

A Systematic Review of Contextual Factors and Self-Injurious Behavior of Foster Care Youth

Jackson de Carvalho, PhD
Associate Professor
Prairie View A & M University
Prairie View, Texas 77446
United States of America

Felix O. Chima, PhD
Professor
Division of Social Work, Behavioral & Political Science
Prairie View A&M University
United States of America

Abstract

Self-injurious behaviors (SIBS) defined as "any socially unaccepted behavior involving deliberate and direct physical harm to one's own body without the intent to die as a result of the behavior itself" (Claes, Vandereycken, & Vertommen, 2005, p. 11) has been the focus of research and writings in professional literature over the past several decades (Trepal & Wester, 2007). An aggregate of factors may be responsible for the self-injurious behavior of foster care youth such as: the significant role of early childhood exposure to trauma, abuse, and/or maltreatment, disrupted parental attachments and exposure to domestic violence on subsequent acts of self-injury (van der Kolk, Perry, & Herman, 1991). Nevertheless, self-injury is one of the most puzzling and least understood human behaviors; it has generated a great deal of false beliefs and stigmatization among the general population. The purpose of this paper is to help educate foster care parents and professionals working with individuals who self-injure. This paper will discuss the history of foster care and the characteristics of youth in today's foster care system. More specifically, the mental health needs of these youth will be explored, as well as the numerous factors that place them at risk for engaging in self-injurious behaviors. Additionally, self-injurious behaviors will be discussed to provide an understanding of this mental health issue and the various systemic barriers that make it difficult for youth in care to access adequate and consistent mental health services.

Keywords: Self-injurious behavior, foster care, youth, parent, practitioners, training

1. Introduction

Over the past four decades, research has consistently correlated juvenile behavioral problems with ineffective parenting skills (Chamberlain et al., 2008). Foster parents are often referred to training programs to help them increase skills in managing their emotional reactions to mental health needs of their foster youth, avoid stress and burnout, and develop effective coping skills. In order to successfully reduce the secondary effects of the mental needs of youth in care, foster parents must be taught effective parenting techniques, including communication skills which impact behavioral change, and have a clear understanding of the mental health system in order to help navigate the appropriate services for the youth. The purpose of this paper is to help educate foster care parents and professionals working with individuals who self-injure. Subsequently, this paper will discuss the history of foster care, the main factors responsible for self-injury and characteristics of youth in foster care, including reasons for placement and subsequent mental health issues. Furthermore, it will discuss the association between early childhood trauma on a developing brain and the propensity of self-injury. Additionally, as parents are essential in the treatment regimen of many adolescent mental health issues, the unique role of foster parents and the subsequent training they receive will be explored. This paper will also examine the current barriers in mental health treatment for foster care youth in an attempt to identify possible gaps in mental health services, which further support the need for further educating foster parents and practitioners on self-injury.

According to Claes, Vandereycken, & Vertommen (2005), self-injurious behaviors (SIBS) is defined as “any socially unaccepted behavior involving deliberate and direct physical harm to one's own body without the intent to die as a result of the behavior itself” (p. 11). Self-injury has been the focus of research studies over the past four decades. A possible reason for this is what was once deemed a trait of severe psychosis and typically found among clients presenting in various psychiatric facilities is now pervasive among individuals in the community at an alarmingly high rate. An aggregate of factors may be responsible for the self-injurious behavior of foster care youth such as: the significant role of early childhood exposure to trauma, abuse, and/or maltreatment, disrupted parental attachments and exposure to domestic violence on subsequent acts of self-injury (Calati & Philippe, 2016; Conradi & Wilson, 2010). Nevertheless, self-injury is one of the most puzzling and least understood human behaviors; it has generated a great deal of false beliefs and stigmatization among the general population (Trepal & Wester, 2007). In fact, Walsh (2006) suggests that the rate of self-injury has grown by 150% in a 20-year period, becoming one of the fastest growing mental health concerns in the United States. The relevant literature has attempted to explain the increased prevalence of SIBS among adolescents, and often points to the interconnecting influences of stressful environmental factors, glorification by the media and the influential nature of peer groups (Walsh, 2006). Without proper support or a sense of connectedness, many adolescents may be vulnerable to these influences and succumb to peer pressure. A qualitative study conducted by Strong (1998) including a sample of twenty adolescents for self-harm found that “children who never had stable, dependent relationships with their parents were unable to develop their own separate identity in adolescence” (p. 52). The increasingly high cost of living often demands both parents to work long hours and spend less time with their families leading to a lack of parental involvement in a child's life resulting into a lack of adolescent's feeling of connectedness to their parents, which current research findings (Bruskas, 2008; Landsverk et al., 2009; Levitt, 2009; Strong, 1998; Walsh, 2006) suggest to one of the main factors responsible for the high rates of self-injury incidence.

2. Literature Review

An extensive review of the current literature showed that the foster care system is comprised of more than half a million youth within the United States (Bruskas, 2008, American Psychiatric Association (2013). Before placement in the foster care system, most of the youth have been victims of prolonged and substantiated maltreatment such as abuse and neglect (Levitt, 2009), which may predispose them to various mental health issues (Walsh, 2006). According to Levitt (2009) three-fourths of these youth entering foster care display biopsychosocial problems requiring professional attention. Such behavioral, physical and mental health needs far exceed the needs of their same aged counterparts not residing in foster care, are not being adequately addressed by the child welfare or mental health system. This kind of neglect often leads to greater overhead for the nation (Levitt, 2009). Consequently, youth in foster care are at increased risk for criminal behaviors, incarceration, poverty and overall negative outcomes. In fact, the studies of Landsverk et al. (2009), revealed a link between untreated youth behavioral problems, increased multiple placements and reduction in both adoption and reunification with birth families. Walsh (2006) suggest that the causes for these unmet mental health needs of youth in care is intrinsically rooted in the complex history of the foster care system, and the various mental health barriers that exist in the United States. Additionally, the various environmental and individual risk factors that predispose foster care youth to developing serious mental health issues are often driven by the effects of disruptive attachment and early childhood trauma leading to neurological brain developmental problems (Washburn et al., 2012).

3. Historical Overview

Historically, early references to foster care can be traced back to The New Testament, the Talmud, and early Christian Church records where dependent and orphaned children were placed with “worthy widows” in the community, orphanages or almshouses. Centuries later, these practices were assumed a duty of law with the implementation of the English Poor Law (1531- 1782), thus bringing about societal changes in which poor and impoverished youth were helped and cared for by being placed in indentured service until they came of age. During the 17th century, these practices were adopted in the United States, when in 1636, Benjamin Eaton, at the age of seven became the nation's first foster child, which was thirty years after the founding of the Jamestown Colony (Simms, Dubowitz, & Szilagyi, 2000). Furthermore, in 1853, Charles Loring Brace began the free foster home movement driven by the unmet needs of a huge number of immigrant children sleeping in the streets of New York (McVey-Noble, Khemani-Patel, & Neziroglu, 2006).

As a response to the staggering number of immigrant children sleeping on the streets of New York City, emerged the increased need of policy and program development to address these vulnerable segments of the homeless population. In 1853, Minister Charles Loring Brace founded the Children's Aid Society and developed the Placing Out Program to help find placements for these children. This program established a trend in which youth from Eastern cities were sent to live on family farms in the Midwest and South, where they could be protected from urban life. This practice also served a dual purpose as children were seen and utilized as a resource to their foster families and provided an extra source of labor or indentured service in exchange for their room and board (Calati & Philippe, 2016; Landsverk et al., 2009; Simms et al., 2000).

The Orphan Train became an unforgettable story of second chances highlighting a significant welfare program that transported orphaned and homeless children from crowded urban center in Eastern United States to foster homes often located in rural areas of the Midwest. Between 1854 and 1929, an estimated 200,000 children were placed on orphan trains to the Midwest where families cared for the children and raised them in return for the value of their labor. Although most reports indicated the children were fairly treated, no laws existed at that time to protect them from abuse or neglect. Generally, the public fostered the idea that parents/guardians did not harm their children. In 1874, however, the case of eight-year-old Mary Ellen challenged this assumption and forever changed how society viewed the rights and protection of children (Landsverk et al., 2009; Lindsey, 1994).

The issue of child protection was pushed to the forefront when Mary Ellen, a young girl who was beaten and neglected by her primary caregivers, came to the attention of authorities. At that time, however, as there was no legal measure available to protect children from abuse, community leaders were forced to appeal to the Society for the Prevention of Cruelty to Animals (SPCA). After the case was heard before the court, it was ruled that the same protection afforded to animals would extend to children, which gave birth to the child welfare system in America. The protection of children received national attention, increasing society's awareness and interest in children's wellbeing and safety. The greatest transformation in foster care was made, from a system that initially developed in finding placements for orphaned children, to one serving neglected and abused children, with an emphasis on removing children from abusive homes and placing them in safer out of home environments (McVey-Noble et al., 2006; Webb, 2006).

4. Current Foster Care System

The current child welfare system is responsible for ensuring the safety and well-being of children and adolescents who have been victims of maltreatment and neglect, which includes children placed in a group and residential facilities. One subset of this system is foster care, in which a certified, stand-in "parent(s)" cares for minor children who have been removed from their biological parents or other custodial adults by state authority and the responsibility for the young person is assumed by the relevant governmental authority (Levitt, 2009; Webb, 2006). At any rate, foster care placement occurs when children are removed from their primary caregiver for their own safety, typically due to substantiated cases of parental illness, poverty, family death, and as a means of helping families experiencing financial hardship (Lindsey, 1994; Simms et al., 2000; Webb, 2006). It is noteworthy, that most of children residing in foster care are placed as a result of neglect, abuse, maltreatment, parental substance abuse and abandonment (McVey-Noble et al., 2006; Simms et al., 2000). Moreover, the various mental health barriers are often exacerbated by foster parent's lack of knowledge to deal with traumatized children. The mental health status of children in care has significantly declined over the past several decades while their length of stay has increased. It is these youth, their childhood experiences and the subsequent mental health issues frequently followed by self-injurious behaviors the focus of this paper.

5. Mental Health Needs of Foster Care Youth

Although the concept of 'well-being' is at the center of the Adoption and Safe Families Act of 1997, a clear definition for the term has yet to be established. Mental health professionals agree, however, that the concept of well-being transcends safety and permanency; it should include the health, education, and mental health needs of youth in care (Levitt, 2009). Unfortunately, researchers have found that a disproportionate number of youth currently residing in care who possess mental health difficulties do not receive appropriate mental health services. Since there are so many juveniles in care in need of mental health services, lack of access to mental health problems amongst this specific population should be considered one of the most serious threats to a child's well-being (Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009).

Regrettably, there are many problems associated with early childhood disruptions in attachments, separation, loss, and trauma, which are not easily overcome and can result in numerous biopsychosocial and emotional issues including self-injury. In fact, research findings conducted by Linares, Montalto, Li, & Oza (2006) indicated that foster care children have a high propensity for between mental health issues particularly their high risk for externalizing and conduct difficulties, including noncompliance, aggressiveness, and emotional lability, depression, and self-destructive behaviors including self-injury. Current literature shows that prevalence rates of foster care youths' emotional and behavioral problems is estimated to range from 70% to 80% (Pecora et al., 2009; Simms et al., 2000).

Trauma and loss.

One of the main building blocks of children's biopsychosocial and emotional health is the belief that their parent is good. It is almost unbearable for children to think otherwise, or to interpret their parent as bad or evil. Even when a parent is abusive or neglectful, children may be unable to process themselves as being unfairly treated and may adopt the belief that their parents are justified in their behaviors. Ironically, this deficit can have a positive function as it may create hope, a sense of security and it elevates the parent as 'all good,' which satisfies this high-level need for all children (Katz, 2008). As such, it is an all too common occurrence that children removed from their parents' care and placed in foster home placements struggle with a multitude of trauma and losses, with the most pervasive psychological experience being profound rejection and abandonment (Levitt, 2009; Pecora et al., 2009). Many blame themselves and feel guilty about their removal from their parents. Even when significant abuse or maltreatment has occurred prior to their removal, many children may wish to return to their birth parents and have mixed feelings about forming an attachment to their foster parents, or feel guilty over wanting to express positive feelings towards them. For many children, this simple act would be an act of betrayal against their own biological parents (Washburn et al., 2012). Since multiple placements are common, foster care children often report feelings of helplessness, insecurity, loneliness and self-doubt. Additionally, they are highly susceptible to feeling undesirable or unlovable if they are awaiting adoption for a long period of time or asked to leave multiple foster homes (Katz, 2008; Anderson & Seita, 2006). It is safe to think that, a child's experiences prior to placement play a significant role in determining how children will cope emotionally in foster care. According to Bowlby (1982), life experiences in children's early formative years can have a profound impact on their attachment abilities, how to manage their emotions and cope with challenges, all of which are the main elements of character development. When children's biopsychosocial and emotional needs are properly met by their caregiver, they learn to trust their environment, develop a healthy, secure level of attachment and cope skills (Calati & Philippe, 2016).

Alternatively, the vast majority of youth placed in foster care, are impacted by early childhood experiences filled with chaos, traumatic events, inconsistent care giving, abuse and neglect (Webb, 2006). As a result, these children often process the world around them as unsafe, unpredictable and that adults cannot be trusted to care for their needs. Their attachment styles reflect this uncertainty and they often present as being anxious or insecure. Since children with attachment disorders expect rejection and hostility from others, they often project personalities (thoughts, feelings and behaviors) ranging from guarded to negative to actively hostile and aggressive (Webb, 2006). It is worth to note, that it is not separation and loss per se that is predictive of negative outcomes as suggested by Bowlby Attachment Theory, but the "adverse contexts (i.e. family dysfunction and maltreatment) in which separation and loss often occur, and the biological factors or later experiences associated with those contexts" (Eagle, 1994, p.421). Additionally, the multiple factors that influence an individual's response to trauma, which include the nature of the circumstances, personal history, and the degree of support they receive after the traumatic experience (Webb, 2006; van der Kolk et al., 1996) cannot be ignored. Regardless, however, the effects of these early childhood experiences unequivocally predispose many foster care juveniles to serious mental health pathology that is clearly linked to how these experiences affect brain development and propensities to self-injury.

Brain Development and Childhood Trauma

The word "trauma" comes from the Greek, meaning, "wound," and in an expanded sense, is now used to refer to an emotional wound caused by a frightening and painful experience. The relevant literature shows two types of trauma, Type I and Type II, have been identified; differing in causation, length of exposure, and recovery. Type I trauma consists of a single event and does not typically lead to long-term symptoms. Type II trauma, however, consists of numerous frightening events occurring over time and in many cases, involves physical or sexual abuse (American Psychiatric Association, 2013; Cohen, Mannarino, Deblinger, 2006; Webb, 2006).

It is the Type II of trauma that children in foster care typically endure as result of experiencing prolonged physical, emotional, and/or sexual abuse, neglect, or maltreatment at the hands of their caregiver. Additionally, when the person who inflicts the trauma is a caretaker, such as in the experiences of many youth placed in care, the child's response is likely to be more complicated and more resistant to treatment than the reactions of a child who was traumatized by a stranger as the result of a random event (Webb, 2006). Thus, a child entering foster care who has been exposed to numerous acts of trauma, loss or abuse is likely to have greater tendencies to self-injurious behaviors. When a developing brain is exposed to chronic and persistent stress, such as the stress experienced by most youth in foster care, the stress response system is continuously activated leading to structural changes in the brain. These changes can include either an increase or decrease in receptor sites for neurotransmitters often resulting in increased heart rate, respiration, blood pressure, and diversion of blood flow to skeletal muscles and alertness (Levitt, 2009, Katz, 2008).

According to Webb (2006), there is a strong link between childhood trauma and self-injury as trauma "alters the early development of the right brain, thereby compromising an individual's capacity to cope with emotional stress" (p. 15). Children who do not learn the ability to manage their emotions in their early formative years may fail to develop this ability later in life and often seek alternative ways of managing their emotions and try to reduce distress through acts of self-injury (Claes, Vandereycken & Vertommen, 2004; Farber, 2000). For individuals who have experienced prolonged or extreme childhood trauma or abuse, such as in the case for many foster care youth, the release and role of endorphins may be a strong contributory factor in engaging in SIBS (Eggersten, 2008). During times of traumatic stress, including childhood physical or sexual abuse, the body secretes endorphins, soothing chemicals that numb physical pain and reduce panic; this temporarily ends the child's physical and emotional distress. According to Katz, (2008), these endorphins may play a role in future acts of SIBS, as they keep the individual from storing their traumatic experiences in verbal memory, despite it being stored as images, sensations, and feelings (Conradi & Wilson, 2010).

6. Self-Injurious Behaviors

The term *picking* or *mutilate* can be defined as to cut up or alter radically so as to make imperfect and to maim, or cripple. With the exception of some major forms of self-injury, the majority of self-injurers inflict only a modest amount of physical damage on their body, which leaves little, if any, long term scarring (Calati & Philippe, 2016; Walsh, 2006). It is plausible to think that when abuse takes place during a person's early formative years, the body may remember the abuse, but the individual may not. Years later, the person may respond to his or her environment in a state of hyper arousal to anything perceived as stressful or dangerous. To help cope with this post-traumatic stress disorder, the act of self-injury may re-activate endorphins and quickly reduce feelings of anxiety, rage, aggression, and depression. In order to illustrate this point, Hyman (1999) provides a quote from a woman who utilizes self-injury for this purpose: Picking is like doing an endorphin kick: bang! And eating isn't. The eating only works if I am doing it; it's not that it has a lasting effect. Picking at something really is a lasting drug-like response. It's like somebody shot up with heroin, you know. It takes my stress level immediately from up here and drops it, and keeps it down there for a while, it doesn't just come running right back up (p.49). Many individuals have reported their self-injuring behavior acts as a coping mechanism and without it, they may have killed themselves. Although SIBS should not be looked at as a protective factor against suicidality, many individuals have reported an attachment to their self-injuring behavior like individuals' attachments to unhealthy romantic relationships that they remain in despite being unhappy (Walsh, 2006; Webb, 2006).

Several researchers and practitioners argue that SIBS can be direct, with both compulsive and impulsive undertones, and indirect, which may or may not have the same etiology and function. Direct forms of SIBS exist along a continuum with three main categories: major, stereotypic, and moderate/superficial. The first category, major, includes severe forms of SIB, such as eye enucleation or castration, commonly associated with psychotic disorders. The second category, stereotypic, includes repetitive acts such as head banging or self-biting, and is usually associated with severe mental retardation. Finally, the third category, moderate/ superficial, includes behavior such as skin cutting, scratching, picking, burning, hair pulling, severe nail biting, and other forms of superficial self-injury. It is this category that contains the most common forms of self-injury and will be the focus of this paper and the training program that will follow (Favaro, Ferrera & Santonastaso, 2004; Walsh, 2006). It is important to note that various forms of indirect SIBS exist in conjunction with direct forms of self-injury, which include, eating disorders, substance abuse, and various risk-taking behaviors. Main types of risk taking behaviors include: situational, physical and sexual risks.

This co-occurrence is important to be noted as the physical harm is usually cumulative, rather than immediate in nature (acute alcohol poisoning and drug overdoses being the exceptions). These types of indirect self-injury are especially concerning for mental health professionals working with adolescents and the parents of these individuals, as adolescence is typically a period of time in which these patterns of behavior will begin to develop (Walsh, 2006). Often, both direct and indirect forms of self-harm occur at a higher rate among individuals exposed to adverse childhood environments (Gratz, 2006; Polk & Liss, 2007). Many theories have attempted to explain the increased incidence of SIBS among adolescents to the interconnected influences of stressful environmental factors, glorification by the media and the influential nature of peer groups (Gratz, 2007; Walsh, 2006). Without proper support or a sense of connectedness, many adolescents may be vulnerable to these influences and succumb to peer pressure. One study examining twenty adolescents for self-harm found that "children who never had stable, dependent relationships with their parents were unable to develop their own separate identity in adolescence" (Strong, 1998, p. 52). Thus, parental involvement and an adolescent's feeling of connectedness to their parent may be considered a preventative factor in self injury.

7. Practical Implications

Detecting and intervening in self-injurious behavior can be difficult since the practice is often secretive and involves body parts which are relatively easy to hide. Although experienced mental health professionals can offer advice based on experience, few studies which actually test detection, intervention and treatment strategies have been conducted. The implications which follow are those which evolve naturally from existing literature, from clinical experience in self-injurious behavior and from interviews with practitioners with significant experience in self-injurious behavior. A lack of information on self-injury has hampered the creation of informational materials and/or treatment options. There is a small but growing body of evidence to assist those helping individual self-injurers. However, little literature exists to explain and address the environmental factors that contribute to adoption of the practice. For those who encounter self-injurious adolescents, creating a safe environment is critical. This can be difficult with youth who have suffered trauma or abuse (Calati & Philippe, 2016; Gratz, 2006; Walsh, 2006). A number of studies in this area suggest that structure, consistency, and predictability are important elements in forming relationships with self-injurious youth. Developing treatment plans which emphasize a) taking responsibility for the behavior, b) reducing the harm inflicted by the behavior, c) identifying and more positively reacting to self-injury triggers and physical cues, d) identifying safe people and places for assistance when needing to reduce the urge to self-injure, and e) avoiding objects which could be used to self-injure (e.g., paper clips, staples, erasers, sharp objects) can help to reduce the harm associated with self-injurious practices and establish trust (Mojtabai and Olsson, 2008). These practical plans should serve to help stabilize the youth and to provide structure and support until community-based counseling can begin. It is thus important to focus on enhancing awareness of the environmental stressors that trigger self-injury and on helping individuals identify, practice, and use more productive and positive means of coping with their emotional states (anxiety, depression, or other conditions that overwhelm their capacity to regulate their emotion). Focusing on elimination of the self-injury behavior without enhancing positive means of regulating emotion may simply lead to adoption of other self-destructive behavior, such as drug abuse. Drug therapy may help in some cases as well. Some patients using prescribed drugs for depression have found a reduction in the urge to self-injure while taking these medications. Therapy may be useful in exploring the underlying causes of self-injury (Walsh, 2006). A combination of the above treatments may significantly reduce or eliminate self-injurious behavior.

Several therapeutic modalities may be used to intervene in the practice of self-injury. Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), and interventions that focus on understanding, tolerating, and accepting emotions (emotional self-regulation) while learning healthy use of coping skills (such as interpersonal effectiveness) are typically most helpful to those who self-injure. While there are few psychotherapeutic treatments that have been designed specifically for self-injurious behavior in adolescents, a review by Washburn et al. (2012) suggests that CBT in combination with medication adjustments can be more effective than just changing a medication. Several other studies (Miller et al., 2007; Lynch et al., 2009; Gratz & Chapman, 2009) also suggested that DBT was the most effective form of CBT because it actively targets the depressive symptoms, suicidal cognitions, and problem-solving deficits that maintain deliberate self-harm. Despite DBT's effectiveness, there is still a need to tailor treatment approaches to self-injurious behavior in adolescents specifically. DBT was initially developed to treat individuals with Borderline Personality Disorder (BPD), considering self-injury only as a symptom of BPD.

Mentalization-based treatments, those which help individuals who self-injure to learn how to separate their own thoughts and feelings from those of others, also show promise. A recent meta-analysis conducted by Calati and Philippe (2016) examining multiple psychotherapies suggests that metallization-based treatment was the only intervention effective in reducing self-injurious behavior in adolescents. Most treatment providers who are familiar with self-injury will use these approaches in ways that they find are most likely to help their client. Collaborative, strength-based approaches are also popular among some self-injury treatment specialist. These modalities integrate aspects of DBT and CBT but also focus strongly on shared goal-setting with the client, engaging family and/or other members of the client's social ecology as a means of support, and on emphasizing existing or easy to develop strengths in the recovery process. Further research is still needed to improve efficacy of treatment specifically in self-injurious behavior in adolescents.

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