**Minimizing Social Contagion in Adolescents Who Self-Injure: Considerations for Group Work, Residential Treatment, and the Internet**

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**Abstract (summary)**

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Social contagion among adolescents is a growing concern as the numbers of youth who self-injure increases. Mental health counselors face challenges in treating self-injurers in settings that are prone to social contagion. This article describes social contagion as one factor motivating self-harm in group settings, residential facilities, and audiences for social and electronic media. It reviews possible benefits and pitfalls of self-injury treatment in these environments and presents approaches to minimize social contagion. Responses to self-injury and social contagion are explored. [PUBLICATION ABSTRACT]

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**Headnote**

Social contagion among adolescents is a growing concern as the numbers of youth who self-injure increases. Mental health counselors face challenges in treating self-injurers in settings that are prone to social contagion. This article describes social contagion as one factor motivating self-harm in group settings, residential facilities, and audiences for social and electronic media. It reviews possible benefits and pitfalls of self-injury treatment in these environments and presents approaches to minimize social contagion. Responses to self-injury and social contagion are explored.

The prevalence of nonsuicidal self-injury (NSSI) among adolescents and young adults has been rising rapidly and significantly (Kerr, Muehlenkamp, & Turner, 2010; Prinstein, Guerry, Browne, & Rancourt, 2009); it has even been described as epidemic (e.g., Plante, 2007; Whitlock, Purington, & Gershkovich, 2009). In one recent study of a community adolescent population, at least 27% had engaged in one or more types of NSSI (Baetens, Claes, Willem, Muehlenkamp, & Bijttebier, 2011). In studying adolescent clinical populations, Jacobson, Muehlenkamp, Miller, and Turner (2008) found that only 52% of patients reported not having engaged in any form of self-injury, and in a different population Nock & Prinstein (2004) found that 82.4% had engaged in at least one NSSI incident. These statistics suggest the importance mental health professionals must place on helping prevent self-injury. It is imperative that counselors working with youth recognize the prevalence of NSSI and understand how certain environments present higher risks.

By definition, intent to die is not a factor in NSSI (Wilkinson & Goodyear, 2011; Yaryura-Tobias, Neziroglu, & Kaplan, 1995). Researchers describe it as a deliberate, adaptive strategy to manage physiological stimulation and emotional distress, without the intention of ending life (Deiter-Sands & Pearlman, 2009; Hyldahl & Richardson, 2011; Plante 2007; Walsh 2006). Most often individuals engage in NSSI to regulate or express affect, relieve tensions, manage dissociative and depersonalization symptoms, gain a sense of control, and influence others (Klonsky, 2009). Consequently, NSSI can become a repetitive, addictive coping strategy that may result in significant scarring, infection, life-threatening injury, and accidental death (Nafisi & Stanley, 2007; Plante, 2007). Understanding the unintended consequences of NSSI is important to preventing it.

With a significant proportion of teens engaging in NSSI, there is growing evidence that self-injury "is a behavior subject to peer influence, perhaps particularly among adolescents . . . [which] presents a large public health concern" (Prinstein et al., 2009, p. 89). Self-injury contagion has been defined as when (a) acts of self-injury occur in two or more persons within the same group within 24 hours, or (b) acts of self-injury occur within a group of statistically significant clusters (Walsh & Rosen, 1985). The primary focus of this article is to identify environments that present a high risk of contagion and suggest ways counselors working with adolescents can minimize and prevent it.

GROUP WORK FOR TREATING SELF-INJURY

Many programs designed to treat adolescents who self-injure consider group therapy to be an essential treatment ingrethent. Self Abuse Finally Ends (SAFE), founded in 1985 by Karen Conterio and Wendy Lader, was the first treatment facility designed specifically for people who self-injure. Since its inception, clinicians at SAFE have used group therapy as a central feature of their treatment programs (Conterio, Lader, & Bloom, 1998). Dialectical behavior therapy (DBT), which combines individual therapy, group skills training, and family education, has emerged as one of the most effective treatments for adolescents who are suicidal or self-injurers (Katz, Cox, Gunasekara, & Miller, 2004; Muehlenkamp, 2006; Rathus & Miller, 2002). Many of the skills needed to reduce self-injurious behaviors (e.g., emotional regulation, distress tolerance, or interpersonal communication skills) are learned and practiced in group therapy. Matthew Selekman (2009) has written extensively on using strengths-based, solution-focused strategies to meet the therapeutic needs of distressed adolescents. He has recently developed a nine-session Stress Buster's Leadership Group for adolescents in both school and community settings who engage in self-destructive behaviors. While these group approaches may differ, they all tend to be didactic, highly structured, and skill-based.

For logistical and developmental reasons, group homes, residential facilities, and hospitals typically use group work as the primary mode of treatment. Groups are more efficient and cost-effective than individual approaches because they enable counselors to work with more youth (Corey & Corey, 2006; Rose, 1998). Also, since much social learning occurs within groups, both formal and informal (e.g., families, classrooms, social groups, gangs, sports teams), adolescents often prefer group work because it tends to be a better developmental fit for them than individual therapy (Richardson, 2001; Towberman, 1993). For example, youth care more about what their peers think of them than how adults may perceive them (Hollander, 2008). Plante (2007) stressed that affirmation and encouragement to try positive coping strategies is more effective in gaining the attention of adolescent self-injurers.

Youth who self-injure tend to feel isolated and disconnected. Among therapeutic factors youth most value hope, universality, and relationship climate (Chase, 1991; Shechtman & Gluck, 2005). While individual counselors can inform youth that they are not alone, the group allows them to experience a sense of universality with their peers (Richardson, 2001; Selekman, 2009; Yalom, 1985) and learn from others at different stages in the recovery process. Adolescent group members can also support and model healthy behaviors and challenge unhealthy choices (Conterio et al., 1998). By assisting others, members can begin to see themselves in a different light. Gladding (2007) noted that one of the most effective ways to boost the self-esteem and self-confidence of youths is to structure situations in which they can help others and feel altruistic.

However, despite the potential benefits of using groups in treating those who self-injure, there are pitfalls that could disrupt the process or even increase NSSI. Walsh (2006) recommended that counselors always be mindful of the risk of contagion whenever persons who self-injure are treated in groups. He also warned that groups that are largely cathartic- where members are encouraged to openly express their emotions and share traumatic experiences - are often counterproductive for young people: Open discussion of self-injury antecedents, behaviors, and consequences can be exceptionally triggering (Walsh, 2006). Many clinicians and researchers assert that group leaders should structure activities to focus on empowerment and replacement or coping skills training and prohibit detailed discussion of self-injury (Conterio et al., 1998; Hollander, 2008; Lieberman, Toste, & Heath, 2009; Selekman, 2009; Walsh, 2006).

It can be very difficult for counselors to maintain this focus because sharing details about self-injury can be alluring. Walsh (2006) recommended acknowledging that although discussing self-injury in detail is important, it should be shared in individual therapy rather than with group members. Conterio et al. (1998) also cautioned that group therapy may at first be seen as an opportunity to compare wounds, so such disclosures should be prohibited from the outset, and mental health counselors should be aware that sharing the graphic detail of self-harm stories can trigger NSSI after the session.

School counselors in particular should be cautious about organizing "cutter-specific" groups because students may view cutting as a criterion for membership (Lieberman et al., 2009). For example, one school social worker who started a cutter-specific group was approached by a girl who asked what severity of self-injury was required to join (Walsh, 2006). Both school and community counselors need to be aware of ways groups can backfire.

NSSI groups are thus most likely to be effective if:

1 . Group leaders have significant training and understanding of treating self-injury and managing contagion.

2. Membership is closed to enhance cohesion and trust.

3. The group is governed by rules that strictly prohibit discussion of details of self-injury and the sharing of wounds or scars.

4. Like DBT groups, the sessions are highly structured, didactic, and dedicated to teaching new skills and behaviors (e.g., emotional regulation, mindfulness, self-soothing, distress tolerance, exercise) to help reduce further incidents of self-injury.

SELF-INJURYWEBSITES AND MESSAGE BOARDS

While the Internet can be a valuable source of support and information for self-injurers, it can also be a breeding ground for contagion. Some 93% of American youth aged 12 to 17 use the Internet, nearly two-thirds of them daily, and 73% of American teens now use social networking sites (Lenhart, Purcell, Smith, & Zickuhr, 2010). In the past decade there has been an increase in the number of websites for and about people who self-injure (D'Onofrio, 2007). Whitlock, Lader, and Conterio (2007) documented over 500 NSSI-focused message boards, and the numbers rise each year. These researchers also observed the parallel between the increase in self-injury information on the Internet and the growth in self-injury awareness in society. Whitlock, Powers, and Eckenrode (2006) recognized the Internet as a transformational mechanism, influencing the communication, support, and social reality of adolescents. Many Internet message boards are populated by adolescent females (Whitlock et al., 2006).

Self-injury websites and message boards may have particular appeal for adolescents who are socially avoidant or feel marginalized (McKenna, Green, & Gleason, 2002). These youth may feel deep relief at being able to make meaningful connections with individuals who share similar concerns and experiences. Also, the anonymity of these sites may encourage more, and more truthful, disclosures about feelings and behaviors (D'Onofrio, 2007). Another potential benefit is positive peer pressure. Just as in group counseling, these adolescents may more readily accept feedback from peers that encourages them to practice safer, more productive ways to express their emotions.

It is important not to minimize the perceived value these sites have for young clients. While social scientists and mental health professionals often focus on the potential for harm, adolescents who use these sites tend to report positive experiences. For example, in a survey of self-harm discussion group members, most said they had reduced the frequency and severity of their NSSI, which they attributed largely to the support and guidance they found online (Murray & Fox, 2006). Baker and Fortune (2008) interviewed 10 members of online self-harm support groups, who consistently reported "'feeling understood', 'feeling part of a community', or 'coping with psychological distress'" (p. 121).

Whitlock et al. (2006) were among the first researchers to study the content of self-injury message boards to better understand their role in sharing information about self-injurious practices and influencing help-seeking behaviors. Focusing on active but lightly moderated boards where the content is less likely to be censored, they analy/ed over 3,000 posts over a two-month period. The most common type of exchange they found was informal support to other posters through comments such as '"We're glad you've come here' and 'Just relax and try to breathe deeply and slowly'" (p. 412). There was also considerable discussion about ways to conceal scars and maintain secrecy.

While 44% of all help-seeking posts showed favorable attitudes toward seeking mental health treatment, about 20% discouraged individuals from seeking treatment or voiced negative views about therapy. Self-injury message boards can also expose vulnerable youth to encouragement for self-injury, with potential for fueling social contagion. On several sites, Whitlock et al. (2006) found that members shared new and often more dangerous cutting techniques and instruments and even offered links to sites where self-injury paraphernalia could be purchased. Again, while many adolescents find comfort and solace in these communities, "the adolescent drive to belong and the satisfaction that comes with associating with a community of similar others may inadvertently feed fundamentally self-destructive behavior for some participants" (p. 415).

Some posters shared that posting videos, artwork, and poetry serves a cathartic function that was helpful in their healing process. A recent study by Lewis, Heath, St. Denis and Noble (201 1) studied NSSI videos posted online. Their analysis of videos posted on YouTube found that the top 100 NSSI videos were viewed over two million times and included graphic images. Uploaders had a mean age of 25.39, which the authors suggested is misleading due to young viewers who would otherwise be prohibited falsifying their age. Again, Whitlock et al. (2007) warned that sites that feature graphic depictions of selfinjury can be highly suggestive and triggering to others who self-injure.

DOnofrio (2007) voiced concerns that persons who self-injure and seek support and encouragement may be negatively influenced by anonymous but forceful "friends" they meet online. Worrisomely, those who self-injure can become better at self-injury by learning from people they meet online. Walsh (2006) observed that some posters use chat rooms to coerce others, model selfdestructive behaviors, compete with others, and discourage others from stopping the injuring or seeking help: "Pecking orders also emerge in chat rooms whereby those who self-injure with the greatest conviction have the highest status.... Most claim to have developed the websites to provide support and help others, but the content ... is often more triggering than therapeutic" (p. 242).

Analyzing several websites, however, Murray and Osbome (2009) found that conversation was frequently geared to understanding and justifying the self-injurious behaviors. Posters explained their behavior as addictive, uncontrollable, and an understandable response to traumatic life events. Both posters and responders provided justifications; this seemed to be an important function of the group, but the justifications were typically not used to encourage self-injury. Rather, most members attempted to discourage continued NSSI. Baker and Fortune (2008) also asserted that participants' experiences with selfharm and suicidal websites are strikingly different from those found in the professional literature and wider media. They postulated that professional criticism and warnings about online message boards may stem more from their "antipsychiatric attitudes" rather than scientific evidence that they are harmful.

In conclusion, self-injury websites and message boards are helpful for some and counterproductive for others, which suggests they should be an area of therapeutic inquiry. In fact, the omnipresence of Internet use among adolescents presents a crucial argument for both assessment of Internet use in general and specific assessment of Internet exposure to self-injury (Whitlock et al., 2007). Mental health professionals should therefore educate themselves about various websites for self-injurers. Whitlock et al. (2007) offered suggestions for follow-up questions if adolescent clients acknowledge visiting NSSI-related sites, and recommended that clinicians maintain a curious, neutral, nonjudgmental tone when asking questions like these:

\* How comfortable do you feel hearing stories from others who self-injure?

\* Have you shared your own story? How did you feel?

\* What do you like most about having friends that you only really know through the Internet?

\* How honest are you when you share information on the Web? (Do you minimize or tend to embellish?)

\* Do you ever take advice from Internet friends? If so, can you provide examples of advice you got . . . that you used? (p. 1 141)

Assessing the mechanisms that influence clients will help counselors determine appropriate interventions and Internet-use recommendations (Whitlock et al., 2009). Whitlock et al. (2007) expressed concern that some sites have minimal or no monitoring for potentially dangerous content, and where there are moderators, they typically have minimal or no training in mental health. With some clients, counselors might assess that it is best to be direct in encouraging or discouraging particular sites or interactive behaviors, clarifying concerns about why some sites might be traumatic or triggering and therefore countertherapeutic. These direct suggestions will likely be more fruitful with adolescents who have entered counseling voluntarily, begun to develop a therapeutic relationship, and voiced a desire to stop or reduce self-injury.

TREATING YOUTH IN RESIDENTIAL FACILITIES

As with group therapy and the Internet, residential treatment offers both benefits and pitfalls. NSSI reportedly occurs in significant clusters in residential settings (Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, & Helenius, 1998; Walsh & Doerfler, 2009; Walsh & Rosen, 1985). Residential here refers to community-based group homes, special education boarding schools, juvenile detention facilities, and psychiatric inpatient settings. Many NSSI experts suggest a need for further research into the residential contagion effect, but few studies have been published (e.g., Lofthouse & Katz, 2009). This population is likely at higher risk of contagion due to peer influence and the prevalence of more severe psychopathology, such as eating disorders and affective regulation issues (Nixon & Heath, 2009; Prinstein et al., 2010; Walsh & Doerfler, 2009). Recognizing the potential for contagion makes it possible to take precautions case by case in determining the benefits of residential treatment and can help in choosing appropriate responses to NSSI in a residential population.

Lofthouse and Katz (2009) cited three studies illustrating the longitudinal phenomenon of NSSI by adolescent inpatients. The first, published in 1999 by Lipschitz et al., reported that 39% of adolescents admitted to an American hospital had incidents of NSSI. In 2002, Nixon, Cloutier, and Aggarwal reported 29.7% of adolescent inpatients at a Canadian facility were engaging in NSSI, with 80% of these injuring at least once per week. Finally, in 2004 Makikyro et al. reported that 67.7% of adolescents in an inpatient unit in Finland occasionally or frequently engaged in NSSI. Data reported by Boxer (2010) suggested a comparable increase in NSSI in a Midwestern inpatient facility. His analysis of 476 adolescent patients explored the relationship between reported history of self-harm and length of stay at the first critical incident of NSSI. Specifically, 33% patients with no history of self-harm had a critical incident of self-harm, at an average of 60.3 days after their stay began. Similarly, 39% of patients with a history of self-harm had a critical incident, at an average of 61.5 days into their stay. These comparable data suggest not only the increase in NSSI among adolescent inpatients both with and without self-harm histories but also the increase in exposure to NSSI in the residential environment. This raises the question of whether the benefits of inpatient care are worth the risks associated with the contagion effect.

Several arguments can be made for residential treatment despite concern about social contagion. In specific clinical cases, when the need for structured, intensive treatment is the primary goal of patient care, placement in a residential facility may be preferable to nonresidential options, such as partial hospitalization or outpatient care. For example, best clinical practices require mandatory hospital ization of an eating-disordered client because the primary treatment goal is sustaining life (Maxmen, Ward, & Kilgus, 2009). For these clients, although they may be at higher risk of NSSI due to contagion, inpatient treatment is optimal because the principal concern is adequate nutrition.

Furthermore, social contagion is just one variable affecting the likelihood of NSSI onset; intrapersonal reinforcement, such as relief from negative emotions, is more highly correlated to NSSI, Nock and Prinstein (2004) have suggested. In their analysis of adolescent inpatient NSSI, they found that most adolescents hurt themselves for automatic reinforcement: the increase or decrease (regulation) of physiological or emotional experience. For these patients, the function of their self-harm would be to feel a sense of relief. Fewer patients, although a significant number, endorsed the function of social reinforcement. For them, their decision to engage in NSSI would be to convey a message to others, such as "I want you to know how unhappy I am." Recognizing the function of a patient's self-harm behavior is thus a beneficial aspect of inpatient care. If a patient does begin to engage in NSSI, staffare prepared to determine the clinical significance and have unlimited access to the patient, which is arguably more structured than outpatient care or attention to the injury by less trained individuals, such as family members or school staff.

But although residential care staffare trained in working with NSSI, adolescents in residential settings are also more likely to have contact with emotionally disturbed youth, who may influence them to consider or increase self-harm (Boxer, 2010; Lofthouse & Katz, 2009; Plante, 2007). Walsh and Doerfler (2009) cautioned that social contagion is one example of residential treatment risks; people who exhibit emotional dysregulation living together can aggravate dysfunctional behaviors like NSSI. Plante (2007) addressed such concerns as the increased risk of peer influence due to underlying personality and impulse control disorders. She suggested that a sense of inclusion with these peers often involves NSSI as an act of initiation. Beyond the influence of the affective symptomology, often observed in residential populations, peer socialization effects also prompt adolescent NSSI (Prinstein et al., 2010).

Residential staff can work to avoid the risks by understanding the role of peer influence and social contagion in eliciting NSSI in an adolescent community. The first step is making an appropriate referral for residential care. Because ethical treatment recognizes the client's right to the least restrictive service, counselors are not to encourage unnecessary hospital ization (White Kress, McKormick, & Kelly, 2003). After referral to a residential program, however, precautions and suggestions guide clinicians toward the appropriate response to NSSI, such as educating the patient, confronting what triggers social contagion, and encouraging youth to build and share healthy coping skills (e.g., Walsh, 2006). The use of empirically supported responses to residential NSSI will create a consistent level of standard care (Muehlenkamp, 2006; Walsh & Doerfler, 2009). For example, McDonell et al. (2010) found that adolescent inpatients receiving DBT experienced a decrease in NSSI, an increase in global functioning, and a reduction in psychotropic medications. This is consistent with Walsh's treatment guide (2006), which suggests emphasizing healthy coping skills and communication. Although communicating with peers in a communal environment is beneficial for those who feel isolated and may benefit from peer support, counselors are advised, however, to educate residents on the negative effects of sharing stories of self-injury and instruct them instead to share stories of healing and healthy coping behaviors.

SUMMARY AND FUTURE RESEARCH

This article has identified several environments as being at high risk for social contagion of NSSI, namely group treatment, social media, and residential facilities. It also identified methods of preventing social contagion, such as (a) building a clinical understanding through training and research in how social contagion may affect adolescents; (b) working with clients who engage in NSSI to help them become aware of appropriate venues to discuss selfinjury, such as individual therapy sessions; (c) asking clients who self-injure to cover up scars, wounds, and bandages, which can be triggering; (d) prohibiting graphic detail about NSSI when group therapy begins; (e) incorporating strengths-based strategies into treatment to encourage healthy coping behaviors; (f) assessing client Internet use, especially exposure to self-injury imagery; (g) determining the appropriate level of treatment and avoiding unnecessary hospitalizations that may trigger NSSI in vulnerable clients; and (h) instructing group members to share stories of healing and healthy coping behaviors to both decrease the opportunity for contagion and inspire altruistic motives.

Further investigation of the differences between the environments analyzed here would help to refine understanding of social contagion and lead to more effective ways of preventing contagion among adolescents. Allocating resources and clinical attention to this population would therefore be more economically efficient as clinicians face limitations in balancing clinical treatment and prevention programs. Another opportunity for research is further understanding of social contagion and NSSI within groups not mentioned here. Atmospheres like foster care and the home may also be at high risk for contagion if one member is engaging in NSSI. Recognizing the implications of peer influence and family dynamics may bring insight into the contagion effect.

Moreover, the role of mental health counselors working with youth engaging in NSSI extends past the therapeutic relationship to the client's family system and school setting. Providing referrals for information to individuals concerned with the adolescent, such as parents and other caretakers, is useful in attending to NSSI and contagion among peers. The following websites provide information grounded in clinical research and professional standards:

\* S.A.F.E Alternatives: http://www.selfinjury.com

\* American Self-Harm Information Clearninghouse: http://selfinjury.org

\* First Signs Support Network: http://www.firrtsigns.org.uk

\* Mayo Foundation: www.mayoclinic.com/health/self-injury/DS00775 (Mayo Foundation for Medical Education and Research, 2010)

\* Helpguide: www.helpfuide.org/mental/self\_injury.htm (Smith & Segal, 2011)

Empowering members of the client's family and care system to understand self-injury will help them to comprehend the messages the client is sending and be alert to counteract opportunities for contagion. It is crucial that the counselor as a provider of information is clear about what is appropriate Internet material, such as empirically validated information for families, and about possible misinformation on sites containing blogs and graphic imagery. Prevention of contagion begins with both understanding NSSI in youth and empowering the people in their lives who have opportunity to preclude self-injury.

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