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A Strengths Perspective in Working with an Adolescent with Self-cutting Behaviors

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ABSTRACT: This paper describes the use of a strengths perspective in working with an adolescent with self-cutting behavior. While a disease model stresses diagnosis, labeling, medication, control, and manipulation; a strengths perspective advocates understanding of feelings and meaningfulness behind symptoms, identifying needs, and developing abilities, facilitating interpersonal communication, and building a better social environment for the adolescent client with self-cutting behaviors. A case example demonstrates this approach.

Introduction

In Hong Kong, teachers and social workers commonly observe self-cutting behaviors among adolescents in secondary schools. Yip, Ngan, and Lam's (2002) study showed that self-cutting behaviors were most commonly found among year 8 and Year 9 female students in Hong Kong. Many of them cut themselves repeatedly on their wrists. They cut themselves to release their suppressed negative emotions, resulting from interpersonal conflicts and unhappy childhood traumas. Yip et al.'s findings were consistent with international studies. Pattison and Kahan (1983) and Diclemente, Ponton, and Hartley (1991) study showed that adolescent self-cutters are the predominant group among self-mutilators, with a peak

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incidence from 16 to 25 years old. The way of self-cutting is usually light and superficial cutting on skin without harming the arteries (Pao, 1969; Ross & Mckay, 1979; Simpson, 1980). Most self-cutting and self-mutilation are repetitive behaviors (Brain, Haines, & Williams, 1998; Briere & Gil, 1998), with some even cutting themselves over 100 times (Gardener & Gardener, 1975; Pao, 1969; Siomorpoulous, 1974). Suyemoto (1998) summed up several perspectives from past literature, including an environmental perspective (Applewhite & Joseph, 1994; Himber, 1994; Paris, 1998; Turell & Armsworth, 2000; Walsh & Rosen, 1988); an anti-suicide perspective (Applewhite & Joseph, 1994; Hirsch, 1998; Pattison & Kahan, 1983; Walsh & Rosen, 1988); a sexual perspective (Burnham, 1969; Podvoll, 1969; Ross & Mckay, 1979); an affect regulation perspective (Brain et al., 1998; Herpertz, Sass, & Favazza, 1997; Milligan & Waller, 2001); a dissociation perspective (Zanarini, Ruser, Frankenburg, & Hennen, 2000). Also, mishandling of self-mutilation and self-cutting by parents or by professionals may provoke further self-cutting (Gardener & Gardener, 1975; Pao, 1969).

Drawing on these theoretical perspectives, the writer illustrates how to use a strengths perspective in helping a Chinese female adolescent to eliminate her self-cutting behaviors. (Pattison & Kahan, 1983).

The Strengths Perspective

The strengths perspective has been recognized as one of the most important perspectives in helping clients with various problems—particularly with mental illness (Rapp, 1992; Saleebey, 1996; Sullivan, 1997; Sullivan & Rapp, 1994; Weick, Rapp, Sulllivan, & Kisthardt, 1989). This perspective advocates an ecological system approach, an emphasis on wholeness and integrity, as well as focusing on the client's experience in assessment and intervention (Saleebey, 1997; Sullivan, 1997). The merits of the strengths perspective are in its ability to decode, explore and develop clients' own strengths, as well as to cultivate resources for clients to resolve their own problems, actualize their own goals, and fulfill their own needs (Saleebey, 1997, p. 25). Saleebey (1997) asserts several principles in the strengths perspective. They are:

1. Every individual, group, family and community has its own strengths.
2. Trauma and abuse, illness, and struggle may be injurious but they may also be sources of challenge and opportunity.
3. We should assume that we do not know the upper limit of the capacity to grow and change of individual clients, and should take individual, group and community aspiration seriously.
4. We best serve clients by collaborating with them.
5. Every environment is full of resources. (Saleebey, 1997, pp. 12–16)

Within these principles, clients with self-cutting behaviors are not only restrained or impaired by their own symptoms and problems. Instead, they are also persons with normal needs, unlimited potentials, and resources. Within this orientation, the writer contrasts a strengths perspective and a disease orientation in intervention with a female Chinese adolescent with self-cutting behaviors.

A Disease Orientation in the Intervention of Self-cutting Behaviors

In a disease orientation, clients with self-cutting behaviors are viewed as problematic and pathological. Social workers and related professionals diagnose the symptoms, try to control the problem behaviors, and regard medication as the only alternative in treatment and intervention. By means of the following case illustration, the writer elaborates the disease orientation in intervention in detail.

Carol: The Angry and Manipulative Adolescent

Carol (not her real name), was a Chinese female adolescent under the care of her school social worker in a secondary school in Hong Kong. The school social worker was employed by a welfare organization in Hong Kong in which the writer was the professional consultant. To protect the confidentiality of the client, her personal information and identity are properly disguised.

> 'Carol was a 14-year-old Chinese girl studying in year 8 in a secondary school in Hong Kong. Her father was an officer in the Fire Brigade.

He tried hard to discipline Carol and required her to obey him strictly. Whenever Carol failed to follow his orders, he would beat her hard, or punish her severely by not allowing her to have dinner, or by locking her in her room for several hours. Sometimes, when the father was drunk, he would physically abuse both Carol and her mother. At first Carol was very afraid of her father. However, as she grew older, she tried to fight back. She would yell at her father or fight with him when he tried to hit her. Her mother was kind and tried to resolve the conflict between Carol and her father. Under her father's rigid discipline and punitive control, Carol was angry and tried every means to rebel. She would do everything to provoke her father and anger him. She learned to smoke cigarettes, date many boyfriends and stayed outside all night. Facing all these confrontations, her father tried to lock her up at home, but Carol broke the lock and escaped. Spontaneous conflicts with her father made Carol emotionally very unstable and highly manipulative and impulsive. Her relationships with her boyfriends were very unstable. Whenever she argued with her boyfriend or her boyfriend failed to follow her ideas and views, she would suddenly become enraged. She would immediately pick up and cut herself with any pointed objects such as broken glass, a needle, or even use her own fingernails. Her boyfriends were easily threatened by her impulsive behavior. Some were so afraid that they left Carol. As a consequence, she changed boyfriends frequently. If she quarreled with her father or her close friends, she would cut herself afterwards. Self-cutting seemed to become her only way of venting her frustration and served as a means of controlling others. Once she had a severe quarrel with her school teacher and cut her wrist deeply. The whole school was alarmed and Carol was sent to a psychiatric outpatient clinic for treatment. She was diagnosed by the psychiatrist as suffering from borderline personality disorder. By the time her school social worker approached the writer for professional consultation, Carol had already been involved in self-cutting for three years.'

Diagnosis and Labeling of Pathological Symptoms

Self-mutilation has long been a problem in our modern society. Seventy-five per 1000 persons in the general population engage in self-harming behavior (Favazza & Conterio, 1988). For persons aged 15–35, self-mutilation has the highest prevalence of 1800 per 100,000 persons. Briere and Gil (1998) showed that 4% of the general population and 21% of a clinical sample reported self-mutilation. There are various forms of self-mutilation, such as self-cutting (Swenson, 1999), body cutting and tattooing (Jeffreys, 2000), genital self-mutilation (Agoub & Battas, 2000), and oral self-mutilation. Among the various types of self-mutilation, self-cutting is the most

common type done by adolescents. Within a disease orientation, self-mutilation and self-cutting are diagnosed as pathological problems. Together with emotional instability and problems in interpersonal relationships, adolescent clients with self-cutting behaviors are typically diagnosed as suffering from borderline personality disorder (American Psychiatric Association, 1994). However, the label of borderline personality disorder may humiliate the adolescent client, and further intensify their feelings of emptiness and frustration that can provoke further self-cutting behaviors. This label is also an excellent excuse for social workers and teachers to declare their inability to handle clients with mental illness and make psychiatric referrals and medication as the only alternative for further intervention. In Carol's case, the social worker had similar perceptions towards Carol's symptoms and diagnosis.

> Social worker: 'Once Carol performed self-cutting by sitting on the edge of the top floor [the roof?], the whole school was alarmed and then she was sent to a mental hospital. Before that she had been sent to the psychiatric outpatient clinic because of an incidence of open self-cutting in front of her teacher. She was diagnosed as suffering from borderline personality disorder. Facing the symptoms and label, I was a bit confused. I tried to interpret from them that Carol was not only a problem student but also a mental patient. Frankly speaking, the label of borderline personality disorder made me feel much better. I could excuse myself for being unable to help Carol to resolve her self-cutting behaviors. As she was a psychiatric patient, all she needed was a psychiatrist and medication. The psychiatrist asserted that borderline personality disorder was a kind of mental illness that was very difficult to handle. It seemed that Carol's situation was out of the competence and expertise of social workers and teachers. From that time onwards, the teachers and principal as well as me found that we could not do anything for Carol unless we had specialized training in this area. We had to leave this case in the hands of the psychiatrists.'

However, Carol felt very uneasy and distressed when faced with the label of a mental patient with borderline personality disorder. This label made her feel very frustrated and angry. It further provoked her self-cutting behaviors.

> Carol: 'I felt very distressful about being labeled as a mental patient with borderline personality disorder. My psychiatrist told my mother about this label with a very simple explanation that it was a serious mental disorder that may need treatment and hospitalization if necessary. I got the feeling I was very sick and very problematic. In the past, I only felt self-cutting was my way of releasing my deep-

> seated anger and frustration. But now, I felt there was something wrong in my body as well as in my mind. I was sick and could not live a normal life. My father accused me of creating my whole mental illness. My classmates tried to get away from me saying I was an 'insane girl'. I was looked down on by my teachers, my classmates and my relatives. One night, I cried bitterly in my bed. The feelings of severe emptiness and frustration overwhelmed my mind, I picked up my cutter and cut my wrist several times. Perhaps, self-cutting was my lifelong mental illness to release my frustration and anger. Who could help me? I was so helpless and worthless.'

Control and Manipulation

Within a disease orientation, adolescents with self-cutting behaviors are pathological, problematic and trouble making. They create extreme disturbances and nuisances to both schools and families. They make trouble for teachers, school social workers and family members. Thus, teachers, social workers and parents may try every means to control and manipulate them.

> Carol: 'They all thought I was a trouble maker, creating a disturbance at school and challenging school discipline. The discipline master required me to report to him every recess and after school. The class prefect had to record my behavior in class in detail. Every day I went to school, my class mistress would search my bag and my school uniform to see whether or not I had brought any cutter, knife, or any sharp thing that I could cut myself with. At home, my father ordered my mother to hide all cutters, knives, and anything made of glass. I was not allowed to go out to meet my boyfriends. I was treated as a prisoner at home, in the school or anywhere I went. Indeed, all my teachers and the principal and my father were hypocrites. They did not care about my feelings. All they wanted was tight control and manipulation so I could not create any more trouble for them.'

Medication and Dependence

Within the disease orientation, medication often seems to be the sole treatment for persons with borderline personality disorder. Instead of a holistic and multi-dimensional view, social workers with a disease orientation tend to believe that medication is the only alternative for treatment of clients with self-cutting behaviors and borderline personality disorder. Appropriate medication can stabilize emotional fluctuation. The biochemical approach stresses

that brain studies of borderline clients show abnormalities in neurotransmitters of serotonin. Many have symptoms of hypothyroidism. Approximately 20% have low vitamin B12 levels, with symptoms of fatigue, leg stiffness and dysesthesias'. However, medication can never reduce the environmental stress and interpersonal conflicts faced by adolescent clients with self-cutting behaviors and borderline personality disorder. Also, prolonged and inappropriate medication may create over-dependence on medication physically and psychologically.

> Carol: 'Everybody, including my social worker reminded me that I was sick and needed prolonged medication. I had to take pills both in the morning and in the evening. In fact, the pills made me feel tired and a bit sleepy. In the morning, I did not want to get up. During class lessons, I felt sleepy. I told my psychiatrist about the side effect of the medication. but he firmly asserted that medication was the only alternative to stabilize my emotions and reduce my impulse to self-cut. Frankly speaking, it was not the pills that stopped my self-cutting. Instead I was too tired and sleepy to cut myself or to quarrel with others. Because of the effects of the medication, I was unable to do anything except sleep, and felt permanently dizzy and tired. I wanted to stop taking the medication, but my parents watched me closely and required me to take the pills in front of them. After several months, I started to convince myself that I was sick and needed medication. I was used to feeling sleepy. I lost confidence in doing normal daily activities and relied on medication.'

The Strengths Perspective in Dealing with Self-cutting Behaviors

With a strengths perspective, persons with self-cutting behaviors are regarded as normal persons with capabilities, potentials, interests, needs and cognition. Social workers should focus their attention on identifying needs and capabilities beyond self-cutting behaviors. They should understand feelings and the meaningfulness of self-cutting behaviors. They should facilitate communication between adolescents and their significant others and build up a supportive social environment for the adolescent.

Understanding Feelings and Meaningfulness of Self-Cutting Behaviors

Self-cutting behaviors are meaningful for adolescents. They are used as a means to release the client's unresolved anxiety, anger and frustration. This perspective is echoed by the anti-suicide, sexual, and dissociation perspectives in interpreting self-cutting behaviors. In the anti-suicide perspective, self-cutting is distinguished from suicide. The feelings of hopelessness, despair and the use of highly lethal methods, which are commonly found among suicidal adolescents, are not found in adolescents with self-cutting behaviors. Instead, the sense of psychological relief and sensation are common among adolescents with self-cutting behaviors (Applewhite & Joseph 1994; Hirsch, 1998; Pattison & Kahan, 1983; Suyemoto, 1998; Walsh & Rosen, 1988). In the sexual perspective, self-cutting behaviors are used as a defense against unresolved or unpleasant sex impulses and may be seen as a complex symbol of self-castration or a substitute for masturbation (Burnham, 1969; Podvoll, 1969; Ross & Mckay, 1979). In the dissociation perspective, adolescents with self-cutting behaviors experience a sense of losing their identity and the reality of others (Miller & Bashkin, 1974; Ross & Mckay, 1979; Zanarini et al., 2000). The sight of blood serves as a point of reference for the individual to release his or her sense of inner frustration (Diclemente, Ponton, & Hartley, 1991; Givoviacchni, 1956; Kafka, 1969; Swenson, 1999). All these perspectives indicate that social workers should pay full attention to the unresolved feelings behind the self-cutting behaviors. They should listen empathically to adolescent clients. How do clients feel? What do they mean? Why do they want to cut themselves? Appropriate empathic listening makes the clients feel that they are respected and understood. Under the writer's supervision, Carol's school social worker learned how to listen to Carol's feelings and explore the meaningfulness behind her self-cutting.

> Social worker: 'Instead of commenting on or criticizing Carol's self-cutting behaviors, I learned to listen carefully to Carol's feelings related to her self-cutting. Carol said that she usually felt deeply frustrated with a heavy sense of emptiness and depersonalization. Her mind and body seemed to be suppressed and twisted by these unpleasant feelings. They were so unpleasant and so overwhelming that Carol wanted to get rid of them at once. The quickest way was to cut herself. The pain and sight of blood seemed to bring her back to reality, to

regain her feeling of being an integrated person. Also, the sight of blood and the scars were very powerful tools to empower Carol to protest against others' oppression, control, and abuse of her. After all these empathic listening sessions, I was able to establish a good rapport with Carol.'

Identifying Needs and Abilities Behind Self-Cutting

It is important that the social worker can identify the client's needs and abilities beyond self-cutting. This is particularly true for adolescents as they are undergoing drastic physical, psychological and social development. As with other normal adolescents, clients with self-cutting behaviors still need to be respected, loved, cared for and properly educated. In a boundaries perspective, poor object relations, diffused ego boundaries, and confused body experiences are found among adolescents with self-cutting behaviors (Asch, 1971; Podvoll, 1969; Rohricht & Priebe, 1997; Suyemoto, 1998; Waska, 1998). Fowler, Hilsenroth, and Nolan (2000) study showed that self-cutting behaviors are related to the primary process of aggression, severe boundary disturbance, pathological object representation, defensive idealization, and self-evaluation. In other words, adolescents with self-cutting behaviors are usually deprived of a clear ego boundary, satisfaction with self and other relationships, and a confident self-identity. They need to build up a clear and confident self-identity from a stabilized and trustworthy relationship with their significant others.

Social worker: 'The more I listened to Carol's feelings about her self-cutting, the more I pitied Carol. She was deprived of a caring and kind father figure. Her father was rigid, disciplinary and very often abusive and punitive. He required Carol to follow his orders and commands strictly. He was always very drunk. When Carol was a small girl she was often tied up by her father, who beat her fiercely only because she did not follow his orders. Carol's mother was caring but dared not oppose her husband. She was also abused and beaten by Carol's father. All these traumatic experiences made Carol become rebellious. She was angry with her father, her mother, or any figure of authority who tried to control or discipline her. She tried to strive for autonomy but she only achieved this through her self-cutting behaviors. To resolve these dilemmas, I tried to identify with and develop Carol's potentials and abilities and helped Carol to develop an assertive and mature self-identity and self-image. Carol had special talents in fashion design and singing. I encouraged Carol to join the fashion design class at a nearby youth center. She seemed to enjoy this class very much. Her

special talents were highly praised by her teacher. One of Carol's designs was selected for a fashion design competition in Hong Kong. As Carol's talents were recognized, she gradually regained a more positive self-image. It seemed that her frustration and anger towards herself and her father were lessened.'

Facilitation of Interpersonal Communication and Emotional Ventilation

Adolescents with self-cutting behaviors have deficits and problems in controlling their emotions (Herpertz et al., 1997; Milligan & Waller, 2001; Suyemoto, 1998), in coping with stress and in reducing their tension (Brain et al., 1998). Self-cutting behaviors are related to the regulation and ventilation of feelings of anger, anxiety and depression (Diclemente et al., 1991). Within the strengths perspective, it is important that social workers help adolescents with self-cutting behaviors to have better interpersonal communication and be able to express their emotions better, especially when dealing with interpersonal conflicts. The social worker helped Carol to develop better interpersonal communication and emotional expression.

Social worker: 'Carol learned to have better interpersonal communication with her father and her boyfriends. She learned to refuse them gently but assertively. She learned to tell her father quietly that she felt humiliated and hurt by his cursing, physical violence, restraint and punitive discipline. She told her father that she had long been looking for a kind and caring father. She sincerely hoped that her father could achieve that. Carol's sincere disclosure greatly impressed her father. He became kinder than before. She tried to interact with her father more naturally and politely instead of by confrontation and quarreling. She learned how to express concern towards others and to express her frustration constructively. Gradually, she developed better interpersonal relationships with her significant others. The frequency of her self-cutting behaviors was greatly reduced.'

Building a Better Social Environment

Self-cutting is a means of responding to traumas and unpleasant experiences in childhood and in adolescence (Applewhite & Joseph, 1994; Himber, 1994; Ross & Mckay, 1979; Suyemoto, 1998; Turell & Armsworth, 2000; Walsh and Rosen, 1988). With a strengths

perspective, it is important that the social worker help the adolescent build a better social environment in order to prevent further self-cutting.

> Social worker: 'It was important that Carol should have a better social environment. I encouraged her family to have meaningful and healthy interaction. I had several counseling sessions with her father. On the one hand, I tried to appreciate his responsibility in rearing and disciplining Carol. On the other hand, I discussed his style of parenting. I showed him a pamphlet on child abuse and the related legislation. He did not want to jeopardize his own career as a civil servant by potential legal charges related to his past child abuse. He agreed to control his temper. I persuaded him to join a treatment group for alcoholic addiction at a nearby social welfare agency. Carol's father seemed to get better control of his drinking, and Carol began to have a better relationship and interaction with her father. Also, she seemed to enjoy her new friendships within the fashion design group. She stopped cutting herself'

Conclusion

This paper is an attempt to contrast the disease orientation and the strengths perspective in helping an adolescent with self-cutting behaviors. The strengths perspective encourages the social worker to identify the clients' needs and potentials; and to understand the clients' feelings and the meaningfulness of their self-cutting behaviors. The social worker should facilitate adolescent clients to express and air their unpleasant feelings constructively, and help them to have better interpersonal communication with others. It is crucial that the social worker hold the belief that no matter how bad the situation is, the clients still have their strengths and potential.

References

Agoub, M., & Battas, O. (2000). Male genital self mutilation in patients with schizophrenia. *Canadian Journal of Psychiatry*, *45*(7), 670–670.

American Psychiatric Association (1994). *Diagnostic & statistical manual of mental disorder* (4th ed.). Washington, DC: American Psychiatric Association.

Applewhite, L. W., & Joseph, M. W. (1994). Confidentiality: Issues in working with self harming adolescents. *Child and Adolescent Social Work Journal*, *11*, 279–291.

Asch, S. S. (1971). Wrist scratching as a symptom for Anhedonia: A pre-depressive state. *Psychanalytic Quarterly*, *40*(2), 603–611.

Brain, K. L., Haines, J., & Williams, C. L. (1998). The psychophysiology of repetitive self-mutilation. *International Journal of Psychophysiology*, *30*(1–2), 218.
Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry*, *68*(4), 609–620.
Burnham, R. C. (1969). Symposium on impulsive self-mutilation: Discussion. *British Journal of Medical Psychology*, *42*, 233.
Diclemente, R., Ponton, L., & Hartley, D. (1991). Prevalence and correlates of cutting behaviour: Risk for HIV transmission. *Journal of American Academy of Child & Adolescent Psychiatry*, *30*, 735–739.
Favazza, A. R., & Conterio, K. (1988). The plight of chronic self mutilators. *Community Mental Health Journal*, *24*, 22–30.
Fowler, J. C., Hilsenroth, M. J., & Nolan, E. (2000). Exploring the inner world of self-mutilating borderline personality patients. *Bulletin of the Menninger Clinic*, *64*(3), 365–385.
Gardener, A. R., & Gardener, A. J. (1975). Self mutilation, personality & narcissism. *British Journal of Psychiatry*, *127*, 127–132.
Givoviacchni, P. L. (1956). Defensive meaning of a specific anxiety syndrome. *Psychoanalytic Review*, *43*, 373–380.
Herpertz, S., Sass, H., & Favazza, A. (1997). Impulsivity in self-mutilative behavior: Psychometric and biological findings. *Journal of Psychiatric Research*, *31*(4), 451–465.
Himber, J. (1994). Blood rituals: self-cutting in female psychiatric inpatients. *Psychotherapy*, *31*(4), 620–631.
Hirsch, M. (1998). Suicidal tendencies and self-mutilation: Overlaps and differences. *Forum Der Psychoanalyse*, *14*(2), 123–138.
Jeffreys, S. (2000). Body art and social status: Cutting, tattooing and piercing from a feminist perspective. *Feminist Psychology*, *10*(4), 409–429.
Kafka, J. S. (1969). The body as transitional object: A psychoanalytic study a self-mutilating patient. *British Journal of Medical Psychology*, *42*, 207–212.
Miller, F., & Bashkin, E. (1974). Depersonalization and self mutilation. *Psychoanalytic Quarterly*, *43*, 638–649.
Milligan, R. J., & Waller, G. (2001). Anger, impulsivity in non-clinical women. *Personality Individual Difference*, *30*(6), 1073–1078.
Pattison, E. M., & Kahan, J. (1983). The deliberate self harm syndrome. *American Journal of Psychiatry*, *140*, 867–872.
Pao, P. N. (1969). The syndrome of delicate self cutting. *British Journal of Medical Psychology*, *42*, 195–206.
Paris, J. (1998). Does childhood trauma cause personality disorder in adults. *Canadian Journal of Psychiatry*, *43*(2), 148–153.
Podvoll, E. M. (1969). Self-mutilation within a hospital setting: A study of identity and social compliance. *British Journal of Medical Psychology*, *42*, 213–221.
Rapp, C. (1992). The strength perspective of case management with persons suffering from severe mental illness. In D. Saleebey (Ed.), *The strengths perspective in social work practice* (pp. 45–58). White Plains, New York: Longman.
Rohricht, F., & Priebe, S. (1997). Disturbance of body experience in schizophrenia patients. *Fortscrite Der Neurologie Psychiatrie*, *65*(7), 323–336.
Ross, R. R., & Mckay, H. B. (1979). *Self-mutilation*. New York: Lexington Books.
Saleebey, D. (1996). The strengths perspective in social work practice: Extension and cautions. *Social Work*, *41*(1), 296–395.
Saleebey, D. (1997). Introduction: Power in people. In D. Saleebey (Ed.), *The strengths perspective in social work practice* (2nd ed.), (pp. 45–58). New York: Longman.
Siomorpoulous, V. (1974). Repeated self-cutting: an impulse neurosis. *American Journal of Psychotherapy*, *28*, 85–94.

Simpson, M. A. (1980). Self mutilation as indirect self destructive behaviour. In N. L. Faberow (Ed.), *The many faces of suicide* McGraw Hill.

Swenson, C. R. (1999). A bright red scream: self mutilation and the language of pain. *Psychiatric Services*, *50*(9), 1234–1235.

Sullivan, W. P. (1997). On strengths niches, and recovery form serious mental illness. In D. Saleebey (Ed.), *The strengths perspective in social work practice* (2nd ed.), (pp. 183–196). New York: Longman.

Sullivan, W. P., & Rapp, C. A. (1994). Breaking away: The potential and promise of a strengths-based approach to social work practice. In R. G. Meinert, J. T. Pardeck, & W. P. Sullivan (Eds.), *Issues in social work: A critical analysis* (pp. 83–104). Westport, CT: Aubum House.

Suyemoto, K. L. (1998). The functions of self-mutilation. *Clinical Psychology Review*, *18*(5), 531–554.

Turell, S. C., & Armsworth, M. W. (2000). Differentiation incest survivors who self-mutilate. *Child Abuse Neglect*, *24*(2), 237–249.

Waska, R. T. (1998). Self mutilation, substance abuse, and the psychoanalytic approach: Four cases. *American Journal of Psychotherapy*, *52*(1), 18–27.

Walsh, B. W., & Rosen, P. M. (1988). *Self-mutilation: Theory, research and treatment*. New York: The Guilford Press.

Weick, A., Rapp, C., Sullivan, W. P., & Kisthardt, W. (1989). A strengths perspective for social work practice. *Social Work*, *34*(2), 350–354.

Yip, K. S., Ngan, M. Y., & Lam, I. (2002). An exploratory study of peer influence and response to adolescent self-cutting behavior in Hong Kong Smith studies. *Social Work*, *72*(3), 379–401.

Zanarini, M. C., Ruser, T., Frankenburg, F. R., & Hennen, J. (2000). The dissociative experiences of borderline patients. *Comprehensive Psychiatry*, *41*(3), 223–227.