to maintain its culture in spite of adversity stemming from historical trauma. The same history also provides clinical assessment clues that can be instrumental in gaining a clearer cultural understanding of the dynamics in the family (Gone, 2009).

Using the DSM to Assess Positive Adaptation and Resiliency Factors in Native American Families

Wright established a foundation for the integration of the DSM into a broader multi-method assessment when working with Native Americans families. As he points out, culturally appropriate coping mechanisms, adaptations, and resiliency apply specifically to Native American families. According to Wright (1967):

> For every major Norwegian or German family, there is a parallel Native American family. To the extent that the DSM is useful to the former, it should be even more useful to the latter, since the same DSM diagnostic categories represent actual effects in the latter, even though the cultural meanings of those effects may be quite different. The cultural meanings of the same DSM categories may be quite different in White and American Indian families. The fact is that the DSM is probably no better place than the pediatric setting . . . to fill the gaps in knowledge regarding normal personality and positive mental health.

In short, the DSM can be utilized beyond the usual pathology-based schema to serve as a strengths-based tool for assessment. From a practitioner’s standpoint, any current mental-health-related problems in a family may be accessed through a culturally responsive prism. In this case, AR factors are relevant for assessment during clinical interviews with Native American families. This assessment approach draws upon the culturally distinct examples of adaptation and resiliency originating from previous generations of Native Americans. Given the full scope of the diagnostic process, a strengths-based assessment approach must also identify effective psychocultural resources employed by clients (Nichols & Schwartz, 2000; Walsh, 2002).

When employing the DSM in a multi-method assessment of Native American families, it should be noted that Axis I includes clinical disorders as well as “Other Conditions That May Be a Focus of Clinical Attention” (APA 2000). AR factors meet the criteria of “other conditions” of clinical attention because they are culturally specific to Native Americans and other diverse ethnoracial groups. According to the DSM, normal variations in a Native American family’s frame of reference can be

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misjudged by clinicians unfamiliar with the subtleties of the cultural group. An assessment in this case may be further enhanced by relying on Native American beliefs, practices, views of self, communication styles, and adaptive coping mechanisms (APA, 2000).

Practitioners assessing families may determine how the use of oral history and expressions of family adaptation and resiliency are communicated from one generation to the next. A rich oral history has been an adaptive source of strength to Native Americans by affirming the tribe through the retelling of stories. These stories act to instill hope through cultural affirmation (McGoldrick et al., 1982; Sue & Sue, 2008).

The stories passed from generation to generation are relationship lessons that emphasize respect for the land and other creations (animals, earth, and sky) as well as sense, the Ghost Dance served as a way to garner some meaning out of the adversity. Similarly, Native American symbols and motifs act as sources of history marked by adaptation and resiliency over multiple generations (Evensen, 1998).

When performing a cultural AR assessment, the psychologist may look to the DSM to provide relevant guidance. For example, the use of the multi-axial system promotes a comprehensive and systematic evaluation that devotes attention to psychosocial, environmental, and other levels of functioning that might otherwise be “overlooked if the focus were on assessing a single presenting problem” (APA, 2000). The assertion is that AR factors are consistent with the intent of the full scope of the assessment using the DSM. The complexity of the clinical issues prevents a detailed discussion in the DSM of exactly what each AR factors that are relevant for assessment, should include examples of a wide range of American families that can be understood differences found in diverse Native American families (Alcántara & Gone 2007; Belcourt-Dittloff & Stewart, 2000). The longevity of a rich Native American ancestry provides Native Americans with a cultural claim to other individuals and an immediate connectedness through the dynastic ethos. Relationships are valued in the Native American culture, and this kinship narrative is passed on from generation to generation (Weaver & White 1997). This moral compass, passed on by tribal elders, has a tendency to promote growth and continuity in the face of adversity. The AR factors from the family’s past can be relived and adapted to present-day circumstances.

AR factors are also manifested and observed in the Native American values of collectivism, sharing, and spirituality. Of course, this connectedness depends on the degree to which the individual embraces the cultural, core AR factors (Sue & Sue, 2008).

Native American women have historically fulfilled a variety of roles critical to adaptation and resiliency in the family. Although not much is known about the role of Native American women from a family research standpoint, documented history suggests that Native American women represent a lesser known AR factor. Some of their roles are in the private or domestic female spheres of childbearing, child rearing, and food preparation, and others are in the typically male spheres of politics, diplomacy, war, and trade.

The significance of the family in native political systems and the recurring, multi-generational need to reassemble the family after wars and incursions by Europeans and other tribes, meant that Native American women had to reconstruct the family following adversity. Recovery and redefinition are the family norm among Native Americans, and Native American women function as a powerful AR factor, in which they put hardship into a context required for moving past adversity (Shoemaker, 1995).

Women’s role as an important AR factor for any mental-health-related event is unmistakable. Their ability to tap into the communal resources to extend or include

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the elements of nature and the earth. Native Americans respect the seasons, which yield either blessings or destruction. Disregard for the elements, such as water, could result in drowning by the water spirits. Disrespect for the wind could result in being carried away by the storm (McGoldrick et al., 1982).

Adaptive cultural distinctions facilitate cooperation as well as open emotional sharing among families. A resilient sense of connectedness with tradition is perpetuated by the family and punctuated by efforts to maintain or help the culture thrive under adverse circumstances. For example, when the Dawes Act attempted to constrain the Lakota language, the adaptive response was a multigenerational pressure to teach children the language (Stremlau, 2005).

In another powerful instance, the 1890 Wounded Knee Massacre resulted in the Ghost Dance movement as a collaborative and communal form of problem solving. A Piute named Wovoka reported a vision that the “Old Earth” would end and a new one emerge in which Native Americans could live as they had before the coming of Europeans. Wovoka stressed that to transcend the perceived destruction, the Ghost Dance must be performed. In an AR of those culturally relevant elements might be for Native American families or other diverse groups. However, cultural competency implies that a pediatric psychologist would possess the skill set required for applying a relevant biopsychosocial model within settings where they would encounter Native American families (Alcántara & Gone 2007; Belcourt-Dittloff & Stewart, 2000).

A diagnostic connection of the Native American family to these AR factors is critical because they have allowed Native American families to respond to adversity in the past. The AR factors highlighted here are not listed in order of importance or priority. Nor should it be assumed that the differences found in diverse Native American tribes can all somehow be accounted for here.

A review of the AR factors in Native American families that can be understood through the use of the DSM is essential and should include examples of a wide range of AR factors that are relevant for assessment, such as:

- Patterns of kinship and a rich ancestry;
- Collective values;
- A strong female presence; and
- The desire to pass on cultural attributes.

Native American “family” culture includes immediate and distant relatives, as well as individuals who are not biologically connected. The AR factor must also be anchored to unique individual-family experiences that reflect a healthy response to adverse circumstances (Belcourt-Dittloff & Stewart, 2000). The longevity of a rich Native American ancestry provides Native Americans with a cultural claim to other individuals and an immediate connectedness through the dynastic ethos. Relationships are valued in the Native American culture, and this kinship narrative is passed on from generation to generation (Weaver & White 1997). This moral compass, passed on by tribal elders, has a tendency to promote growth and continuity in the face of adversity. The AR factors from the family’s past can be relived and adapted to present-day circumstances.

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Women’s role as an important AR factor for any mental-health-related event is unmistakable. Their ability to tap into the communal resources to extend or include
more family members beyond blood kin results in more sources of social, emotional, and material support. The result has been an ability to achieve a degree of community mastery over adverse circumstances (Hofffoll et al., 2002).

Maintaining the relational networks and collective interdependence of Native American culture should be supported. Practitioners may form a clinical alliance with a medicine person or tribal healer who has some history of assisting with the management of distressing events. An assessment of these factors has broader implications for intervention, particularly with regard to enhancing client compliance with the required medical/psychological regimen (Roubidoux, 2005).

The assessment contributions of the DSM can be yoked to Native American healing in a manner that transcends traditional and relevant clinical issues (McCabe, 2007; Wright, 1967). A multi-method assessment assumes a range of interlocking cultural, clinical, physiological, and psychosocial environmental components. The DSM’s function in this effort is to provide an assessment framework for structured clinical judgment resulting in a cogent case conceptualization serving as an evidence-based treatment source for Native American families (Goodheart et al., 2006).

Cultural Applications of the DSM-5

The DSM has a history of difficulty in its use with diverse groups (Johnson, 2005). It is, in effect, an evidence-based system for categorizing mental disorders based on mental and behavioral phenomena. Yet, the features of these phenomena are not entirely universal and are always significantly culture bound (APA, 2000).

In order for the DSM to accurately identify relevant AR factors in Native American families, adjustments must be made to the way in which the DSM is applied. Such adjustments are supported by APA ethical codes and various ethnic minority practice guidelines. Current efforts to integrate the DSM-5 with the International Classification of Diseases (ICD-11) have added a scientifically based motivation for making cultural considerations more explicit within the structure of the manual.

It is advisable for the practitioner to exercise informed judgments when working with Native American families (Meehl, 1959). Anchoring the DSM to AR factors as part of a multi-method assessment relevant for Native American families represents the skill set needed to obtain cross-cultural competencies with this population. To avoid possible assessment errors, clinicians must become aware of the cultural portals in the DSM and the implications for activating AR factors.

In addition to providing a common clinical language that can be used among practitioners and other professionals when working with diverse cultural groups, the DSM has several culturally relevant portals. For instance, Appendix I of the DSM includes an Outline for Cultural Formulation, which assists the practitioner in evaluating the impact of an individual’s cultural context on diagnosis and treatment. The language used in the DSM-5 also allows the pediatric psychologist to provide psycho-culturally relevant descriptions of families in an empirically defensible and systematic format consistent with the focus of clinical attention (Kazdin, 2006).

Some have suggested that the DSM should be modified to include a separate Axis for relational issues. However, a family relational assessment with the DSM contains too many caveats to justify its use (Yingling et al., 1998). Such augmentation would require a massive overhaul of the DSM and significant research to support diagnostic recommendations stemming from that effort (LeBow & Gordon, 2006).

The approach recommended here takes the existing culturally responsive portals contained in the DSM-5 and uses them as a multi-axial source as part of a multi-method Native American family assessment of AR factor. An examination of the following five DSM-5 axes reveals culturally useful diagnostic information.

Axis I: Clinical Disorders and Other Conditions That May Be the Focus of Clinical Attention—The V Codes

The DSM offers several culturally relevant options on Axis I, which identifies the “pathology” related to the reason for the clinical presentation. However, by itself, or even if expanded to include other diagnostic categories, Axis I still may not be sufficient to capture other areas that require clinical attention. Native American families have many AR factors that could be the focus of clinical attention and management (APA, 2000; Gibbs & Huang, 1989).

The diagnostic criteria of a particular disorder can be culturally augmented by using V codes that point toward family assessment issues. V codes are categories of behavioral and cultural relevance that are not due to a mental disorder but that nonetheless warrant clinical attention. The V code allows a more refined clinical focus for Native American family functioning that
expectations of an individual’s culture, leading to impairment (APA, 2000). The psychologist is directed to obtain additional information about a client’s cultural background. In addition, if a personality disorder can be exacerbated by family circumstances, then the reverse is probably also true. In such a case, factors relevant to Native Americans may allow some clinical feature of personality disorders to remit through AR factors if they are properly assessed and activated.

Using Axis II may also prompt a culturally responsive clinician to assess the full range of issues confronting diverse Native American populations such as reservation versus urban Indians. The DSM actually encourages the use of supplementary information from other informants that could include family as well as other prominent personality features that further enhance culturally related treatment communications. Currently, the individual is diagnosable, but the family is not diagnosable through widely accepted mental health entities (APA, 2000).

**Axis III: General Medical Conditions**

According to the DSM:

[Axis III is designed] for reporting current general medical conditions that are potentially relevant to the understanding and management of the individual’s mental disorder.

The pediatric psychologist should be aware of the connections between mind, body, and spirit that must be identified on Axis III for Native Americans, because they function as a basis for cultural understanding and treatment (APA, 2000; Sue & Sue, 2008; Hays & Iwamasa, 2006). For instance, collaboration with native healers could be used to relieve grief reactions (McGoldrick et al., 1982). Axis III promotes communication among various health care service providers (APA, 2000).

**Axis IV: Psychosocial and Environmental Problems**

Currently, the DSM-IV-TR lists nine psychosocial and environmental (PE) problems. The multi-axial evaluation report form contained in the DSM allows a practitioner to specify exactly how AR factors or other culturally relevant factors might be the focus of clinical attention (APA, 2000). The current format of the nine DSM PE factors also allows an examiner to assess for culturally relevant information about the presenting problem using family and other sources. The process of data gathering PE variables could be instrumental in gaining the extended family support needed during the treatment phase. The current list of PE variables in the DSM-IV-TR should be expanded to allow for a more culturally comprehensive assessment on Axis V.

Several PE variables may be operating in Native American families (Alcántara & Gone 2007). Beiser (1981) recommends a multi-axial model for evaluating Native American children that takes into account culture, strengths, age-appropriate and developmental factors, as well as social environment. For instance, the multigenerational impact of coercive cultural assimilation is relevant for family assessment (Gone, 2009). The same assessment is a prerequisite for operationalizing AR factors with Native American families.

**Axis V: Global Assessment of Functioning**

The multigenerational transmission of historical trauma provides a rich source for assessing AR factors in Native American families (Gone, 2009). These AR factors occur on a continuum that may be assessed using Axis V of the DSM-IV-TR. Axis V allows for the most direct dimensionally based assessment of AR factors associated with diverse ethnoracial groups. This axis is used to report a pediatric psychologist’s structured clinical judgment of the overall level of family functioning (APA, 2000).

The Global Assessment of Functioning (GAF) is particularly relevant for Native American families. Based on the current structure of the DSM-IV-TR, the GAF has the potential for yielding one of the best sources of diagnostic and treatment data including adaptation and resiliency within Native American families. The relational assessment has long been recognized within the field of family therapy.

There are five primary reasons for using the GAF scale as a culturally responsive diagnostic option with Native American families:

1. The scale allows for assessment of optimal family functioning and adaptability.
2. The scale permits a culturally relevant gauge over time of a family’s flexibility in response to various events or psychological demands, which is one index of resiliency.
3. Communication and clinical decision making can be highlighted as they pertain to optimistic family functioning.
4. The scale has the potential of providing a more comprehensive discussion of a Native American family consistent with a multi-method assessment. In some respects, the adjusted systematic use of this axis creates more confidence in the reliability of the assessment (Dana & Back, 1983).
5. The GAF scale prompts examination of boundaries, subsystems, and sexual function within the family that are also vital for understanding AR factors. For instance, cultural coping strategies may be identified because this axis, more than others, requires a systematic approach during the assessment that by default is expected to capture culturally relevant data (Kazdin, 2006). Clearly, other family functioning assessment tools outside the DSM can be used to confirm the factors highlighted through Axis V.

**The Practitioner’s Self-Reflective Cross-Cultural Transformation Assessment**

The cultural competency of a practitioner is a primary factor in assessments within the family context. Before embarking on an assessment, a culturally responsive self-examination is required. The specialization of working with youth developed out of an awareness that mental or physical disorders could not be treated in isolation or in the absence of culture (Roberts et al., 2003; Routh et al., 1983). The Native American family can be very diverse, including members with multiple identities, such as mixed black Indians, mixed tribal affiliation, and reservation versus urban Indians. The diversity in these families can pose a challenge for pediatric...
Many of the culturally specific elements associated with Native Americans may elicit unintentional reactions, such as a sense of being foreign or less clinically relevant.
References


From the Literature: What’s Hot . . . What’s Not
by Lorraine Dubuisson*

**EBD and MS in Adolescence**

Factors Associated With Emotional and Behavioral Outcomes in Adolescents With Multiple Sclerosis

Till, C., Udler, E., Ghassemi, R., Narayanan, S., Arnold, D.L., & Banwell, B.L.
Multiple Sclerosis Journal

Multiple Sclerosis (MS) is a chronic disease that affects the central nervous system and that worsens over time. This study examines the potential emotional and behavioral consequences of an MS diagnosis before 18 years of age. In addition to the cognitive and physical damage caused by the disease, researchers wondered what impact adapting to a chronic and debilitating illness might have on the emotional health of adolescents. Thirty-one children being treated for MS at the Toronto Pediatric Demyelinating Disease Clinic at the Hospital for Sick Children and their parents filled out the Behavioral Assessment System for Children–2nd Edition (BASC-2). The study states that:

- Our results show that parents of youth with MS reported more difficulties related to their child’s mood, adaptive functioning, and attention compared with parents of healthy controls, as well as the adolescent patients themselves.

- Depression and attention problems were reported in the sample, but the study warns that adolescents with MS may routinely underreport anxiety or other issues so as not to be perceived as different from their peers.

**PTSD After Natural Disasters**

Responses Over Time of Child and Adolescent Survivors to the 2008 Wenchuan, China Earthquake

Han, L., Zhang, Y., & Zheng, Y.
Social Behavior and Personality
40:1147–1152, 2012

From Hurricane Katrina to the tsunami of 2004 to the recent nuclear crisis in Japan, large-scale disasters occur on a relatively frequent basis worldwide. This study investigates the aftermath of a severe earthquake that devastated China in 2008. One hundred eighty-eight child and adolescent survivors of the natural disaster were assessed at two weeks and at one year following the earthquake using the Mental Health Scale and the Coping Scale. Many of these children had lost family members and/or their homes in the earthquake. According to the findings, there were gender differences in coping with the natural disaster. For example:

- Boys scored higher than girls in the “felt lonely” and “asking for help” items in the second week, while girls scored higher than boys in the “sensitive,” “depressed,” “self-blaming,” and “rationalization” items one year after the earthquake.

As might be expected, symptoms were most acute immediately following the earthquake, but the study suggests that early interventions and support for a vulnerable population in the aftermath of natural disasters can improve future mental health outcomes.

**Modifications to DSM-V Proposal**

DSM-V Diagnostic Criteria for Bereavement-Related Disorders in Children and Adolescents: Developmental Considerations

Kaplow, J.B., Layne, C.M., Pynoos, R.S., Cohen, J.A., & Lieberman, A.
Psychiatry: Interpersonal & Biological Processes
75:243–266, 2012

Generally speaking, mourning the death of a loved one does not lead to clinical psychiatric problems in youth (although peer suicide and the death of a parent have been linked to major depressive disorder). Bereavement can, however, trigger emotional and behavioral disorders such as depression and separation anxiety:

- Two bereavement-related disorders are proposed for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V): Adjustment Disorder Related to Bereavement, to be located in the main body of the text as an official diagnostic entity; and Bereavement-Related Disorder, including a Traumatic Death Specifier, to be located in the Appendix as an invitation for further research.

The authors of this article propose a list of developmentally informed modifications to the criteria for these disorders based on a review of the literature. They offer age-appropriate modifications to the criteria and highlight the difficulties of quantifying, for example, a “normal” duration of bereavement for a child.

**Negative Peer Contagion**

Examination of Negative Peer Contagion in a Residential Care Setting

Heufner, J.C., & Ringle, J.L.
Journal of Child & Family Studies

Following a literature review of the studies that focus on negative peer contagion as it occurs in juvenile justice, educational, and residential care settings, Heufner and Ringle describe a study they conducted on a group of adolescents admitted to a treatment facility for cognitive behavioral therapy as a consequence of behavioral problems. The literature review reveals a significant and negative correlation between time spent in the juvenile justice system and subsequent criminality. Studies situated in educational settings also found increases in aggression among students participating in after-school programs designed to decrease aggressive behavior. Essentially, the aggressive behavior is magnified in the group setting, presumably because the students negatively influence each other.

Heufner and Ringle’s study explores the potentially negative consequences of residential treatment for adolescents. In particular, they wonder what effects negative peer density (NPD), time spent in the program, and caregiver experience have on behavioral problems exhibited by patients in residential care settings. Their findings suggest that although NPD is not related to an increase in behavioral problems, both time spent in the program and caregiver experience demonstrate strong relationships with behavior. The longer an adolescent remained in treatment and the more experienced his or her caregiver was, the fewer problem behaviors he/she exhibited over
Some of the teenagers, however, reported encountering religious discourse in professional mental health care settings that was unwanted or off-putting.

peer contagion is a likely result; if the opposite is true, problem behaviors decrease.

Role of Religion in Suicide Prevention

Spirituality and Religion in Youth Suicide Attempters’ Trajectories of Mental Health Service Utilization: The Year Before a Suicide Attempt


In this study of 15, primarily female, Canadian teenagers who attempted suicide within the previous two years, researchers scrutinize the role of organized religion and spiritual beliefs on a suicidal youth’s decision to seek help. Previous studies have indicated that religion and spirituality can provide some protective elements to suicidal teens but that not all expressions of religion and spirituality support improve mental health. Within the interviews conducted for this study and the questionnaires administered to participants, three themes emerged:

• Religious community members acted as a bridge, step, or provider to mental health services;
• Religious/spiritual discourses were encountered within services; and
• Many youths reported changes in spirituality/religious beliefs the year before their suicide attempt.

Some of the teenagers reported that fellow parishioners who work in the mental health field gave them advice or referrals or that pastors or youth leaders counseled them on their mental health issues. Some of the teenagers, however, reported encountering religious discourse in professional mental health care settings that was unwanted or off-putting. At least one participant indicated that religious or spiritual discussions can be an important component of the treatment process for youth who have attempted suicide; however, the topic must be handled delicately.

Finally, although some of the teenagers reported that they continued to participate in and feel engaged by religious and spiritual activities, many of them reported that their interest in religion waned in the year before they attempted suicide. These findings together suggest that partnerships between religious communities and mental health care services can lead to earlier identification of suicidal teens as well as improved treatment for them.

Some of the teenagers, however, reported encountering religious discourse in professional mental health care settings that was unwanted or off-putting.

The study found that subjective social status—how youth perceive their socioeconomic status as compared to their peers—is most strongly connected to the development of mental disorders. Results also indicate that parental education is a more significant factor than family income.

Disruptive Behavior Disorder

Disruptive Behavior Disorders: Multidimensional Analysis


Disruptive behavior disorder (DBD) includes oppositional defiant disorder (ODD), conduct disorder (CD), or disruptive behavior disorder not otherwise specified (DBD NOS). DBD generally manifests in early childhood and affects a greater percentage of males than females. This study begins with the hypothesis that lower academic achievement, coming from a family with a history of psychiatric problems and/or divorce, and higher comorbidity will strongly predict the development of DBD. A sample of nearly 2,000 child and adolescent patients was assessed using the Child Symptom Inventory (CSI) and the Wechsler Intelligence Test for Children (WISC-R) in combination with the collection of other data relevant to the study. The authors state that:

According to our hypothesis, the estimated multivariable logistic regression model shows that the variables [of] male sex, comorbidity, repetition of courses, borderline intellectual functioning, and lower educational level of mother have a significant positive effect on increasing the likelihood of DBD, considering the presence of all the proposed variables.

Gender-Specific Interventions for Girls With EBD

Understanding the Experience of Girls With EBD in a Gender-Responsive Support Group


Fewer girls with EBD are marked for special education services, and those who are will generally be treated with interventions that have been tailored to the male
experience of EBD. In this study, Srsic and Rice consider the impact of Girls Circle, an intervention designed to meet the specific challenges of the female experience of EBD, on five teenage, African-American girls attending the same day school.

Girls Circle met once a week for 10 weeks and was focused, in this instance, on “Relationships with Peers.” Example session titles included “Girlfights or Girlfriends” and “Accepting All Different Parts of Myself.” The program was heavily discussion oriented. The authors briefly describe each participant’s history and include a variety of quotations from each participant throughout the article. Problems with truancy, drug abuse, violence, and understanding social cues are among the issues the girls faced. Srsic and Rice found that this group of girls with EBD valued the same aspects of friendship that their typically developing peers valued. The girls were concerned about negative factors such as jealousy that undermine healthy relationships, often to the degree that they avoided forming and/or were quick to end friendships in which these negative factors arose. The group lacked positive female role models and examples of healthy female relationships, but the girls positively influenced each other during their experience in the program. Srsic and Rice conclude the article with a list of recommendations for practice, including:

- Training in gender difference and gender-responsive programming;
- Early intervention;
- Extended time for intervention;
- Consideration of environment;
- Continued research into best practices for treating girls with EBD;
- Continued research to evaluate the efficacy of gender-responsive programming; and
- Continued qualitative research about girls with EBD.

If girls can be treated with interventions specifically adapted to their experience with EBD, Srsic and Rice speculate that their outcomes will be greatly improved.

**Internet Delivery of PST for Youth**

*Effects of Internet-Based Guided Self-Help Problem-Solving Therapy for Adolescents With Depression and Anxiety: A Randomized Controlled Trial*


Despite evidence for the effectiveness of Internet-based guided self-help problem-solving therapy (PST) in adult samples, very few studies evaluate its efficacy for adolescents—even though it may offer a method of treating adolescents who would not otherwise seek professional mental health care. The 45 participants of this study took part in five weekly guided self-help PST lessons delivered through the Internet. Participants were reminded about the sessions and were offered support during the process through email. The participants reported experiencing depression or anxiety before beginning the intervention. Each week, participants were asked to describe their problems, rank them according to severity, and work on developing and implementing an actionable plan to solve the most severe problems. Surprisingly, the study found no statistical difference between the reduction in anxiety and depression levels for the participants and those of the control group. Possibly, the lack of difference was the result of the control group’s undergoing unreported treatment for their depression or anxiety, the severity of the depressive and anxious symptoms of the participants, website problems that prevented optimal delivery of the content of the intervention, or the depth and complexity of the self-reflection required to benefit from the intervention.

**The Effect of Supplements**

*Influences of Micronutrient and Omega-3 Fatty Acid Supplementation on Cognition, Learning, and Behavior: Methodological Considerations and Implications for Children and Adolescents in Developed Societies*


This review of the literature examines the influence of micronutrient and omega-3 fatty acid supplementation on cognition, learning, and behavior in children and adolescents living in developed countries. According to the literature:

Existing evidence suggests that children and adolescents in developed countries may perform better on tests of nonverbal intelligence and on behavioral measures after receiving vitamin and mineral supplements with or without n-3 PUFA supplementation compared with those receiving placebo, regardless of age and supplementation formula.

The most positive results occurred in trials lasting three months or longer and in trials in which the participants were malnourished or of low socioeconomic backgrounds.

**Examination of SLI**

*Longitudinal Patterns of Behavioral, Emotional, and Social Difficulties and Self-Concepts in Adolescents With a History of Specific Language Impairment*

Lindsay, G., & Dockrell, J.E. *Language, Speech, and Hearing Services in Schools* 43:445–460, 2012

This study of adolescents living in the United Kingdom studies the relationship between specific language impairment (SLI) and behavioral, emotional, and social difficulties. Previous studies have indicated that language difficulties in childhood often lead to behavioral difficulties in adolescence. Lindsay and Dockrell write:

To our knowledge, this is the first paper that presents a longitudinal analysis of both behavioral, emotional, and social difficulties (BESD) and self-concept domains at 8, 10, 12, and 16 years of age, and also self-concept at 17 years, in a sample of students with a history of SLI. In addition, we examine the association of the children’s language and literacy abilities at 8 and 10 years with these behavioral and self-concept domains at 16 and 17 years.

The study found that at age 16, the sample experienced more problems with peers, more conduct problems, and more emotional symptoms than their peers, although the increase in conduct and peer problems did not appear to be associated with language difficulties at 8 and 10 years of age. The sample also experienced a reduction in hyperactivity at 16.
## Calendar of Events, December 2012 – February 2013

**December**

12-14  

**January**

17-18  

21-24  

24-25  

27  

28-31  

**February**

12-15  

13-16  

17-20  

20-23  

21-23  