

AN ABSTRACT OF THE DISSERTATION OF

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Among the many mental health concerns schools face today, self-injury is quickly gaining attention. It is estimated that almost 14% of adolescents have self-injured and the numbers are predicted to rise (Ross & Heath, 2002). Adolescents spend more of their waking hours in the school building than at home or with friends (Kush, 1991). This offers school staff considerable opportunity to observe student behavior and to interact with students. School counselors, in particular, are in a unique position to address the mental health needs of students as they are often the first mental health professional the student encounters (Froeschle & Moyer, 2004) and are identified by students as the most likely school employee to whom they would divulge personal problems (Armacost, 1990).

The purpose of this research project was to determine the frequency with which school counselors encounter self-injuring students, their knowledge regarding self-injury, and their confidence in working with self-injurers. Additional goals included determining what supports counselors perceive that they need in order to

work effectively with this population and describing the appropriate role of counselors when working with self-injurers.

Data were collected via a questionnaire designed by the author. A sample of 1,000 school counselors was drawn from a membership list obtained from the American School Counselor Association (ASCA), the largest school counseling organization in the United States. Four hundred and forty-three counselors returned usable questionnaires. The key finding was that most school counselors are working with self-injurers despite low levels of self-reported knowledge and confidence. In order to improve counselors' knowledge and confidence levels, educational opportunities for counselors must be made available. Once trained, counselors can then act as an informant to the school community about this issue. Also, counselors need links to professional therapists for referrals when self-injuring students are identified in the school. Designating school counselors as the school contact for self-injurers is a logical choice based on their educational background, current roles, and job responsibilities, but along with that responsibility must come support from school administration in terms of training and resources to ensure counselors and school staff are adequately prepared to serve students.

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Self-Injury in the Schools: School Counselors' Perspectives

by
Susan Roberts-Dobie

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Susan Roberts-Dobie, Author

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PREFACE

This dissertation was compiled in a format blending the five traditional chapters with completed articles. The chapters are: Introduction, Review of the Literature, Research Design and Methodology, Results, and Conclusions and Recommendations. The Results Chapter is comprised of three articles. Article one describes school counselors' frequency of contact with self-injurers and their practices when doing so. Article two describes the perceived needs of school counselors regarding their work with self-injurers. Article three discusses the appropriate role of school counselors when working with self-injurers.

**Self-injury in the schools:
School counselors' perspectives**

CHAPTER 1

INTRODUCTION

Background

Among the many mental health concerns schools face today, self-injury is quickly gaining attention. It is estimated that almost 14% of adolescents have self-injured and the numbers are predicted to rise (Ross & Heath, 2002; White Kress, 2003). Self-injury usually begins in the adolescent years (Conterio & Lader, 1998). These years are tumultuous, full of physical, emotional, and social change (Santrock, 2001). Adolescence has always been hard, but it is harder today because of the cultural changes in the last twenty years; divorce, drugs, sexual activity, and pressure to be thin. All of these pressures build (Pipher, 1994). Today's girls, especially, "are under more stress...they have less varied and effective coping strategies to deal with that stress, and they have fewer internal and external resources on which to rely" (Pipher). In order to calm that stress, many turn to self-injury (Conterio & Lader).

Self-injury is "a volitional act to harm one's own body without intention to cause death" (Yaryura-Tobias, Neziroglu, & Kaplan, 1995, p. 33). Most cases involve self-cutting, but can involve bruising, burning, or bone breaking. Self-injury is not a suicidal behavior. Three factors generally distinguish between the two (Lloyd, 1997). First, methods of self-injury are of low lethality, meaning they are unlikely to cause death, and cause little purposeful physical damage. Second, self-injury is highly repetitive. Most self-injurers have multiple episodes of self-injury over a long period

of time as evidenced by Bach-y-Rita's finding (1974) that the self-injurer averaged 93 scars upon entering therapy. Third, very few self-injurers report suicidal intent or ideation while self-injuring (Walsh & Rosen, 1988).

Theories abound on the reasons for self-injury: the body focused culture, body alienation, emotional deprivation, abuse, divorce, and biology, but none alone adequately explain why people injure themselves and why suddenly there is an increase in this behavior. The increase in reports of self-injury is most likely due to the media attention given to self-injury via television shows such Beverly Hills, 90210 and Seventh Heaven, and disclosures of self-injury by celebrities such as Angelina Jolie, Johnny Depp, and Princess Diana. This sudden attention is similar to the attention eating disorders received in the 1970s. As awareness grew and better therapeutic techniques were developed, people began to seek help, creating an "epidemic of disclosure" (Levenkron, 1998; Conterio & Lader, 1998).

- Despite the interest of the mainstream culture in self-injury, little empirical research exists. Much of the existing research consists of case studies (Solomon and Farrand, 1996) and when research has been conducted, much of it involves clinical samples with psychiatric disorders such as Borderline Personality Disorder, making this literature difficult to extrapolate to other populations (Herpetz, 1995). There are no published studies analyzing self-injury in adolescent community samples and only one analyzing self-injury among adolescents in a school setting (Ross & Heath, 2002).

The school setting is a prime location for prevention and identification programs for self-injury. Students spend more of their waking hours in the school building than at home, at work, or with friends (Kush, 1991). This allows

considerable time to both observe student behavior and have direct interaction with students. School counselors, specifically, are in a unique position to work with the mental health needs of students. Students with emotional disorders, such as depression, anger management, autism, and post-traumatic stress disorder are increasingly being identified in the school setting (Dollarhide & Saginak, 2003). A review of school counselor literature reveals information on how school counselors can assist children and adolescents with divorce, homelessness, sexual abuse, parental alcoholism, suicidal thoughts, tobacco use, body image, rape, pregnancy, domestic violence, dating violence, racism, sexual preference, eating disorders, bullying, substance abuse, AIDS, and grief. School counselors' roles often include working with students facing these issues, training school staff to manage these needs in the classroom, and providing referrals to outside resources.

Unlike teachers, counselors typically have time reserved in their day for working individually with students. Students identify school counselors as the most likely person in the school building to whom they would divulge a personal problem (Armacost, 1990), thus counselors are often the first mental health professional the student encounters (Froeschle & Moyer, 2004). Their actions often have long-term positive or negative implications, as they may determine whether or not a student is seen by another professional (Froeschle & Moyer). Junior high and senior high school counselors are uniquely positioned, as self-injurious behaviors may both begin and end in the junior high and senior high school years (White Kress, Gibson, & Reynolds, 2004; Ross & Heath, 2002; Suyemoto and MacDonald, 1995). Their roles and responsibilities offer school counselors unique opportunities to identify and intervene

with adolescent self-injurers. This early intervention is essential, before the self-injurious behaviors become more severe.

In order to identify and intervene, school counselors must be knowledgeable about the topic of self-injury and the steps to take when a student is self-injuring. To date, no public health or health education journal has published an article on self-injury in the non-psychiatric population and school counseling literature has published fewer than five articles. There is little literature addressing the school counselor and self-injury, although there is parallel literature describing school counselors and other health concerns such as suicide and eating disorders. The purpose of this research project was to determine the frequency with which school counselors encounter self-injuring students, their knowledge regarding self-injury, and their confidence in working with self-injurers. Additional goals included determining what supports school counselors perceive that they need in order to work effectively with this population and describing the appropriate role of school counselors when working with self-injurers.

Research Questions

This study focuses on the following questions:

1. Are counselors familiar with the topic of self-injury and, if yes, from what sources have they learned about this topic?
2. Do counselors consider themselves knowledgeable on this topic?
3. Which school staff members are currently working with self-injurers? Do school counselors feel providing consultation to self-injurers is part of their role as a school counselor?
4. How confident are school counselors in providing services either to self-injurers or to parents, teachers, or other students about self-injury?
5. What portion of this sample of school counselors has worked with self-injurers during the 2002-2003 school year? And what portion has worked with self-injurers ever?
6. What are the demographics of the self-injurers they have worked with?
7. Of those who have worked with self-injurers, how did they become aware of the self-injury and what actions did they take when working with these students? Of those who have not worked with self-injurers, what do they predict they would do in the future? How do the predicted and real actions differ?
8. According to counselors, are teachers and students knowledgeable about self-injury?
9. At what grade level do school counselors think the risk for self-injury begins?
10. Is self-injury included in the curriculum and does that differ if there is a health educator on staff or if the school has a Coordinated School Health Program?

11. Are there specific patterns of responses creating factors that could describe different attitudes toward self-injury?
12. How prevalent do school counselors estimate self-injury to be (indirect measure of prevalence)?
13. Do schools have an identified policy for self-injury? What health concerns do schools have identified policies for?
14. Is there measurable interest in learning more about self-injury?

Assumptions

1. The assumption is made that respondents are truthful in their responses.
2. The assumption is made that respondents' answers refer only to self-injurious behaviors that meet the criteria of the given definition.
3. The assumption is made that school counselors are aware of only a small fraction of the students who self-injure as many self-injurers hide this behavior.
4. The assumption is made that treatment of self-injury is not part of the school counselor's role. Only a professional therapist is qualified to provide treatment, but school counselors are an important mechanism to link self-injuring students to therapists.

Limitations

1. The sample will be drawn from the American School Counseling Association membership list. Although this is the largest school counseling association in the United States, less than 10% of the nation's school counselors are members. The results may not be representative of all school counselors if there is a systematic difference between members and non-members.
2. Sampling 1,000 of the approximately 7,000 working members of ASCA may provide too small a sample to consider the results generalizable to all members of ASCA or to school counselors who are not ASCA members.
3. Volunteer bias will be present as those who respond to the questionnaire may be more interested or more experienced in self-injury than those who do not respond.
4. By framing all questions in the 2002-2003 school year, school counselors' experiences with self-injurers in previous years will not be accounted for.
5. As all data is self-reported, respondents may provide socially desirable answers.
6. Correlation does not prove causation. As many of the results will be correlations, it is important not to assume cause and effect.
7. As counselors' positions require varying degrees of educational planning versus counseling responsibilities, some counselors will have had more opportunities for experience with self-injurers than other counselors.
8. Newer counselors may still be registered with ASCA as students and thus not be included in this sample.
9. As self-injury is a hidden behavior, no counselor will have a complete picture of the extent of self-injury in the school.

CHAPTER 2

REVIEW OF THE LITERATURE

Self-injury Overview

Psychologists and sociologists have only studied self-injurious behavior (SIB) for approximately 65 years (Suyemoto & Kountz, 2000), but the behavior was recorded as long ago as Biblical times. Mark 5:5 refers to a demon-possessed man who was “always, night and day...crying and cutting himself with stones” (King James Version). In the Middle Ages, a religious sect known as the “flagellants” roamed through Europe, lashing themselves with cat-o’-nine-tails to atone for society’s sins, believing that self-flagellation would appease God’s anger and prompt forgiveness (Conterio & Lader, 1998). Throughout history people around the world have altered their bodies in painful ways, such as tattooing, piercing, foot binding, or scarring as a way to decorate the body or to affiliate with a certain tribe. Today, self-injury has taken on a new function. People are now using self-injury as a coping mechanism. When their emotional pain is too great to bear, when they have no other way to communicate distress, they pick up a knife and let the pain bleed out.

This literature review will focus on repetitive self-injury as a coping behavior used to regulate emotion, as opposed to a symptom of a mental illness or organic disease. Self-injurers are not psychotic, but injure themselves in an impulsive effort to gain relief from intolerable feelings (Perlmutter, 1982). People use a wide variety of methods to injure themselves; cutting, burning, bruising, pulling hair, biting, interfering with the healing of wounds, and the breaking bones. The common bond among self-injurers is a struggle with inner pain that seems too vast to cope with and

the relief SIB brings them from these feelings. This paradox has earned SIB the moniker, the “wounding embrace”, because self-injurers are both harming and comforting themselves simultaneously (Conterio & Lader, 1998).

Defining and Categorizing Self-injurious Behaviors

Everyone engages in some behaviors that are either unhealthy or harmful. People also do things, such as piercing ears or getting a tattoo, that inflict injury, but are primarily intended for other purposes, such as decoration or group affiliation. Some forms of self-harm, like full body tattooing among Polynesian peoples, are injurious, but culturally sanctioned, while other forms, like self-castration, are seen as pathological. The dividing line is sometimes blurry. An obvious distinction is when the behavior causes intentional immediate physical harm. Intentionally hitting yourself with a hammer, for example, is clearly self-injurious behavior. Actions like overeating, smoking, or not exercising also hurt the body in the long run, but immediate physical damage is not the desired effect of the behavior (Martinson, 1998). Some actions, such as punching a wall, are hard to categorize. A person may be expressing anger or hurting himself as a way to cope with negative feelings.

A wide variety of terms have been used in the literature to describe these behaviors. Frequent terms used include: self-injurious behavior (Winchel & Stanley, 1991); self-mutilation (Walsh and Rosen, 1988); deliberate self-harm (Kahan & Pattison, 1984); non-fatal deliberate self-harm (Morgan, 1979); delicate self-cutting (Pao, 1969); and self-inflicted violence (Alderman, 1997). In addition to the multiple terms commonly used to describe self-injurious behaviors, many and varied

definitions also exist in the literature. Walsh and Rosen (1988, p. 10) define self-mutilative behavior as “deliberate, non-life-threatening self-effected bodily harm or disfigurement of a socially unacceptable nature”. Winchel and Stanley’s (1991, p. 306) definition is more specific. It defines self-mutilation as “the commission of deliberate harm to one’s own body. The injury is done to oneself, without the aid of another person, and the injury is severe enough for tissue damage (such as scarring) to result. Acts that are committed with conscious suicidal intent or are associated with sexual arousal are excluded.” Favazza (1999, p. 125) defines self-mutilation as the “direct and deliberate destruction of body tissue without conscious suicidal intent”. This lack of consensus in nomenclature and definition complicates generalization across studies, in terms of theory, research, and treatment (Suyemoto, 1998).

Although research reports measure many forms of self-injury, some only include skin cutting and others include self-injury, drug overdoses, and suicidal behavior together.

Much work has been done to categorize self-injurious behaviors. In 1935, Menninger defined six categories of self-mutilation. The six categories were multi-dimensional, but not exhaustive or mutually exclusive. His categories included “neurotic self-mutilations”, such as nail biting or skin picking; “religious self-mutilations”, which included ascetic self-flagellation; “puberty rites”, such as hymen removal or circumcision; “self-mutilation in psychotic patients”, including self-enucleation and extremity amputation; “self-mutilations in organic diseases”, such as intentional breaking of fingers; and lastly, “self-mutilation in normal people: customary and conventional forms”, including trimming of hair and shaving. Criticisms of Menninger’s schema include the misclassification of hygiene behaviors,

such as shaving, as self-injurious and his failure to include self-injuring behaviors in the mentally disabled (Walsh & Rosen, 1988).

In 1979, Ross and McCay used a behavioral-descriptive approach to categorize self-injurious behaviors. The categories refer to the type of action used to inflict the harm. The categories are cutting, biting, abrading, severing, inserting, burning, ingesting or inhaling, hitting, and constricting. No attempt was made to differentiate the behaviors based on level of disturbance, cultural context, or psychodynamic determinants (Walsh & Rosen, 1988). Their classification system simplified the categories, but disregarded the psychological state or social acceptability of the act.

In order to include the wide variety of human behaviors that involve alteration of the physical appearance, Walsh and Rosen (1988) suggested four types of self-injurious behavior (see Table 0.1). Each type varies in its degree of physical damage, the psychological state the person is in at the time of the act, and the perceived social acceptability of the behavior. Self-injurious behaviors are included in Type I if physical damage is superficial to mild, the psychic state at the time of the act is benign, and the social acceptability of the act is broad. Examples include nail biting, ear piecing, or small tattoos. Type II behaviors are acceptable in certain subcultures, such as large tattoos among sailors or ritualistic scarring among African tribes. They cause mild to moderate damage to the body and the psychological state that accompanies the act is benign to agitated. Type III behaviors are generally unacceptable to all social groups, but may be accepted among a few like-minded peers. These include wrist and body cutting and self-inflicted cigarette burns. The physical damage is mild to moderate and the person is often in a state of psychic crisis

when inflicting the injury. Type IV is associated with psychotic decomposition and is entirely unacceptable among all groups, even among peers. The physical damage is severe. These behaviors include injuries such as auto-castration or self-enucleation. Walsh and Rosen identified Types III and IV as self-injury, but not behaviors in Types I and II. The distinction, in their opinion, is the deviance from normal behavior. This continuum is helpful as it allows all self-injurious behavior to be viewed among a full range of behaviors.

Type	Examples	Degree of Damage	Psychological State	Social Acceptability
I	Ear piercing Nail biting Small tattoos (professionally applied) Cosmetic Surgery	Superficial to mild	Benign	Acceptable in all or most groups
II	Punk rock piercings Ritualistic scarring among clans Large tattoos among sailors	Mild to moderate	Benign to agitated	Acceptable only within a subculture
III	Wrist and body cutting Self-inflicted cigarette burns	Mild to moderate	Psychic crisis	Generally unacceptable in all social groups, may be acceptable with a few like-minded peers
IV	Autocastration Self-enucleation Amputation	Severe	Psychotic decomposition	Entirely unacceptable with all groups and all peers

Favazza (1996) identified the first step in classifying self-harm as sorting out what makes a method of self-injury pathological, as opposed to culturally-sanctioned. Culturally sanctioned self-injury, he found, falls into two groups: rituals and practices. Rituals are distinguished from practices in that they reflect community tradition. They usually have deep underlying symbolism and represent a way for an individual to connect to the community. The full body tattooing of Polynesia, "moko", is an example of ritualistic self-harm. Comparatively, a practice has little underlying

meaning to the practitioners and is sometimes a fad. Practices are done for purposes of ornamentation, showing identification with a particular cultural group, and in some cases, for perceived medical/hygienic reasons. Most tattoos and piercings seen in the United States today fall into this category. As cutting and burning behaviors are not accepted by the majority of the culture, Favazza considers them pathological, not culturally sanctioned.

There are five issues that can be addressed when differentiating SIB from other behaviors: directness, social acceptability, frequency and degree of damage, intent, and psychological state (Suyemoto & Kountz, 2000). 1) The directness of SIB distinguishes it from indirect self-harm behaviors such as drunk driving or smoking cigarettes. The primary purpose of SIB is harm; whereas pleasure or addiction, not harm, is the primary purpose of smoking cigarettes. 2) In virtually all subcultures, self-injury is socially unacceptable. This differs from injurious behaviors, such as full body tattooing among Polynesian peoples or female genital mutilation in some African countries, in which case the injuries are both acceptable to and encouraged by the culture. 3) The damage from SIB is minor to moderate, resulting from repetitive behavior. This distinguishes it from the more extreme injuries seen in psychotic patients such as autocastration or self-enucleation, which is a single violent act. 4) SIB is not a suicide attempt. The intent of the person is to end the negative emotions, not to end life. 5) Finally, SIB is different from the stereotypical self-injury often seen in persons who are mentally retarded or autistic as it is not related to cognitive or organic impairment or a need for self-stimulation.

Classification of Self-injury in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*

Self-injury is one of the specific diagnostic criteria of Borderline Personality Disorder in the DSM-IV (Suyemoto & Kountz, 2000). Because of this, self-injurers may, based solely on their cutting behavior, be diagnosed as Borderline, even if they have no other symptoms of the disorder. Although many borderline patients self-injure, not all people who self-injure have Borderline Personality Disorder. This mistaken diagnosis is fairly common as there is no separate diagnosis for people whose only symptom is repetitive self-injury. Self-injurers may also be mistakenly classified as depressed, anxious, or suicidal. Favazza (1996) calls for a new separate diagnosis of “repetitive self-mutilation syndrome” (RSM). He argues that repetitive self-injury should be listed on Axis I among the “impulse control disorders, not elsewhere classified” along with kleptomania, pyromania, pathological gambling, and trichotillomania. The essential feature would be the “recurrent failure to resist impulses to harm one’s own body physically without conscious suicidal intent”. The diagnostic criteria for RSM would be:

- A. Preoccupation with harming oneself physically;
- B. Recurrent failure to resist impulses to harm oneself physically, resulting in the destruction or alteration of body tissue;
- C. Increasing sense of tension immediately before the act of self harm;
- D. Gratification or a sense of relief when committing the act of self harm; and
- E. The act of self-harm is not associated with conscious suicidal intent and is not in response to a delusion, hallucination, transsexual fixed idea, or serious mental retardation (Favazza, 1996, p. 256).

Distinguishing Self-injury from Suicide

Many definitions of self-injury specifically differentiate between self-injury and suicide (Kahan & Pattison, 1984; Walsh & Rosen, 1988). Suicide and self-injury

are very different behaviors. "A person who truly attempts suicide seeks to end all feelings, whereas a person who self-mutilates seeks to feel better." (Favazza, 1998, p. 262) Suicidal behavior is considered an out of control behavior, compared to the total control a person who self-injures maintains (Solomon and Farrand, 1996). There are three factors generally thought to distinguish self-injurious acts from suicidal acts (Lloyd, 1997). First, methods of self-injury are low lethality, meaning they are unlikely to cause death and cause little purposeful physical damage. Second, self-injury is highly repetitive. Most self-injurers have multiple episodes of self-injury over a long period of time as evidenced by Bach-y-Rita's finding (1974) that the self-injurer averaged 93 scars upon entering therapy. Third, very few self-injurers report suicidal intent or ideation while self-injuring (Walsh & Rosen, 1988).

Epidemiology

It is difficult to accurately estimate the number of people who self-injure because it is sometimes difficult for outsiders to distinguish self-injurious behavior from suicide attempts. In some studies, no attempt is made to distinguish between the two behaviors, thus suicidal behavior, such as an overdose, is included in the data. In other studies, only one type of self-injury (such as cutting or burning) is included (Suyemoto, 1998). As the injuries are often purposely hidden, reports from hospitals, police, or social service agencies underreport the occurrence.

In the general population of the United States estimates range from 14 to 600 per 100,000 (.014-.6%) annually. The rates are higher in adolescents and young adults. Ross and Heath (2002) found almost 14% of junior and senior high students

had engaged in at least one act of self-injury. The estimates in the general college student population range from 1.8-12% (Suyemoto & Kountz, 2000). The incidence of self-injury in the psychiatric population is far higher than in the general population. Estimates range from 4.3% to 20% in all psychiatric inpatients (Darche, 1990; Doctors, 1981; Langbehn & Pfohl, 1993). Studies focusing solely on self-injurious behaviors in psychiatric populations of adolescents show a much wider range of estimates, almost 4% in one study (Darche, 1990) and more than 60% in another (DiClemente, Ponton, & Hartley, 1991). Favazza and Conterio (1988) estimate the prevalence of self-injurious behavior to be .75% in the general population of the United States and 1.8% in the 15 to 35 age group.

Favazza and Conterio (1988) paint the "portrait" of the typical self-injurer entering therapy as female, in her mid-20s to early 30s, with a history of hurting herself since her teens. She tends to be middle- or upper-middle-class, intelligent, well educated, and from a background of physical and/or sexual abuse or from a home with at least one alcoholic parent. She may also have an eating disorder. While there is no argument that the typical patient is female, single, intelligent, and from a middle to upper-middle class family, the number of minorities and males who self-injure is believed to be vastly underreported. One report estimates that males may account for as many as 40% of self-injurers, but their injuries (cuts and bruises) are overlooked as a product of "macho outbursts" such as fighting or sports injuries (Edwards, 1998).

The first time people self-injure is usually in middle to late adolescence, but they are usually not seen in therapy until their early-twenties (Conterio & Lader, 1998; Favazza & Conterio, 1988). By the time they reach therapy, five to ten years after the

behavior began, they have an average of 93 scars (Bach-y-Rita, 1974). Ross and Heath (2002) found ninth grade to be the most frequently reported time to begin self-injuring and that many self-injurers stop the behavior by age eighteen (Suyemoto & MacDonald, 1995).

Self-injury has been reported almost exclusively in Whites. There are two common explanations for this phenomenon. First, as data is often collected in therapists' offices. If Whites have better access to therapy, they would appear to have higher rates of the behavior. Another possible explanation is that white females are truly more likely to self-injure because they are exposed to greater social pressures and weaker family ties than minority adolescents (Conterio & Lader, 1998). Until recently, self-injury was regarded solely as problem in Western nations, but it is now beginning to be seen in non-Western cultures. Changes in the conventional sociocultural values related to weakening religious ties have been implicated in the increasing number of reports in these cultures (Osma & Ibrahim, 1997).

The "Epidemic of Disclosure"

Self-injury in adolescents and young adults has received increased attention in the popular media in recent years (MacAniff-Zila & Kiselica, 2001). In 1992, when Princess Diana admitted that she cut herself with razors, pen knives, and lemon slicers, the disease became mainstream. Television's *Seventh Heaven* and *Beverly Hills, 90210* have run episodes on self-injury and rapper Eminem's song *Stan* contains the lyrics, "Sometimes I even cut myself to see how much it bleeds, it's like adrenaline the pain is such a sudden rush for me." Suddenly, mental health professionals were seeing

an increase in cases in their offices. It looked like an epidemic, but it is better described as an “epidemic of disclosure” (Levenkron, 1998; Edwards, 1998; Eminem, 2000). Those who had long suffered silently were able to give a name to the violence they had been inflicting upon themselves after it became mainstream. They were now looking for therapy for a behavior which had long historical roots, but had never been recognized as a mainstream mental health complaint.

Etiological Considerations

Few non-self-injurers can understand why a person hurts his or her own body. There are many theories attempting to explain self-injury, though none are wholly accepted. Favazza (1996) discusses several possible reasons why people self-injure. They may be trying to escape from emptiness or depression, to ease tension, to continue abusive patterns, to reduce physiological arousal, or to repress sexuality. Conterio and Lader (1998) describe seven cultural forces they believe foster this behavior. 1) The increasing disenfranchisement of society. 2) Children having fewer adult confidants and less verbal communication with adults due to parental divorce. 3) A quick-fix ideology. The American culture emphasizes immediate gratification, so any negative emotion must be immediately relieved, either by a pill or a knife. 4) The normalization of addiction. The media perpetuates the idea that everyone is addicted to something and every family is dysfunctional. 5) A body-focused culture. Many believe we can change how we feel by changing how we look on the surface. 6) Gender bias. Females need better ways to express their frustration with a society that is sometimes repressive. 7) Latchkey kids. Adolescents sometimes raise themselves

and turn to their own peers, rather than their parents, for guidance. Conterio and Lader (1998) claim that these forces, in combination with people who are fragile to begin with, lead to emotional deprivation. It is this emotional deprivation that compels someone to self-injure.

Green (1978) also explored the emotional deprivation hypothesis, finding a significantly higher incidence of self-destructive behavior (self-biting, self-burning, hair pulling, head banging, suicide attempts, and suicidal thoughts and gestures) reported among physically abused children (40.6%), compared to non-abused but neglected children (17.2%), and “normal” controls (6.7%). Green hypothesized that abuse exposed a child to “the threat of abandonment” corresponding to Freud’s concept of “traumatic neurosis”, and the child was attempting to escape after an abusive episode. Similar research by Darche (1990) showed that adult women who experienced childhood sexual abuse, childhood physical abuse, or witnessed violence as children, were more likely to display self-injurious behaviors. He did not find this same connection between self-injury and childhood emotional abuse or neglect, but he did find that incest and sexual abuse were associated with self-injury in adolescent female psychiatric patients.

Walsh and Rosen (1988) measured all variables that had previously been reported in the literature to be significantly associated with self-injury. Using stepwise multiple regression, they developed a predictive model of adolescent self-injury. Their model indicates that certain conditions must be present in both childhood and adolescence for self-injury to occur. Their model shows that persons are at risk for self-injury if in childhood: 1) they were in foster care or their parents divorced, 2) they

experienced serious illness or injury, 3) they were physically or sexually abused, or 4) there was a familial impulse disorder, AND if in adolescence: 1) they experienced a recent loss, 2) showed body alienation, 3) abused substances, or 4) experienced peer conflict. This model was found to predict 67% of subsequent cases of self-injury.

Another hypothesis is that self-injurious behavior is maintained by negative reinforcement. After a self-injurious act, an aversive stimulus, such as emotional pain, is terminated or avoided (Carr, 1977). This hypothesis corresponds well with descriptions of the feelings associated with self-injury. Feelings of extreme tenseness, anxiety, anger, or fear are reported immediately before self-injury. Most report feelings of relief, release, calm, or satisfaction during the act, which end the feelings of anger, tension, or dissociation that precipitated the act (Suyemoto & Kountz, 2000). Self-injury seems to bring an immediate decrease in tension that results in a relaxed state. It is one way for those who lack a more adaptive means to achieve psychological homeostasis and regulate intolerable emotions (MacAniff-Zila & Kiselica, 2001).

Biological models of SIB, based on animal research, are also common, although not easy to extrapolate to humans. For example, auto-mutilation in certain types of rats can be induced by administering caffeine or other stimulants. Since stimulants increase dopamine levels in the brain, it is plausible that the increased dopamine levels cause the mutilating behaviors. The role of dopamine has also been studied in rats that have undergone 6-OH-dopamine-induced denervation of dopaminergic neurons. These rats self-bite when given dopamine agonists. It is suggested the agonists induce the SIB behavior via activation of D_1 receptors and the

destruction of the dopaminergic neurons may lead to hypersensitivity of the D₁ receptors, “priming the animal for pathological responses to dopamine agonists later in life” (Pies & Polpi, 1995, p. 581).

Another animal model involves Clonidine, a drug used to treat hypertension and symptoms of drug withdrawal. Its major action is to stimulate neurotransmitters in the brain. Bhattacharya, Jaiswal, Mukhopadhyay, and Dalta (1988) found that Clonidine produces severe auto-biting in isolated, food deprived mice; the larger the dose, the more frequent the biting on the forearms. The behavior was further increased when mice additionally received drugs that reduced the serotonin levels. The behavior was reduced by drugs that increased the serotonin levels (as cited in Favazza, 1996).

Biologic models exist for organic mental illnesses that involve self-injury. People with Lesch-Nyhan syndrome self-inflict severe mouth and face injuries. Autopsied brains from these patients show decreased levels of dopamine. Supersensitive dopamine receptors, due to initial dopamine deficiency, have been suggested to be at fault. In Cornelia deLange syndrome, in which self-injurious behaviors and excessive grooming are associated with mental retardation, depressed whole blood serotonin levels have been found (Pies & Polpi, 1995). Carlson (1986) demonstrated that reduced levels of serotonin lead to increased aggressive behavior in mice. In this study, serotonin inhibitors produced increased aggression and serotonin excitors decreased aggression in mice. Since serotonin levels have also been linked to depression, and depression has been positively identified as one of the long-term consequences of childhood physical abuse, this could explain why self-injurious

behaviors are seen more frequently among those abused as children than among the general population (Malinosky-Rummel & Hansen, 1993). The belief that self-harm may result from decreases in necessary brain neurotransmitters is a promising line of research.

Coccaro, Kavoussi, Sheline, Berman, and Csernansky (1997) have done much to advance the hypothesis that a deficit in the serotonin system is implicated in self-injurious behavior. They found that irritability is the core behavioral correlate of serotonin function, and the exact type of aggressive behavior shown in response to irritation seems to be dependent on levels of serotonin. If subjects had normal levels of serotonin, irritability was expressed by external responses, like screaming or throwing things. If serotonin levels were low, aggression increased and responses to irritation escalated into internal behaviors, such as self-injury or suicide.

Chernaik (1991) combined the biologic model with the emotional deprivation model by hypothesizing that since pain leads to increased brain levels of endorphins, possibly there is a psycho-physiological mechanism causing addiction to high endorphin levels in childhood, due to repeated psychological and physical abuse. The now-adult, at times of stress, can raise endorphin levels by inflicting self-injury (as cited in Winchel & Stanley, 1991). Whether addiction to self-injury, either physiological or psychological, is possible is a topic that needs further exploration.

Many self-injurers have certain behaviors or emotional characteristics in common. These include a strong dislike of themselves, hypersensitivity to rejection, chronic anger, a tendency to suppress anger, a high level of aggressive feelings, impulsivity, depression, chronic anxiety, irritability, a lack of coping skills, a lack of

feelings of control, and avoidance (Martinson, 1998). Even knowing of these indicators, people who self-injure are often difficult to recognize because they hide their scars, much like the battered woman or the anorexic (Vietmier, 1997).

Although many studies report child sexual abuse as one major predictor of self-injurious behavior, some studies refute this. Brodsky, Clotre, and Dulit (1995) showed that abuse as a child is not a marker for dissociation and self-injury as an adult. They believe a more plausible explanation is that there is some basic characteristic present in people who self-injure that is not present in those who do not, and the characteristic is something more subtle than child abuse. Linehan (1993) describes people who self-injure as having grown up in "invalidating environments". While an abusive home certainly qualifies as invalidating, so do other more "normal" situations. Linehan says,

An invalidating environment is one in which communication of private experiences is met by erratic, inappropriate, or extreme responses. In other words, the expression of private experiences is not validated; instead it is often punished and/or trivialized. The experience of painful emotions [is] disregarded. The individual's interpretations of her own behavior, including the experience of the intents and motivations of the behavior, are dismissed... Invalidation has two primary characteristics. First, it tells the individual that she is wrong in both her description and her analyses of her own experiences, particularly in her views of what is causing her own emotions, beliefs, and actions. Second, it attributes her experiences to socially unacceptable characteristics or personality traits.

Examples of invalidating remarks include: "You say no, but you mean yes, I know.", "You really did do it." (something she in truth, hadn't), "Stop lying.", or "You're just not trying hard enough." Everyone experiences invalidations like these at some time, but people brought up in invalidating environments hear them constantly. Some parents mean no harm, but are unable or are too uncomfortable with negative emotion

to allow their children to express it, and the result is unintentional invalidation.

Chronic invalidation can lead to almost subconscious self-invalidation and self-distrust, and to feelings of "I never mattered." (Martinson, 1998).

Another plausible explanation of the self-injurious behaviors is the calming effects they provide. Haines, Williams, Brain, and Wilson (1995) found that reduction of psycho-physiological tension may be the primary purpose of self-injury. It may be that when a certain level of physiological calm is reached, the self-injurer no longer feels an urgent need to inflict harm on his or her body. The lack of pain during self-injury may be due to dissociation in some self-injurers and to the way in which self-injury serves as a focusing behavior for others (International Child and Youth Care Network, 1997). Self-injury's calming effect may become a coping mechanism. For example, when children are abused, they have no control over the situation. Their abusers can hurt them any time, and they are powerless to stop it. When these children grow older and are faced with stressful situations, there is often a strong desire or expectation for some sort of pain, since pain is associated with stress in their minds. People who have had these associations forced on them may cut themselves because self-injury is a pain that satisfies the psychological desire for pain, but it is also a pain that the victim can stop. The person is finally in control. While the cutting itself is harmful and can cause shame and guilt later, the control feels good (Conterio & Lader, 1998). This coping mechanism is illustrated in this quote from a teenage girl who cuts herself.

Cutting helps to bring me back to the here and now. It's not going to solve the problems, but it can stop me from being trapped. It can end the feelings of having to live through everything over, and over, and over, and over, and over, and over --

that I have had to endure for years on end, anyway. It doesn't make them go away but it's a safe feeling of knowing "Ok, I can feel this, I can feel the blade cut through my skin. I am here and it's not happening now." Sometimes it is plain and simple, the pain is too much and I just want it to stop. I'm angry and I can take it out on my body. I'm scared. Whatever the feelings are that whirl around in my mind, constantly and endlessly; I just want it [sic] to stop. I want to feel the physical pain -- not the most horrible torture. When it boils down to it, I would prefer to be hurting physically then [sic] emotionally. That pain does eventually subside. (Bethanii, 2000)

Solomon and Farrand (1996, p. 111) further described this coping mechanism as an adaptive act and a “means of survival born of the will to carry on, despite overwhelming feelings of helplessness, despair, and self-hatred”. This description, in fact, liberates self-injurers from a medical model that trivializes their experiences, both past and present, and which “fails to recognize the meaning of their actions within a context of survival in impossible circumstances” (Solomon & Farrand, p. 111). One reason cited for the preference for physical damage over emotional pain is that physical pain is more manageable. Physical pain’s origins are obvious and unproblematic compared to the origins of emotional pain, which may be unclear and too difficult to face (Solomon and Farrand).

Typical Symptoms and Associated Features

Self-injurers characteristically have difficulty verbalizing emotions and distancing feelings. Self-injury enables the passive emotions that come from negative feelings to be turned into an active, physical event that can be externalized and controlled. Thus, self-injury is used to communicate the intensity of pain and create physical evidence of emotional injury. This allows self-injurers to feel that their emotions are real, justified, or able to be tolerated (Suyemoto & Kountz, 2000). The

precipitating event is usually a perception of interpersonal loss, such as the breakup of a relationship or a therapist's vacation. Feelings of extreme tenseness, anxiety, anger, or fear are reported immediately before self-injury. Often, but not always, the person responds to the overwhelming emotion by dissociating (Suyemoto & Kountz). People almost always isolate themselves before self-injury. Most report feeling no pain during the act. A majority report feelings of relief, release, calm, or satisfaction during the act, which ends the feelings of anger, tension, or dissociation that came before (Suyemoto & Kountz).

Self-injurious behavior is often co-reported with other impulse control problems such as eating disorders, kleptomania, and trichotillomania. Favazza and Conterio (1989) reported 61% of their self-injuring patients either currently had an eating disorder or had an eating disorder in the past. Sometimes they coexisted and sometimes one replaced the other for a time. Favazza and Conterio described this not as a causal element of SIB, but as an alternative choice for coping with similar situations. Among other comorbidities reported are bulimia (40.5%), multiple personality disorder (34%), and substance abuse (60%) (Favazza & Conterio, 1988).

Although both males and females self-injure, females report self-injury with far greater frequency (Favazza, 1996). This difference may be due to females seeking out psychiatric services more frequently than males, but it is more likely due to females' tendency to turn their emotions inward, rather than using outward expressions such as fighting or drug use. The gender divide may also be related to gender bias, driving females "to more severe emotional extremes...Self-injury is just

one example of the measures girls will take to express their frustration, anger, and rage” (Conterio & Lader, 1998, p. 23).

Treatment of Self-injury

Treatment for self-injury consists of ending the feelings that prompt the behavior, not just ending the behavior. The aim of counseling should help the patient “use words, rather than destructive gestures, as a sign of emotion” (MacAniff-Zila & Kiselica, 2001). This is a difficult population to treat in psychotherapy. They are psychologically frail individuals who are hypersensitive to rejection and disappointment. Their potential for acting out, manipulation, and intimidation is high (Malon & Berardi, 1987). Adolescent self-injurers are an especially challenging population to work with (Church, 1994; Hanna, Hanna, & Keys, 1999). They are often hesitant to enter into a helping relationship and have little motivation to change (Rutter & Rutter, 1993; Sommers-Flanagan & Sommers-Flanagan, 1995) and developmentally, they are looking to assert their autonomy, rather than feel controlled (Miller & Rollnick, 1991). Self-injurers also have difficulty trusting others and forming therapeutic relationships (Levenkron, 1998).

Levenkron (1998) suggests five predictors of successful recovery. 1) The child’s age when parental dependency, neglect, or abuse began. 2) The frequency of the parental dependency, neglect, or abuse. 3) The severity of the misconduct in abusive cases or the intensity of neediness of the parents in benign cases. 4) A feeling that life is good enough to get better for. And 5) Having a supportive person upon whom the patient can depend and trust.

Pharmacological treatment has had limited success, but can be an important adjunct to treatment. Antidepressants (such as Prozac) increase the serotonin levels in the brain and have reduced SIB in some patients. This may be due to the alleviation of the impulsivity that underlies the behavior. Naltrexone (a drug used to block the release of the body's natural opiates) has been used to take away the "high" achieved by self-injury. Pharmacological treatment alone has not been found sufficient to modify all the thoughts, behaviors, and relationships that seem to contribute to self-injury (Strong, 1998).

Marsha Lineham's dialectal behavior therapy (DBT) appears to be beneficial to self-injurers. DBT focuses on all forms of self-harm (including suicide attempts), viewing them as faulty problem-solving strategies. It also deals with behaviors that interfere with therapy, such as missing therapy sessions and alcohol abuse. Patients are taught daily life skills and goal setting. DBT employs many strategies including problem solving, capability enhancement, and contingency management (Favazza, 1996). Patients are taught to examine in moment-to-moment detail the chain of events that leads to SIB and what alternatives could be employed.

Psychodynamic therapy is probably the most used long-term treatment for self-injury (Favazza, 1996). To help self-injurers, psychodynamic therapy employs interpreting childhood experiences and setting limits to control acting out. The goal is that self-injury will be transformed into direct, verbally communicated behaviors (Favazza).

Evans, Morgan, and Hayward (2000) attempted to intervene when self-injurers felt the urge to self-injure. Emergency room physicians gave all self-injuring patients

(including suicide attempts) a card in an envelope. Half of the patients received a “green card”, a card offering information on a crisis hotline to call when they felt like injuring themselves. When they called the hotline, a psychiatry student talked to them until the urge had passed. A control group received an envelope with a card containing information unrelated to self-injury. At follow-up assessments, the “green card” subjects were offered significantly fewer subsequent psychiatric out-patient appointments compared to the controls. Thus, the hotline seemed to decrease the need for psychiatric care.

Another form of treatment is trauma resolution, the therapy used with Post-Traumatic Stress Disorder. Patients are taught “grounding” to gain control over dissociative states. Then, relaxation training and stress management are taught to help control the anxiety that triggers the self-injury. Sometimes, eye movement desensitization and reprocessing (EMDR) is used to help the patient defuse the emotional impact of traumatic memories through exposure to imagined situations while in a relaxed state (Strong, 1998).

SAFE (Self Abuse Finally Ends) Alternatives outside Chicago, Illinois, is the nation’s only in-patient center for self-injurers. It started with only a few patients in 1985 and now receives more than 700 calls a month. The therapists push injurers to take responsibility and control in counseling sessions. Controversially, patients are required to give up self-injury immediately to enter the program. They report a 75% decrease in serious recidivism in patients who participate in their five week program (Conterio & Lader, 1998).

There is as much confusion about what will “cure” self-injury as about what causes it. In a 1998 review, Hawton et al. evaluated the effectiveness of ten different approaches to treating self-harm: problem-solving therapy, a special emergency room card getting the patient faster treatment in the ER, intensive education and outreach, and DBT were compared to standard aftercare; inpatient behavior therapy was compared to inpatient insight-oriented therapy; admission to the hospital was compared to discharge after the ER visit; Flupenthixol (an antipsychotic drug) and antidepressants were each compared to a placebo; follow-up by the initial treating therapist was contrasted to follow-up by a different therapist; and long-term therapy was compared with short-term therapy. They found no significant difference in the percentage of repeaters who were in the long-term vs. the short-term therapy trials, the antidepressant vs. placebo trials, the intensive intervention/outreach vs. standard aftercare trials, the emergency card trials, the hospital admission vs. the discharge trials, and the inpatient behavior vs. the insight-oriented therapy studies. The problem solving studies showed a distinct reduction in self-injurious behaviors among those who received problem-solving therapy, but the results of the combined studies did not reach statistical significance. The Flupenthixol study showed significant reduction in repeat self-harm, but it was a very small study and there is some concern that the possible side effects of Flupenthixol outweigh any benefit. The two trials showing a significant decrease in repeat self-harm among the experimental group were the dialectical behavior therapy studies (the DBT group had fewer repeaters) and the same vs. different therapist doing follow-up (the percent of repeaters was higher in the group that saw the same therapist).

As in any type of therapy, increasing the patient's ability to express emotion and maintain a stable sense of self help therapy to be more successful (Suyemoto & Kountz, 2000). Strategies to help express emotion include learning to cope with and express feelings and finding insight into the purpose of the self-injurious behaviors. To maintain a stable sense of self, the therapist can create a positive relational experience involving a certain degree of merger to enable a separation process (Suyemoto & Kountz).

In addition to standard therapy, hospitalization is an option. As previously mentioned, SAFE Alternatives is an inpatient program specially designed for self-injurers located at MacNeal Hospital in Illinois. The program combines milieu therapy, cognitive-behavioral therapies, and group and individual exercises to help patients gain an awareness of why they hurt themselves and how to stop. It is the only inpatient unit in the United States specifically for self-injurers (Conterio & Lader, 1998). The Sanctuary at Friends' Hospital in Philadelphia is an inpatient unit for trauma survivors that is aware of the special needs of self-injurers, but does not specialize in self-injury. Butler Hospital in Rhode Island offers a partial hospitalization program that uses dialectical behavioral therapy to treat a diverse patient population, including self-injurers (International Child and Youth Care Network, 1997).

Unless a cure, such as a medicine, is found to stop self-injury, therapy will be necessary to help self-injurers recover. In order to help those who self-injure, therapists must understand the role this powerful coping mechanism plays in their clients' lives. Whether it is primarily a means of releasing tension, grounding,

communicating, or reliving painful experiences, understanding why a person self-injures is key to helping him or her stop using self-harm as a primary coping mechanism (Martinson, 1998). Insisting on immediate cessation of self-injurious behavior as the primary goal of therapy may be counter-productive, warn Solomon and Farrand (1996, p. 118); "techniques based on the premise that self-injury should not be reinforced by attention, or on the use of sanctions such as withdrawal of treatment, will almost certainly cause greater distress".

Therapists also need to examine their own motives for wanting clients to stop or stabilize their self-injurious behavior. Too often, care providers focus on stopping the injury as quickly as possible because they are not comfortable with it. Self-injury repulses them, makes them feel ineffective, or frightens them. Situations like this can easily deteriorate into a power struggle in which the therapist insists that the behavior stop and the client chooses to self-injure covertly and becomes reticent and distrustful, reducing the chance that a useful therapeutic alliance will be formed (Levenkron, 1998; White, McCormick, & Kelly, 2003). It is appropriate, however, for therapists to work with clients to create a plan for dealing with self-injurious impulses and getting their lives and self-injury stabilized. When a client is self-injuring, the self-injury and its accompanying crises take over, leaving no time in therapy to deal with core issues. To have a minimum of stability, therapists must balance trying to stop the self-injurious behavior and allowing it to dominate the therapy (Martinson, 1998).

Prevention of Self-injury

Just as treatment for self-injury must focus on learning to manage the emotions that lead to the self-injury, rather than on ending the behavior itself; prevention of self-injury must focus on removing the antecedents usually associated with self-injury. Ending societal problems such as physical abuse, sexual abuse, and emotional abandonment would reduce the future number of self-injurers (Levenkron, 1998). Describing the cycle of emotions that lead to self-injurious episodes, Sutton (1999) says fear causes “disturbed emotions” such as anger, denial, defensiveness, inferiority, or guilt and these “disturbed emotions” lead to self-harming behaviors. Then, engaging in the self-harming behaviors leads to more fear, which causes more “disturbed emotions”, which lead to more self-injurious behaviors. This creates a cycle that continues indefinitely. Breaking this cycle, by addressing the self-injurer’s root fears can help to prevent further self-injury (Sutton). Teaching general coping strategies, such as stress management, communication skills, body satisfaction, and self-esteem to adolescents may prevent self-injury, as students may be able to manage their emotions before they escalate into self-injurious behaviors (White, Trepal-Wollenzier, & Nolan, 2002).

School Counselor Overview

There are between 70,000 and 100,000 school counselors currently employed in the United States (United States Department of Labor, 2003). All states require school counselors to hold state school counseling certifications. Many states also require counselors to have teaching certificates (United States Department of Labor).

Most school counselors have at least a master's degree. Degree programs include coursework in eight core areas: human growth and development; social and cultural diversity; relationships; group work; career development; assessment; research and program evaluation; and professional identity. One major professional organization, the American School Counselor Association, represents the profession. This organization has approximately 12,000 members, including current counselors, students, and retirees (ACSA, 1999).

The role of the professional school counselor is defined by the American School Counselor Association (ASCA) as a “certified/licensed educator who addresses the needs of students comprehensively through the implementation of a developmental school counseling program...They are specialists in human behavior and relationships who provide assistance to students through four primary interventions: counseling (individual and group); large group guidance; consultation; and coordination.” (ASCA, 1999) Counseling is further defined as a “confidential relationship in which the counselor meets with students...to help them resolve or cope constructively with their problems and developmental concerns”. Large group guidance is defined as offering all students “a planned, developmental program of guidance activities designed to foster students’ academic, career, and personal/social development”. Consultation is the “collaborative partnership in which the counselor works with parents, teachers, administrators, school psychologists, social workers, visiting teachers, medical professionals, and community health personnel in order to plan and implement strategies to help students be successful in the educational system”. Lastly, ASCA defines leadership as a “process in which the counselor helps organize,

manage, and evaluate the school counseling program” (ASCA, 1999). In today’s school environments, all of these responsibilities must be accomplished in increasingly less time. Although the recommended student to counselor ratio is 250-to-1, the national average is now 477-to-1 (“School Counselors”, 2004). In addition to counseling and educational planning duties, almost all counselors (86%) report responsibility for non-counseling duties such as filing, reception, or requesting records (Burnham & Jackson, 2000).

The role of school counselor has changed as schools and society have evolved. Societal changes such as poverty, homelessness, and substance abuse have pushed the school counselor into more and more of a mental health counselor role, in fact, Lockhart and Keys (1998) have suggested that the time has come for school “guidance” counselors to redefine themselves as school “mental health” counselors. Others, however, would argue that the answer is for schools to link more effectively to mental health counselors in the community. Ponec, Poggi, and Dickel (1998) describe school counselors as the “first line of defense” in screening concerns that require additional time and more specialized treatment than the school professionals can provide.

Previous Health-Related Research with School Counselor Samples

As school counselors are often the personnel identified by school districts to provide secondary and tertiary interventions for health problems in the schools, they have been surveyed about their experiences or involved in interventions with a variety of health concerns, including eating disorders, drug use, teen pregnancy, sexual

identity, and suicide prevention. Price, Desmond, Price, and Mossing (1990) examined school counselors' knowledge of adolescent eating disorders. Participants were 337 members of the American School Counselor Association. Seventy-two percent reported having worked with anorexic or bulimic students. The majority of respondents were very knowledgeable regarding the signs and symptoms of anorexia and bulimia nervosa, recognizing 12 of 14 symptoms. Eleven percent rated themselves as very competent in helping students with eating disorders, 49% reported they were moderately competent, and 40% reported they were not very competent. Most (75%) did not believe treating students with eating disorders was part of their role as a school counselor and would rather refer the student to another resource. The three most common referrals were to eating disorders programs (40%), to their parents (34%), or to a psychiatrist or other physician (34%).

In a similar study, focusing on the ability of school personnel to recognize symptoms of depression, Maag, Rutherford, and Parks (1988) found that counselors were better able to recognize symptoms of depression than regular classroom teachers or special education teachers. Highlighting the role schools can play in depression, Maag and Rutherford (1988) comment:

School personnel can play a strategic role in early identification of depression. Children spend more time in school than in most other structured environments outside the home, and often have their most consistent and extensive contact with trained professionals in school. Schools represent an ideal milieu for assessing depression because students' behaviours, interpersonal relationships, and academic performance, all important indicators of mood and ability to cope, are subject to ongoing scrutiny. School personnel are often in a position to be the first to notice developing depression.

School counselors' ability to identify students at risk for suicide was measured by King, Price, Telljohann, and Wahl (2000). Three-hundred and forty members of ASCA were asked about the risk factors and appropriate steps to take when a student is suicidal. Most of the counselors correctly answered seven of the eight knowledge questions. More than 70% knew nine of the sixteen risk factors. Despite their high levels of knowledge, only 38% believed they could recognize an individual student at risk for suicide. King and Smith (2000) assessed school counselors' knowledge of suicide risk factors and counselors' perceived ability to take appropriate steps when confronted with suicidal students after participating in Project SOAR (Suicide, Options, Awareness and Relief). Most participants indicated that they could recognize suicidal warning signs, assess student risk, offer appropriate support, and take the proper steps when working with high-risk students. School counselors who had completed Project SOAR were more likely, when compared to school counselors nationwide, to report confidence in these skills.

McClanahan, McLaughlin, Loos, Holcomb, Gibbons, and Smith (1998) developed a training project to prepare school counselors to work in prevention, early detection, and appropriate referral of students at high risk for substance abuse. The project trained junior high and high school counselors to work as support group facilitators for students at highest risk for substance abuse. Participants in the training reported greater perceived self-efficacy, comfort, confidence, and competence in working with students at risk of substance abuse.

Price and Telljohann (1991) surveyed school counselors about their experiences working with gay and lesbian students. They reported that 71% of junior

high and high school counselors had counseled at least one gay or lesbian student. In a follow-up study of Kindergarten-12th grade counselors, Fontaine (1998) examined attitudes and knowledge about homosexuality and experiences in counseling gay and lesbian students. Ninety-three percent reported having had contact with students with sexual identity issues. Most counselors underestimated the number of gay and lesbian students in the school and counselors identified “choice of the lifestyle” as the highest contributing factor to homosexuality.

The wide range of results found in these research projects show the variance in the level of knowledge and skills school counselors bring to their job. All counselors may not be prepared, academically or emotionally, to deal with the serious mental and emotional health problems that youth have today. Regardless of their preparedness, youth in every school need the resources of a school counselor ready and willing to meet their needs. Although providing therapy is not within the role of the school counselor’s job, helping students deal with issues that interfere with optimal learning is. The challenge is the balance between counseling responsibilities and educational planning responsibilities.

Although a primary goal of school counseling and guidance is to develop and maintain good mental health among students, educational planning responsibilities consume most of a counselor’s day (Partin, 1993). There is great confusion among school administrators, teachers, parents, and counselors about what their role is or should be (Burnham & Jackson, 2000). Some counselors are mainly focused on individual students’ emotional needs while others are delivering career counseling or administering tests. Burnham and Jackson (2000) compared counselors’ self-reported

daily activities to Myrick's comprehensive developmentally-based guidance program model. They found that school counselors devote 2-75% of their time to individual counseling ($M = 24.24$, $SD = 15.22$), although Myrick's model suggested that no more than 15% of a counselor's time should be spent on individual counseling. They also found that counselors underused small group and classroom guidance, but were overburdened with non-guidance duties, such as scheduling classes, enrolling students, and working with test materials and results. Burnham and Jackson stressed the importance of consultation and collaboration with non-school counselors as an important method for reducing the amount of time counselors spend with individual students.

Counselor Collaboration with School Health Educators

It is increasingly recommended that school health educators be involved in the development and implementation of mental health programming in schools (Moilanen & Bradbury, 2002). By collaborating with the health educator, counselors expand their reach in a variety of ways. First, by offering staff development training on mental health topics, the counselor impacts a larger audience. The hour the counselor spends training school staff, especially school health educators, has the potential to impact the hundreds of students those teachers have contact with (Otwell & Mullis, 1997). In that regard, staff development may be one way to relieve the pressures of the high student-to-counselor ratios, while also increasing awareness of students' mental health needs (Otwell & Mullis). Second, it is appropriate for school health educators, rather than school counselors, to deliver mental health curriculum in the

classroom setting (Dollarhide & Saginak, 2003). Data indicate that, “the need for prevention is critical, and effective prevention interventions can be delivered by properly trained health educators” (Schiraldi, Spalding, & Hofford, 1998, p.74). Finally, by devising strategies for promoting mental health in the classroom, the number of students in need of psychological services in the future may be reduced (Hershenson & Strein, 1991).

Moilanen & Bradbury (2002) described a project utilizing collaboration between counseling staff and school health educators. Due to Massachusetts Youth Risk Behavior Survey (MYRBS) data showing high rates of depression and suicide in the community, Holliston High School in Holliston, Massachusetts, developed a depression and suicide prevention program. The program consisted of education, depression screening, mental health follow-up, resource information, and evaluation of the program. Collaboration with the school health educator was important because it offered an access point to provide information to the entire student body and it provided an existing framework in which to conduct evaluation. Following the program, data from the MYRBS showed a decrease in the number of adolescents who seriously considered suicide, made a plan to commit suicide, and received medical treatment due to a suicide attempt. There was, however, no decrease in the actual number of suicides. This program exemplifies what Schiraldi, Spalding, and Hofford (1998) describe as the “great untapped resource” of health educators. Health educators are well positioned in schools to work collaboratively with school counselors to reduce mental health concerns among adolescents.

School Counselors as a Bridge to Therapy

Referring students outside the school for treatment is one of the most important roles of today's school counselor (Baker, 1992). School counselors are the "first line of defense" in screening concerns that require additional time and more specialized treatment than the school professionals can provide (Ponec, Poggi, & Dickel, 1998). They are in an ideal position for communicating to parents the necessity of additional support and then to collaborate with the referral resource to assist treatment efforts at school and home. In a study reviewing the referral practices of school counselors (Ritchie & Partin, 1994), counselors reported referring an average of 30 students a year to other professionals. In elementary school, child abuse was the most frequent reason for referral, followed by family concerns and emotional concerns. In junior high school, family concerns were the most frequent reason for referral followed by emotional concerns. In high school, emotional concerns, followed by alcohol/drugs were the most frequent causes for referrals. Over half (57%) of the counselors reported that referrals were made when other professionals had more experience in an area or would be more able to assist with the problem. Only 34% indicated that a lack of time to work with students was the primary reason for making a referral (Ritchie & Partin).

Unfortunately, many counselors reported making referrals to professional therapists they were unfamiliar with or had never met. The less familiar counselors were with their referral resources, the more likely they were to report problems with the therapist, such as the therapist being ineffective or uncooperative (Ritchie & Partin, 1994). Links between schools and qualified, competent community-based

therapists are essential in order for school counselors to provide appropriate resource referrals. School counselors and professional therapists can then work as a team help to provide a continuum of care and integrated services. This team approach could take many forms; consultation at the school, qualified therapists working in school-based health clinics, or a school-based mental health center (Porter, Epp, & Bryant, 2000). School-based mental health centers are the solution of choice for the American Academy of Pediatrics. Their Committee on School Health is currently urging the development of three levels of in-school mental health service, including prevention and education programs, targeted services for students with identified mental health needs, and services for students with severe mental health problems (American Academy of Pediatrics, 2004).

Connecting School Counselors and Self-injury

School counselors are in a unique position to work with the mental health needs of students. Students spend one-third of their day at school; more time than at home, at work, or with friends (Kush, 1991). This allows counselors considerable time to both observe student behavior and have direct interaction with students. School counselors are both visible and accessible to adolescents (Lambie & Rokutani, 2002). Unlike teachers, counselors typically have time reserved in their day for working individually with students, and the school setting is especially ideal because almost every adolescent in the United States has access to the public school system (Kush).

Although the age at which self-injury begins varies between individuals, people usually begin self-injuring in adolescence, some time after puberty (Herpertz, 1995; Conterio & Lader, 1998). One study reported ninth grade as the average time of onset of self-injurious behaviors (Ross & Heath, 2002) and Suyemoto and MacDonald (1995) found that age 18 was the most common age for people to stop using self-injury as a coping mechanism. Thus, junior high and senior high school counselors are uniquely positioned to intervene, as self-injurious behaviors may both begin and end on their watch (White Kress, Gibson, & Reynolds, 2004).

School counselors are the “first line of defense” in detecting student problems that may require additional specialized treatment not offered in the school setting (Ponec, Poggi, & Dickel, 1998; Ritchie & Partin, 1994). The job of the school counselor is not intended for or amenable to providing in-depth counseling. In many cases, school counselors need to refer students to professional counselors outside the school (Remley & Sparkman, 1993; Sheeley & Herlihy, 1989). While a student participates in professional therapy, school counselors are able to provide a connection between the school, the parents, and the therapist (Lambie & Rokutani, 2002). To support the ongoing therapy, the counselor can coordinate with the professional therapist to reinforce coping strategies and interventions during the school day (Lieberman, 2004).

The school counselor’s office may also be used as a safe haven when a self-injurer feels negative emotions are overwhelming and needs to be excused from class (Froeschle & Moyer, 2004; Lieberman, 2004). They can provide the non-judgmental support self-injurers need and build a trusting connection by letting self-injurers talk,

cry, or complain while helping them to implement their coping strategies (Lieberman). The counselor can arrange for home tutoring or make-up work if a student misses classes for an extended period of time. It is also possible for the counselor to initiate the development of a Section 504 plan to modify a student's course schedule if necessary (White Kress, Gibson, & Reynolds, 2004). Counseling preparation programs provide graduates with academic background in mental and social development appropriate for interacting with self-injurers (ASCA, 1999). Additionally, their role within the school may involve monitoring grade changes and attendance records, which may be symptomatic of self-injury or other health concerns. Their role also allows counselors to follow students over the course of several years to provide continuous support (Lambie & Rokutani, 2002).

Students identify school counselors as the most likely person in the school building to whom they would divulge a personal problem (Armacost, 1990) and are often the first mental health professional the student encounters (Froeschle & Moyer, 2004). Thus, their actions can have long-term positive or negative implications as they may determine whether or not a student is seen by another professional (Froeschle & Moyer). Counselors can intervene by providing education and referrals, working as advocates, listening, validating self-injurers' experiences, or offering them a safe place within the school (White Kress, Gibson, & Reynolds, 2004). Their roles and responsibilities offer school counselors unique opportunities to identify and intervene with adolescent self-injurers. This early intervention is essential, before the self-injurious behaviors become more severe.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

Sample

The sample was drawn from a membership list obtained from the American School Counselor Association (ASCA), the largest school counseling organization in the United States. ASCA represents more than 7,000 of the approximately 100,000 school counselors in the United States. The initial mailing list contained 7,110 names. Approximately 5,000 members' names were excluded from the list by ASCA because they were retirees or pre-service counselors. An additional four hundred and fifty possible participants were determined ineligible for reasons such as living outside the United States, identification as a university professor, identification as a school board member, or identification as a counselor in private practice. Of the remaining 6,660 possible participants, 1,000 were randomly selected. Subjects were arranged within the dataset alphabetically by state. In order to ensure the entire list was sampled, every seventh name was chosen until 1,000 names were selected. The decision to send questionnaires to 1,000 school counselors was made based on similar projects' response rates and sample sizes (King, Price, Telljohann, & Wahl, 1999; Price, Desmond, Price, & Mossing, 1990; Fontaine, 1998; Wilson, Thomas, & Schuette, 1983).

Procedure for Data Collection

The project was started after receiving approval from the Institutional Review Board at Oregon State University and permission from ASCA to use its membership

list. The questionnaire, along with a postage-paid return envelope and a cover letter explaining the purpose of the study, the participants' confidentiality, and the right to refuse participation, was mailed April 11, 2003 (see Appendices A and B). On April 21, 2003, a follow-up postcard was mailed to all members of the sample (see Appendix C). The purpose of this postcard was to thank those who had responded and to encourage non-respondents to return their questionnaires. On May 5, 2003, a final mailing was sent. This mailing was only sent to members of the sample who had not yet responded. It included a new cover letter encouraging participation, a copy of the questionnaire, and a postage-paid return envelope (see Appendix D). Completion of the questionnaire was considered consent to participate.

Each questionnaire was numbered 1001 to 2000 to track which participants had returned their questionnaire and which participants needed to be included in the second mailing. As questionnaires were returned, they were noted on the mailing list. The identifying number was then removed from the questionnaire and replaced with a sequential number, 1-517.

Survey Instrument

The questionnaire (see Appendix A) was designed by the author for use in this study in order to assess school counselors' experiences, opinions, and behaviors regarding self-injurious behavior in their school population. A survey design specialist, a Professor of Educational Leadership, Counseling, and Post-Secondary Education, and the author's major professor were contacted frequently during the design phase as expert consultants. The survey was pilot-tested with five school

counselors and wording was modified based on their suggestions. The counselors were chosen to elicit a cross-section of inputs. One counselor was male. One counselor was at the beginning of her career, three were mid-career, and one was retiring. Two worked in rural schools, two in suburban, and one in an urban school with a large minority population. One was an elementary school counselor, one worked with all grade levels, one worked with junior high and high school, and two worked with high school only. All five counselors reported having worked with at least one self-injurer.

In order to assure that participants' responses were referring to the same set of behaviors, a definition of self-injury was included at the beginning of the survey ["deliberate destruction of body tissue, not including suicide attempt or overdose on alcohol or drugs", based on Favazza (1996)]. As there are multiple definitions of self-injury commonly used, providing a definition increases the survey's validity. A definition of counseling was also included to assure that all responses regarding counseling referred to helping behaviors and not to treatment behaviors. The definition used ("meeting with students to help them resolve or cope constructively with their problems") is from the American School Counselor Association (1999).

The experiences portion of the questionnaire (Questions 2-17) is loosely modeled after Price, Desmond, Price, and Mossing's (1990) study of school counselors' knowledge of eating disorders. Price, Desmond, Price, and Mossing reported results from 337 members of the American Association of School Counselors (now known as ASCA) on their self-reported level of competence in working with eating disorders, whether or not respondents thought treating eating disorders was part

of their role as a school counselor, and their referral patterns. They also measured knowledge of anorexia and bulimia through a series of true and false questions.

The author developed the knowledge/attitude scale (Question 23) based on common themes associated with self-injury in a comprehensive review of the literature. These statements are neither true nor false in every self-injury scenario, but are either often reported with self-injurious behavior or are commonly believed myths about self-injurious behavior. These opinion statements were also used to measure counselors' knowledge of self-injury.

Information on 15 demographic variables (Questions 26-27 and 29-41) related to the school or the counselor was collected in order to compare differences among existing groups (such as male/female, years of experience, elementary level/high school level). Additional questions asked about existing policies on a variety of health-related issues, documentation practices, and the presence of a health educator on staff or a Comprehensive School Health Program. Questions 42-45 requested open-ended replies on school counselors' opinions about self-injury. Comments given in this portion of the questionnaire will be used in the second phase of this research project, developing a self-injury training program for school counselors.

Validity

The instrument has face validity, in that its contents seem to measure factors related to counselors' experiences with self-injury and it appears to be a reasonable method for doing so (Portney & Watkins, 2000). It also has content validity. It measures a wide variety of factors related to self-injury. To increase content validity,

definitions of both “self-injury” and “counseling” were included on the questionnaire to ensure participants’ responses were referring to the same behaviors. As there are no previous studies on this topic, there are no comparative measures for either construct or criterion validity. As this is a descriptive, rather than a predictive study, face and content validity are of greatest concern.

Procedure for Data Analysis

Data entry and cleaning. Completed questionnaires were returned to the Main Office of the Department of Public Health, Oregon State University. Questionnaires were held there and then mailed in three large batches to the author’s home in Iowa. All questionnaires received before July 21, 2003 were included in the analysis. Two surveys were received after this date. The questionnaires were coded so that every response had a whole number equivalent. Qualitative responses were coded into predetermined categories.

After all questionnaires ($n = 517$) were recorded in Microsoft Excel 2002, the author then visually checked 10% of questionnaires with the spreadsheet for accuracy. She checked every 10th questionnaire, starting with number seven. Seven was used because it was the one-digit random number generated by www.random.com. Thirteen data entry errors were found over 6,292 data points. That is equivalent to a 0.2% error rate. Two surveys were removed from analysis because they were returned totally blank. One survey was removed because the respondent only answered question one. Sixty-four respondents were removed because they responded “no” to question one, they were not currently employed as a school counselors in the United

States. Data were then moved to SPSS (Statistical Package for the Social Sciences, v. 10.0.7).

Missing data. Ten questionnaires were removed from analysis because they were missing more than 20% of the responses. Questionnaires missing some data, but less than 20% of the responses were analyzed using SPSS Missing Values Analysis. This procedure was performed by Dr. Wade Hill of the University of Montana. The method Expectation Maximization (EM) was used to impute the missing data. EM computes a regression model to predict the expected value and then repeatedly runs the model to ensure the best possible fit. EM assumes data is missing completely as random. After being imputed, non-continuous data were rounded to whole numbers to facilitate the use of statistics such as chi-square.

Data analysis. After the dataset was cleaned and missing data were imputed, outliers were identified using frequency histograms for univariate outliers and Mahalanobis D^2 and Cook's Distance Measure for multivariate outliers. All data points identified as outliers were checked for accuracy. Descriptive statistics, t tests, chi squares, and correlations were used in data analysis. As much of the data were neither normally distributed, nor linear in nature, the non-parametric statistics, such as Spearman correlation coefficients, were used when appropriate.

CHAPTER 4

RESULTS

ARTICLE 1: School counselors' practices regarding students' self-injurious behaviors: A summary and implications for practice

ABSTRACT

The purpose of this study was to examine school counselors' practices related to students' self-injurious behaviors. Participants were drawn from a list of 7,110 members of the American School Counselor Association and were asked to complete a 46-item questionnaire on students' self-injurious behaviors. Of the 1,000 randomly selected counselors, 443 (44%) returned usable questionnaires. There were 374 female and 69 male respondents; the mean age was 44.4 years. The majority held at least a master's degree. Most (81%) of the school counselors reported working with a self-injurer during their career and 51% reporting working with a self-injurer during the 2002-2003 school year. School counselors were most likely to be informed about cases of self-injury via a self-injurer's peer (67%). Seventeen percent of counselors identified themselves as highly confident in working with self-injurers; 73% identified themselves as moderately confident; and 10% identified themselves as not very confident in their ability to work with self-injurers. Findings suggest that counselors feel they are the appropriate person in the school to work with self-injurers, but most need more training in order to be able to identify self-injurers and refer them to appropriate resources.

INTRODUCTION

Self-injury, defined as a “volitional act to harm one’s own body without intention to cause death” (Yaryura-Tobias, Neziroglu, & Kaplan, 1995, p. 33), has become widespread among today’s adolescents and young adults. It is estimated that 700 in every 100,000 people self-injure (Dunkle, 1990) and among adolescents and young adults the number may be as high as 12% (Suyomoto & Kountz, 2000). Most cases involve self-cutting, but others involve bruising, burning, or bone breaking. Self-injurious behaviors usually begin in adolescence (Conterio & Lader, 1998). Ross and Heath (2002) found the average time of onset to be the freshman year of high school. Although these behaviors can last for a lifetime, often they subside by age 18 (Suyemoto & MacDonald, 1995). The typical self-injurer entering therapy is female, in her mid-20s to early 30s, and has been hurting herself since her teens. She tends to be middle- or upper-middle-class, intelligent, and well educated (Favazza & Conterio, 1988). By the time she reaches therapy, she has an average of 93 scars (Bach-y-Rita, 1974).

The adolescent years, when self-injury often begins and ends, are tumultuous, full of change physically, emotionally, and socially (Pipher, 1994; Santrock, 2001). Adolescence is especially challenging today because of the cultural changes in the last twenty years; divorce, drugs, sexual activity, and pressure to be attractive (Pipher). In professional literature, adolescence is frequently represented as a negative stage in life, full of “storm and stress to be survived or endured” (American Psychological Association, 2002, p. 3). According to Pipher, adolescent females specifically, are “under more stress...and they have less varied and effective coping strategies to deal

with that stress, and they have fewer internal and external resources on which to rely” (p. 28). This stress may be one reason why self-injury is more common in females than males (Conterio & Lader, 1998). Females are the focus of almost all self-injury research, although one report estimates that males may account for as many as 40% of self-injurers. It may be, however, that their injuries (cuts and bruises) are overlooked as a product of adolescent ‘macho outbursts’ such as fighting or sports injuries (Edwards, 1998).

Stress is only one theory to explain the recent increase in cases of self-injury. Other explanations include the body focused culture, body alienation, emotional deprivation, abuse, divorce, and biology (Conterio & Lader, 1998), but none alone adequately explain why people injure themselves and why suddenly there is an increase in reports of this behavior. Therapists have seen a significant increase in the number of clients searching for help with their self-injury. Levenkron (1998) describes this as an “epidemic of disclosure” due to the attention self-injury has gained as a cultural phenomenon in the past decade. Books have been published, self-injury has been featured on teen-focused television programs such as *Beverly Hills, 90210* and *Seventh Heaven*, and it has been revealed that Princess Diana cut herself with frequency. But, despite the interest of the mainstream culture in self-injury, little empirical research exists. Much of the existing research consists of case studies (Solomon and Farrand, 1996) and when research has been conducted, much of it involves clinical samples with psychiatric disorders such as Borderline Personality Disorder, making this literature difficult to extrapolate to other populations (Herpetz, 1995). Another problem with much of the current literature is that little differentiation

is made between self-injury and suicide, which are very distinct behaviors. When a person attempts suicide, he seeks to end all feelings, but a person who self-injures is trying to feel better (Favazza, 1998). Self-injury is not a failed suicide attempt, but a coping mechanism for negative emotions. The final challenge with the current literature is the lack of published studies analyzing self-injury in community samples of adolescents or in the school setting.

Schools are one institution that stands in a position to help these youth. They have contact with large groups of youth, are found in virtually every community (Kush, 1991), and schools are currently involved in a multitude of mental health services. School counselors specifically, due to their training and role to assist student success, are well positioned to play a role in the mental health needs of youth. Students with emotional disorders, such as depression, anger management, autism, and post-traumatic stress disorder are increasingly being identified in the school setting (Dollarhide & Saginak, 2003). A review of school counselor literature reveals information on how counselors can assist children and adolescents with divorce, homelessness, sexual abuse, parental alcoholism, suicidal thoughts, tobacco use, body image, rape, pregnancy, domestic violence, dating violence, racism, sexual preference, eating disorders, bullying, substance abuse, AIDS, and grief, to name a few. Although seemingly every other mental health need is being addressed by school counselors, little is known about what services counselors provide to self-injurers or what supports they need in order to work more successfully with this population.

In addition to addressing mental health issues, it is often the school counselor's job to help other school staff, such as administrators, nurses, and teachers to manage

these needs in the school setting or provide referral to outside professionals. Their role as referral agent provides an all-important link to resources outside of the school building. In fact, students report the task “making referrals” as the most essential guidance activity they want from a school counselor (Wiggins & Moody, 1987).

Whether identifying symptoms, making referrals to an outside mental health therapist, briefing school staff on health information, or helping a self-injurer plan for academic success, counselors play an important and unique role in the delivery of services to students who self-injure.

The purpose of this research project was to identify how frequently school counselors encountered self-injurers and their actions with these students.

Specifically, the following questions were asked: How frequently do school counselors work with self-injurers? How do school counselors discover which students self-injure? What actions do counselors take with a self-injuring student? How knowledgeable are school counselors about self-injury? How confident do counselors feel in assisting students who self-injure? And what resources are counselors using to learn about self-injury?

METHODS

Participants for the study were randomly drawn from a membership list of the American School Counselor Association, which represents 12,000 of the approximately 100,000 school counselors in the United States. The initial list contained 7,110 names of current school counselors. Approximately 5,000 members' names had been excluded from the list by ASCA because they were retirees or

counseling students. An additional four hundred and fifty possible participants were determined ineligible for reasons such as living outside the United States, identification as a university professor, identification as a school board member, or identification as a counselor in private practice. Of the remaining 6,660 possible participants, 1,000 were randomly selected to receive a confidential questionnaire on self-injurious behaviors in the school setting. Non-respondents were sent a second questionnaire four weeks after the first questionnaire. Questionnaires were initially mailed in mid-April and again in mid-May to allow participants to report behaviors for the majority of the 2002-2003 school year.

The questionnaire was developed by the author based on a comprehensive review of literature. Information on six demographic variables was collected on the questionnaire: age, gender, level of education, number of years as a counselor, work responsibilities, and grade level of the students with whom the counselor works. Also included on the questionnaire were six background and attitude questions: self-perceived confidence in working with self-injurers, self-perceived knowledge about self-injury, personal experience in working with students who self-injure, identification of the most appropriate school personnel to work with self-injurers, how they found out about students who self-injure, and how self-injuring students were assisted. There were 19 general knowledge questions about self-injury, one question identifying nine potential sources of information, four demographic questions about self-injurers with whom they had worked, and eight questions describing their school.

In order to assure participants' responses were referring to the same set of behaviors, a definition of self-injury was included at the beginning of the survey

["deliberate destruction of body tissue, not including suicide attempt or overdose on alcohol or drugs", based on Favazza (1996)]. A definition of counseling was also included to assure that all responses regarding counseling referred to helping behaviors and not treatment behaviors. The definition used ("meeting with students to help them resolve or cope constructively with their problems") is from the American School Counselor Association (ASCA) (1999).

Descriptive statistics, *t* tests, chi-squares, and correlations were used in data analysis. Data analysis was performed using SPSS 12.0 for Windows. A 2-tailed *p* value of .05 or less was considered statistically significant.

RESULTS

Demographics. A total of 443 school counselors (44%) returned usable questionnaires. There were 374 female (84%) and 69 male respondents ranging in age from 25 to 74 ($M = 44.40$, $SD = 10.06$). The majority of respondents (427) held a master's degree, 13 held a doctoral degree, and 3 held less than a master's degree. The number of years the respondents had worked as a school counselor ranged from 1 to 42 ($M = 8.59$, $SD = 7.65$). The greatest number of respondents (145) were high school counselors, 93 were junior high counselors, and 136 were elementary school counselors. Twelve counselors served all three grade levels, 29 served both elementary and junior high, and 28 served both junior and senior high students.

Few counselors described their job responsibilities as either solely educational planning or solely counseling (1% and 8%, respectively). Most (33%) described their responsibilities as "mostly counseling with some educational planning", 31% said

their time was evenly split, and 27% described their responsibilities as “mostly educational planning with some counseling”. Respondents served between 12-3,325 students, with a median of 380 students ($M = 410.48$, $SD = 249.00$). Almost all worked at public schools (90%) versus private religious schools (8%), or private non-religious schools (2%). The percentage of students who qualified for free or reduced lunches was collected as a measure of the socio-economic status of the schools’ population. The percentage of students receiving free or reduced lunches ranged from 0-100%, with a median of 32% ($M = 34.42$, $SD = 25.38$). Most of the respondents worked in suburban schools (44%) or rural schools (37%). Only 14% worked in urban schools and 5% in inner-city schools. Respondents represented all 50 states, but the Midwestern states were most heavily represented (29%). Counselors from the non-contiguous states (Alaska and Hawaii) make up the smallest portion of the sample (<1%).

Chi-square analyses were performed to determine if the sample differed significantly when divided on the basis of various demographic variables. Males and females did not differ significantly in age, education level, number of years worked as a counselor, or in description of work responsibilities. As expected, older respondents were more likely to have worked as a school counselor for a longer period of time [$\chi^2(9, N = 443) = 119.90, p = .00$] and were significantly more likely to have attained a higher level of education [$\chi^2(15, N = 443) = 34.04, p = .00$].

Counselors’ experiences. Eighty-one percent ($n = 357$) of school counselors reported having worked with a self-injurer at some point in their career. The number of self-injurers worked with ranged from 1-60 with a median of three ($M = 4.92$, $SD =$

5.52). Two hundred and twenty-seven (51.24%) of school counselors reported working with a self-injurer in the 2002-2003 school year. The range was 1-15 students, with a median of two ($M = 2.72$, $SD = 2.04$). The 227 counselors who worked with students who self-injured in the 2002-2003 school year worked with 617 students total ($M = 2.72$, $SD = 2.04$). Counselors were asked to report the proportion of self-injurers that were female and to identify the ethnicity of self-injurers with whom they had worked. These totals were then compared to the reported demographics of the school (see Table 1.1). Compared to the overall demographics reported by the school counselors, all ethnicities, except non-Hispanic Whites, were underrepresented as self-injurers. Whites were 71.86% of the sample, but 83.63% of the reported self-injurers. This may be due to either a true racial disparity in the incidence of self-injury, or this may be due to white students feeling more comfortable or having more access to guidance services. Data were not collected on school counselors' race, so it cannot be determined if minority students were more likely to access services when the school counselor was race-concordant.

Table 1.1

Demographic information on total school population vs. self-injurers who counselors worked with in the 2002-2003 school year

Group	% of Total School Population	% of Self-injurers
Females	--	69.00
American Indian or Native Alaskan	2.85	1.95
Asian	2.83	1.73
Black or African-American	11.47	5.01
Hispanic or Latino	10.38	7.53
Native Hawaiian or Pacific Islander	.56	.06
White, Non-Hispanic	71.86	86.63

Note. Totals do not equal 100% as some counselors' totals did not equal 100%.

As self-injurious behaviors usually begin after puberty, it is not surprising that counselors in junior high and high school were significantly more likely to have worked with a self-injurer than elementary-level counselors (75%, 61%, and 29% respectively) [$F(2, 443) = 10.22, p = .00, HSD = .00$ and $.00$, respectively]. The increase in reports at the junior high level may have two interpretations; 1) as early adolescence/beginning of puberty has been identified in the literature as the typical onset for self-injurious behavior (Favazza, 1996), junior high students may be self-injuring either with greater frequency or with less ability to conceal their behaviors, or 2) high school counselors report work responsibilities involving significantly more educational planning and less counseling than junior high counselors [$F(2, 443) = 18.34, p = .00, HSD = .01$]. This change in role may allow for fewer contacts with students dealing with emotional issues, thus fewer are reported. Regardless of grade

level, counselors reporting a responsibility load of more counseling and less educational planning were more likely to have worked with a self-injurer ($r_s = .11, p = .02$). Due to the hidden nature of self-injury, it is assumed that all reports by school counselors underestimate the numbers of cases of self-injury in the school. Junior high and senior high school counselors estimated that about 2% of their entire student body engages in self-injury. This estimate is far lower than Ross and Heath's (2002) finding that almost 14% of adolescents report having self-injured at least once. The discrepancy between the number of self-injuring students they worked with and their estimates of the prevalence of self-injury highlights the hidden nature of this behavior and suggests that a majority of self-injurers are not receiving services from school personnel.

Another factor related to frequency of contact with self-injurers was the socio-economic status of students, as measured by the percent of students in the school receiving free or reduced lunch benefits. As the number of students receiving free and reduced lunch increased, counselors were less likely to report having worked with a self-injurer ($r_s = .12, p = .01$). There are two possible explanations for this finding. One, it is possible that students in low-income schools self-injure less frequently. This explanation is consistent with Favazza and Conterio's (1988) description of the typical self-injurer being middle to upper-middle class. Two, it is possible that in lower-income schools, school counselors have greater student-to-counselor ratios and thus are less likely to identify students who self-injure. There was, however, no statistical relationship between student-to-counselor ratio and the percent of students in the school receiving free or reduced lunch benefits.

Case identification. The counselors who had worked with a self-injurer in the 2002-2003 school year were asked to identify how they became aware of cases of self-injury in their school. Some respondents selected more than one choice, possibly indicating that they had learned of a student's self-injury in several ways or that the counselor had worked with more than one self-injurer. The most common method of discovery was being informed by a fellow student (67%), with being informed by a classroom teacher or coach, a close second (65%). Other methods of discovery included being approached by the self-injurer him/herself (51%), the counselor personally recognized the symptoms (48%), being informed by the school nurse (26%), being informed by a student's parent (18%), and being informed by a school social worker (5%). Not surprisingly, counselors who had worked with more self-injuring students reported a greater variety of methods of discovery. Lower grade levels were associated with being approached by a student who self-injures and being informed by a fellow student ($r_s = -.17, p = .01$ and $r_s = -.25, p = .00$, respectively) and higher grade levels with being informed by a classroom teacher or coach ($r_s = .14, p = .01$). At smaller schools, self-injuring students were more likely to approach the school counselor themselves ($r_s = -.16, p = .02$). These findings highlight the need for school personnel and peers to be educated about self-injury as they are the primary sources for identification of self-injurers for the school counselor.

Methods of assistance. The respondents who had worked with a self-injurer in the 2002-2003 school year ("experienced counselors") were asked to identify methods they had used to assist self-injuring students by selecting from nine possible actions. Those who had not worked with a self-injurer ("inexperienced counselors")

were asked to identify from the same nine choices the actions they predict they would take to help a self-injurer in the future (see Table 1.2). Respondents could choose all that applied. The most common method identified by experienced counselors was providing individual counseling (91%), followed by contacting a parent/guardian (88%), and referring to a psychiatrist (81%). The least common methods were referring to the school nurse (18%), and providing group counseling (13%). Many indicated they had used more than one method to assist students who self-injure.

The actions of the experienced counselors differed significantly from the predicted actions of the inexperienced counselors. The greatest difference was in the number of experienced counselors who contacted the school nurse (18%) compared to the number of inexperienced counselors who predicted they would (58%). Another large difference was in contact with the principal. Far more experienced counselors referred students to the school principal (41%) than the 18% of inexperienced counselors who predicted they would. These differences possibly indicate that those who have yet to work with a self-injurer underestimate the level of attention needed by self-injuring students, thus they may assume the nurse alone can solve the problem. Those who have worked with self-injurers recognize these students need a more complex intervention. The difference may also indicate that each situation merits actions specific to that case, and thus a wide variety of referrals is indicated. This difference in actions taken by counselors with experience working with self-injurers versus the inexperienced counselors highlights the need for school policy on self-injury identifying appropriate actions for counselors to take.

It should be noted that the respondents were provided with a definition of “counseling” (see Methods section), consequently, when 91% replied they were providing “individual counseling”, this refers to assisting students to cope with a problem, not providing individual therapy or treatment for self-injury. Providing therapy for mental health problems is not the role of the school counselor, nor has it been the best model of treatment with other mental health problems, such as eating disorders and suicide (Neumark-Sztainer, 1996; King, Price, Telljohann, & Wahl, 2000). Referring students to a psychiatrist, which most experienced counselors reported, is both an appropriate and necessary step for the proper treatment of self-injury.

Table 1.2

Methods used to assist self-injuring students by experienced counselors compared to the predicted methods of inexperienced counselors

Methods	% of Experienced Counselors	% of Inexperienced Counselors
Provide individual counseling	91	82
Contact parent/guardian	88	95
Refer to a psychiatrist	81	90
Refer to a physician	50	73
Refer to the principal	41	18
Refer to outside social worker or Child Protective Services	34	44
Refer to school social worker	18	34
Refer to school nurse	18	58
Provide group counseling	13	18

Appropriate school contact. School counselors were also asked if they thought the counselor was the most appropriate person within the school to provide consultation to a self-injurer and if the school counselor was the most likely person a

self-injurer would be sent to by other school staff. Overwhelmingly, school counselors reported that they were both the most appropriate contact (75.39%) and the most likely contact (76.74%). Three-hundred counselors (67.72%) reported they were both the most appropriate and the most likely contact. Seven percent reported that the school nurse was the most likely contact. Six percent of school counselors identified the school psychologist as a more appropriate contact than the counselor.

Knowledge of self-injury. Although school counselors identify themselves as the most appropriate school contact for self-injurers, they do not self-report high levels of knowledge on the topic. All but seven of the respondents (98.41%) had heard of self-injury. Those reporting having never heard of, read about, or seen cases of self-injury did not differ in age, gender, years of experience, or education levels from other participants. Respondents who had heard of self-injury were then asked to assess how knowledgeable they believed themselves to be on a scale of one (not at all knowledgeable) to seven (extremely knowledgeable) on three measures: knowledge about the root causes of self-injury, knowledge about the symptoms of self-injury, and knowledge about treatment of self-injury. Respondents scored themselves highest on knowledge of symptoms of self-injury ($M = 3.9, SD = 1.4$), next highest on root causes of self-injury ($M = 3.7, SD = 1.3$), and lowest on knowledge of treatment of self-injury ($M = 3.2, SD = 1.4$). In a composite score of the three measures, 6% of counselors identified themselves as highly knowledgeable in working with self-injurers (a score of 6 or 7); 74% identified themselves as moderately knowledgeable (a score of 3, 4, or 5); and 20% identified themselves as not very knowledgeable in their ability to work with self-injurers (a score of 1 or 2) ($M = 3.60, SD = 1.24$).

Self-reported knowledge (as a combined measure of the three items) was higher in counselors with more years of experience ($r_s = .10, p = .04$), higher levels of education ($r_s = .18, p = .00$), those who worked in higher grade levels ($r_s = .20, p = .00$), those in schools with larger enrollments ($r_s = .13, p = .01$), and those in schools with fewer students qualifying for free and reduced meals ($r_s = -.18, p = .00$). As would be expected, a higher level of knowledge was also associated with having worked with a self-injurer ($r_s = -.47, p = .00$) and having worked with increasing numbers of self-injurers ($r_s = .28, p = .00$). Almost all (92%) of respondents reported an interest in learning more about self-injury. This almost universal thirst for knowledge highlights both the recognition of counselors that they need more training and the need for training opportunities to be made available to counselors.

In addition to a self-assessment of knowledge about self-injury, counselors were asked to agree or disagree with a series of statements about self-injury. The higher a counselor's self-reported knowledge the more likely they were to agree with nine of the true statements (see Table 1.3). For example, counselors with higher levels of self-reported knowledge about self-injury were more likely to agree that self-injury is a way to maintain control ($r_s = .17, p = .00$), is often co-morbid with eating disorders ($r_s = .17, p = .00$), and is a coping mechanism for stress ($r_s = .13, p = .01$). The positive associations between the self-reported knowledge levels and agreement with true statements about self-injury suggest that high self-reported knowledge levels were consistent with increased knowledge about self-injury.

Table 1.3

True statements about self-injury positively related to knowledge scores

Statement	Correlation Coefficient
Self-injury is related to a history of sexual abuse	$r_s = .12, p = .02$
Self injury is a coping mechanism for stress	$r_s = .13, p = .01$
A person feels better after self-injuring	$r_s = .14, p = .00$
Self-injury is addictive	$r_s = .11, p = .02$
Self-injury is a way to maintain control	$r_s = .17, p = .00$
Self-injury is a way to regulate uncomfortable feelings	$r_s = .16, p = .00$
Self-injury is often co-morbid with eating disorders	$r_s = .17, p = .00$
Self-injury is associated with a history of emotional abuse	$r_s = .12, p = .01$
Self-injury is associated with a history of depressive illness	$r_s = .16, p = .00$

Sources of information. Respondents were asked to identify, from a list of nine possible sources, where they had learned about self-injury. The primary sources of information were contact with professional colleagues (76.8%), professional journals (75.5%), knowing someone who self-injures (71.7%), and mass media (63.5%). Less commonly reported sources of information were college classes (42%), professional conferences (37.4%), textbooks (36.2%), the internet (31.4%), and in-service training (27.1%). School counselors who had previously worked with self-injurers reported using a wider variety of learning resources than those who had never worked with a self-injurer ($M = 6$ resources vs. 4 resources, respectively). Those who had worked with a self-injurer were significantly more likely to have used journals, conferences, in-services, professional colleagues, knowing a self-injurer, and the internet as learning resources than counselors who had not worked with a self-injurer. Although counselors with more years of experience were more likely to know a self-injurer, more years of experience was associated with a lower likelihood of using the following resources: the internet ($r_s = .10, p = .04$), college classes ($r_s = .26, p = .00$),

or textbooks ($r_s = .13, p = .01$). This appears to suggest that self-injury may have been addressed more often in college coursework in recent years than in years past and that younger counselors may be more likely to use the internet than their older counterparts for research purposes, possibly due to either comfort or skill levels.

Confidence levels. Finally, respondents were asked to rate, on a scale of 1 (not at all confident) to 7 (extremely confident) their confidence in providing eight services related to self-injury. School counselors were most confident in referring students to outside resources ($M = 6.0, SD = 1.22$). School counselors felt least confident providing group counseling to students who self-injure ($M = 3.1, SD = 1.58$). This, however, may be due to a belief that group counseling is inappropriate in this population. School counselors felt moderately confident following up with a students after identification as a self-injurer ($M = 4.4, SD = 1.58$), identifying students who self-injure ($M = 4.3, SD = 1.48$), counseling friends of self-injurers ($M = 4.1, SD = 1.61$), providing parents information about self-injury ($M = 4.0, SD = 1.67$), providing faculty and staff information about self-injury ($M = 3.9, SD = 1.69$), and providing individual counseling to self-injurers ($M = 3.7, SD = 1.49$).

In a composite score of the eight confidence measures combined, 17% of counselors identified themselves as highly confident in working with self-injurers (a score of 6 or 7); 73% identified themselves as moderately confident (a score of 3, 4, or 5); and 10% identified themselves as not very confident in their ability to work with self-injurers (a score of 1 or 2) ($M = 4.21, SD = 1.26$). Each of the eight individual measures of confidence increased significantly as the knowledge composite score (a combination of the three knowledge measures) increased. The confidence composite

score (a combination of the eight confidence measures) and the knowledge composite score (a combination of the three confidence measures) were highly correlated ($r_s = .80, p = .00$), suggesting that as knowledge increased, confidence also increased. Each of the eight individual measures of confidence also increased significantly if the counselor had worked with at least one self-injurer. Each individual measure of confidence, except “referring to outside resources” increased significantly as the total number of self-injurers a counselor had worked with also increased. This suggests that direct experience working with self-injurers builds confidence to work with future students who self-injure.

DISCUSSION

It has been suggested that self-injury is the new anorexia (Levenkron, 1998). Just as eating disorders became mainstream and recognized in the 1970s, self-injury is gaining recognition today (Conterio & Lader, 1998). As movie stars tell about their self-injury and stories appear in magazines, an “epidemic of disclosure” begins, and therapists report a steep increase in clients seeking help for self-injury (Levenkron). With limelight status, schools, hospitals, and other health service organizations are now forced to decide the actions they can and will take for prevention, identification, and treatment of cases.

Most counselors (81%) report having worked with a student who self-injured, yet only 17% identified themselves as highly confident in working with self-injurers. As counselors with higher levels of knowledge reported higher levels of confidence, opportunities for increased knowledge must be made available to school counselors

and counselors must take advantage of these opportunities. There are many opportunities for increasing knowledge among counselors: state and national counseling conferences can feature speakers on self-injury; if a local expert can be identified, in-service trainings can be provided; articles on self-injury can be featured in counseling publications; resource lists can be provided by professional organizations; websites dedicated to working with self-injurers can be developed, on-line training sessions can be implemented, self-injury can be featured in counseling texts, and additional information can be included in school counselor preparation programs.

All counselors, and especially those who have yet to work with a self-injurer, must assume there are unrecognized cases of self-injury in their schools. Although, white, middle- and upper-class, female adolescents seem to be the typical self-injurers, counselors must not blind themselves to other populations. It cannot be assumed that males and non-Whites do not participate in self-injury. All students displaying relevant risk factors, such as having a history of physical abuse, sexual abuse, body hatred, or depression should be considered as possible self-injurers. As data related to the wide range in the number of self-injurers counselors had worked with revealed no pattern in regression analysis, it appears there is no particular "type" of counselor who works with self-injurers most often. There are a wide variety of counselors reporting a history with self-injurers. This reinforces the need for all counselors to be alert to the signs of self-injury and to learn relevant information to assist them.

Although counselors identified journal articles as the second most common source of information about self-injury, a literature review of school counseling

literature revealed no articles specific to self-injury prior to this survey (April 2003). Counseling literature regarding self-injury is most often found in psychiatry and psychology literature. Thus, the field of professional school counseling must turn its attention to self-injury and be a primary information source to its constituents, because knowledge not only improves confidence, but also the quality of help provided to students.

One role the school counselors consistently reported feeling confident in was referring self-injurers to outside therapy. Ponec, Poggi, and Dickel (1998) describe school counselors as the “first line of defense” in screening concerns that require more specialized treatment than school professionals can provide. But, few counselors report being familiar with the therapists they refer students to. Many report making referrals to therapists they are unfamiliar with or have never met (Porter, Epp, & Bryant, 2000). As successful therapy relies on a good match between patient and therapist, merely a referral to any therapist is not enough. Counselors need to identify local therapists who are qualified to work with self-injurers in advance of needing to refer a student. Then, counselors and therapists can work as a team to provide a continuum of care and integrated services (Porter et al.).

As the most commonly cited methods of identification of self-injurers were via report by peers, teachers, and coaches, counselors need to also integrate services with school staff. Methods should be put in place to inform school faculty, staff, and students about self-injury and the channels to access to report when they suspect a student is self-injuring. Counselors are in an ideal situation to be an information source to the entire school community.

Limitations. Strengths of this study include the large number of counselors surveyed ($n = 443$) and the nationwide, random sample. Also, to our knowledge, this is the first study to address school counselors' experiences with self-injury. The study is limited as the respondents are all members of the American School Counselor Association. Generalizability outside that population may be unjustified. Also, of the 1,000 randomly selected members, 443 returned usable questionnaires. Those who did not respond may be less familiar with self-injury and thus less likely to respond. It may also be the case that counselors with particularly heavy workloads were less likely to respond due to time constraints. The timing of the questionnaires may have impacted responses. Questionnaires were mailed in mid-April, thus counselors with greater year-end responsibilities may have been less likely to respond.

Conclusion. Mental health problems in general, and self-injury in particular, limit the ability of students to reach their potential academically, socially, and emotionally (Lieberman, 2004; White Kress, Gibson, & Reynolds, 2004). School counselors are in a unique position to improve the educational environment for students who self-injure by providing a safe place for them to discuss their problems, reliable referrals to professional help in the community, and information to teachers, administrators, parents, and students. Findings suggest that counselors feel they are the appropriate person in the school to fill these roles, but most need more training in order to feel confident in identifying and providing services to self-injurers. Future research should focus on strategies for training counselors to work with self-injurers and evaluation of those training programs. It is also important to begin research on best practice guidelines for cases of self-injury in the school. After counselors are

trained to work with self-injurers, they need to record their actions when working with self-injurers and the outcomes of those actions. This will provide the baseline data for best practice guidelines, creating an opportunity to test the effectiveness of the most promising strategies.

ARTICLE 2: Supporting counselors working with self-injurers: How school administrators can help

ABSTRACT

The purpose of this study was to determine the perceived needs of school counselors in their work with self-injurers and to consider how school administrators can best facilitate this process. Participants were drawn from a list of 7,110 members of the American School Counselor Association. They were asked to complete a 46-item questionnaire on students' self-injurious behaviors. Of the 1,000 randomly selected counselors, 443 (44.3%) returned usable questionnaires. There were 374 female and 69 male respondents; the mean age was 44.4 years. Counselors made 510 comments regarding the supports they needed in order to successfully work with students who self-injure. The responses were coded into six categories: counselor training, school policy, education, community connections, tangible support, and cooperation. Suggestions are made on how schools can improve these six areas and how school administrators can best help school counselors succeed when working with this population.

INTRODUCTION

Among the many mental health concerns schools face today, self-injury is quickly gaining attention. It is estimated that up to 14% of adolescents have self-injured and the numbers are predicted to rise (Ross & Heath, 2002). Defined as "a volitional act to harm one's own body without intention to cause death" (Yaryura-Tobias, Neziroglu, & Kaplan, 1995, p. 33), self-injurious behaviors exclude suicide

attempts and drug overdoses. Most cases involve self-cutting, but can involve bruising, burning, or bone breaking. Self-injurious behaviors usually begin in adolescence (Conterio & Lader, 1998). Ross and Heath (2002) found the average time of onset to be the freshman year of high school. Although these behaviors can last for a lifetime, often they subside by age 18 (Suyemoto & MacDonald, 1995).

This time period provides a critical window of opportunity for school counselors to work in prevention, intervention, identification, and referral of these students to professional therapy. These years are tumultuous, full of change physically, emotionally, and socially (Pipher, 1994; Santrock, 2001), but what causes adolescents who, on the surface seem calm and well-adjusted, to cut, burn, or otherwise injure themselves? Theories abound on the reasons for the increase in self-injury: the body focused culture, body alienation, divorce, emotional deprivation, abuse, and biology; but none alone adequately explain why people injure themselves and why currently there is an increase in reports of this behavior. The common thread among self-injurers is a struggle with inner pain that seems too vast to cope with and the relief that self-injury brings from these feelings. This paradox has earned self-injury the moniker, the “wounding embrace”, because self-injurers both harm and comfort themselves simultaneously (Conterio & Lader, 1998).

While the cutting itself is harmful and can cause shame and guilt later, the control it embodies, feels good. Physical pain’s origins are obvious and unproblematic compared to the origins of emotional pain, which may be unclear and too difficult to face (Solomon & Farrand, 1996). The use of self-injury as a coping mechanism is illustrated in this quote from a teenage girl who cuts herself.

Cutting helps to bring me back to the here and now. It's not going to solve the problems, but it can stop me from being trapped. It can end the feelings of having to live through everything over, and over, and over, and over, again -- that I have had to endure for years on end, anyway. It doesn't make them go away but it's a safe feeling of knowing "Ok, I can feel this, I can feel the blade cut through my skin. I am here and it's not happening now." Sometimes it is plain and simple, the pain is too much and I just want it to stop...When it boils down to it, I would prefer to be hurting physically then emotionally. That pain does eventually subside. (Bethanii, 2000)

A distinction must be made between suicide and self-injury. "A person who truly attempts suicide seeks to end all feelings, whereas a person who self-mutilates seeks to feel better." (Favazza, 1998, p. 262) Suicidal behavior is considered an out-of-control behavior, compared to the total control a person who self-injures maintains (Solomon & Farrand, 1996). There are three factors generally thought to distinguish self-injurious acts from suicidal acts (Lloyd, 1997). First, methods of self-injury are low lethality, with little purposeful physical damage. Second, self-injury is highly repetitive. Most self-injurers have multiple episodes of self-injury over a long period of time as evidenced by Bach-y-Rita's finding (1974) that the average self-injurer had 93 scars upon entering therapy. Third, very few self-injurers report suicidal intent or ideation while self-injuring (Walsh & Rosen, 1988).

Self-injury, as a cultural phenomenon, has gained significant attention in the past decade. Books have been published, self-injury has been featured on teen-focused television programs such as *Beverly Hills, 90210* and *Seventh Heaven*, and it has been revealed that Princess Diana cut herself frequently. This sudden attention is similar to the attention eating disorders received in the 1970s. As awareness grew and better therapeutic techniques were developed, people began to seek help, creating an "epidemic of disclosure" (Levenkron, 1998; Conterio & Lader, 1998). Despite the

increased interest of the mainstream culture and the therapeutic community in self-injury, little empirical research exists. Much of the existing research consists of case studies (Solomon & Farrand, 1996). When research has been conducted, much of it involves clinical samples with psychiatric disorders, such as Borderline Personality Disorder, making this literature difficult to extrapolate to other populations (Herpetz, 1995). There are few published studies analyzing self-injury in community samples and only one analyzing self-injury among adolescents in the school setting (Ross & Heath, 2002).

Recent education literature has addressed legal and ethical challenges in working with students who self-injure (Froeschle & Moyer, 2004) and strategies for counseling and responding to students who self-injure (White Kress, Gibson, & Reynolds, 2004; Lieberman, 2004). To date though, there has been no discussion in the literature of how schools can better support school counselors in their attempts to assist self-injurers. The purpose of this project was to determine the perceived needs of school counselors in their work with self-injurers and to consider how school administrators can best enable school counselors to be successful in their work with this population.

METHODS

Participants for the study were drawn from the membership of the American School Counselor Association, a group of over 12,000 professionals. A random sample of 1,000 members was selected to receive a confidential questionnaire on self-injurious behaviors. Non-respondents were sent a second questionnaire four weeks

following the first questionnaire. Questionnaires were initially mailed in mid-April and again to non-respondents in mid-May to allow participants to report behaviors for the majority of the 2002-2003 school year.

The questionnaire was developed by the author based on a comprehensive review of literature. Counselors were asked four open-ended questions about working with self-injurers, including the question, "What kind of supports would help you to work with students who self-injure?" Additionally, information on six demographic variables was collected on the questionnaire: age, gender, level of education, number of years as a counselor, work responsibilities, and grade level of the students with whom the counselor worked. Also included on the questionnaire were six background and attitude questions: self-perceived confidence in working with self-injury, self-perceived knowledge about self-injury, personal experience in working with students who self-injure, identification of the most appropriate school personnel to work with self-injurers, how they found out about students who self-injure, and how students were assisted. There were 19 general knowledge questions about self-injury, one question listing nine potential sources of information, four demographic questions about self-injurers with whom they had worked, and eight questions describing their school.

In order to assure participants' responses were referring to the same set of behaviors, a definition of self-injury was included at the beginning of the survey ["deliberate destruction of body tissue, not including suicide attempt or overdose on alcohol or drugs", based on Favazza (1996)]. A definition of counseling was also included to assure that all responses regarding counseling referred to helping

behaviors and not treatment behaviors. The definition used (“meeting with students to help them resolve or cope constructively with their problems”) is from the American School Counselor Association (ASCA) (1999).

RESULTS

A total of 443 school counselors (44.4%) returned usable questionnaires. There were 374 female (84.4%) and 69 male respondents ranging in age from 25 to 74 ($M = 44.4$, $SD = 10.1$). The majority of respondents (427) held a master’s degree, 13 held a doctoral degree, and 3 held less than a master’s degree. The number of years the respondents had worked as a school counselor ranged from 1 to 42 ($M = 8.6$, $SD = 7.7$). The greatest number of respondents (145) were high school counselors, 93 were junior high counselors, and 136 were elementary school counselors. Twelve counselors served all three grade levels, 29 served both elementary and junior high, and 28 served both junior and senior high students. Three hundred thirty-one counselors responded to the question with 510 comments regarding the supports they needed in order to successfully work with students who self-injure. The responses were coded into six categories: counselor training, school policy, education, community connections, tangible support, and cooperation (see Table 2.1). One comment was deleted because it did not fit into any of the categories.

Table 2.1

Sample counselor comments in each category

Counselor Training

General information

In-service training

Published literature on case studies and strategies

School Policy

Protocol of steps to take

Education

Educational materials (books, videos, brochures)

Teacher awareness

Information in the health curriculum

Resource list

Community Connections

List of local professional therapists to refer to

Mentor counselor

Better communication with local therapists

Tangible Support

Time and funding for training

Fewer non-counseling duties

Lower student-to-counselor ratio

Cooperation

Coordination between the counselor, school nurse, and school psychiatrist

Meetings with the student's family

Knowledgeable administrators

Counselor training. School counselors' main needs regarding self-injury involve building their own knowledge and skills. Beyond needing general information ($n = 77, 23\%$), they requested in-service training ($n = 69, 21\%$), published research ($n = 20, 6\%$), and professional conferences ($n = 11, 3\%$). In training, they were looking for specific strategies for prevention, identification, intervention, and referral. This is not surprising considering counselors' low self-appraisals of their knowledge about self-injury. Respondents were asked to assess how knowledgeable they believed themselves to be on a scale of one (not at all knowledgeable) to seven (extremely

knowledgeable) on three measures: knowledge about the root causes of self-injury, knowledge about the symptoms of self-injury, and knowledge about treatment of self-injury. Although all but seven of the respondents (98.4%) had heard of self-injury, only 6% of counselors identified themselves as highly knowledgeable in working with self-injurers (a score of 6 or 7); 74% identified themselves as moderately knowledgeable (a score of 3, 4, or 5); and 20% identified themselves as not very knowledgeable (a score of 1 or 2) ($M = 3.6$, $SD = 1.2$).

School policy. In addition to more information, counselors wanted policy and procedures to follow when working with self-injurers ($n = 21$, 6%). Few school counselors (23%) reported the existence of an identified policy or plan for self-injury compared to other health concerns such as suicide attempt (90%), alcohol use (87%), physical or sexual abuse (98%), sexual harassment (95%), or weapons on school grounds (99%). Of the seventeen policies queried, more school counselors responded to both “no policy” (55%) or “I don’t know” (22%) regarding self-injury than all other policies (see Table 2.2). The number of self-injurers with which a school counselor had ever worked was the only significant predictor of whether or not a school had a policy on self-injury [$\chi^2(1, N = 346) = 4.7$, $p = .03$, $Exp(B) = 1.05$]. This means that for every additional self-injuring student a school counselor has worked with, their school is 1.052 times more likely to have a policy on self-injury in place, or for every 10 additional self-injurers, there is a 50% increase in likelihood that the school has a policy in place. This finding has two possible interpretations, a) as school counselors work with increasing numbers of self-injurers, they are increasingly likely to initiate the creation of a school policy regarding self-injury or b) when school policies

regarding self-injury are in place, counselors are more likely to work with self-injuring students due to increased awareness of the behavior.

Formal policy adoption is important because policies convey what the school board deems important and will prioritize surrounding budget decisions and staff development. Formal policies may also protect schools in the face of legal challenges (Grebow, Greene, Harvey, & Head, 2000). There is currently no legal precedent specific to school involvement in self-injurious behaviors. In general, however, “recent judicial decisions address the student’s right to a safe school environment and the counselor’s and teachers’ responsibility to protect the health and safety of every student” (Coy, 1995, p. 2).

Table 2.2

Responses to question “Does your school or district have identified policies or plans for the following health concerns?” in ascending order

Health Concern	Yes	No	I don’t know
Self-injury	100 (23%)	246 (55%)	97 (22%)
Eating disorder	143 (32%)	233 (53%)	67 (15%)
Pregnancy	278 (63%)	106 (24%)	59 (13%)
Terrorist attack	357 (81%)	49 (11%)	37 (8%)
Bullying	364 (82%)	61 (14%)	18 (4%)
Alcohol abuse	366 (83%)	58 (13%)	19 (4%)
Sexual assault	381 (86%)	38 (9%)	24 (5%)
Alcohol use	386 (87%)	41 (9%)	16 (4%)
Suicide threat	392 (89%)	42 (9%)	9 (2%)
Drug use (including steroids)	395 (89%)	31 (7%)	17 (4%)
Suicide attempt	397 (90%)	38 (8%)	8 (2%)
Weather related dangers (e.g. tornados)	410 (93%)	19 (4%)	14 (3%)
Sexual harassment	419 (95%)	16 (3%)	8 (2%)
Abuse (physical, sexual, emotional, or neglect)	423 (96%)	16 (3%)	4 (1%)
Strangers on school grounds	424 (96%)	13 (3%)	6 (1%)
Bomb threats	433 (98%)	5 (1%)	5 (1%)
Weapons on school grounds	441 (99%)	1 (<1%)	1 (<1%)

Education. Counselors perceived a need for those around them to be more informed on the topic of self-injury ($n = 87, 26\%$). Teachers, parents, students, and administrators were commonly mentioned as groups needing information. Participants requested the availability of quality brochures, websites, books, videos, hotlines, and curriculum, in order to educate these groups. They requested materials to learn from themselves, to train school staff, and to give to students and parents. Resource lists and pre-packaged materials for facilitating groups or teaching classes were also requested.

Counselors did not perceive the teachers in their schools to be well-versed in self-injury. When asked how knowledgeable they thought the teachers in their buildings were, junior and senior high counselors rated them as a 2.9 on a scale of one (not at all knowledgeable) to seven (extremely knowledgeable) ($SD = 1.3$). This is a low to moderate rating of knowledge. Elementary school counselors rated their counselors even lower ($M = 2.6, SD = 1.2$). Junior and senior high counselors perceived their students to be significantly more knowledgeable than their teachers [$M = 3.6, SD = 1.5, t(330.94) = -5.08, p = .00$]. Only 4% of elementary school counselors, 15% of junior high school counselors, and 13% of high school counselors reported self-injury being part of the school's curriculum. In junior high and senior high schools with health educators on staff, self-injury was significantly more likely to be included in the curriculum than in schools with no health educator, [$t(197) = -3.43, p = .00$].

Once the health educator has completed any needed training on the topic via the school counselor, it should be the school health educator, not the counselor,

delivering self-injury information to students. It is the role of the teacher, not the counselor, to deliver and evaluate course content. Training teachers, and then assigning them to disseminate the information to students, delineates roles and frees the counselor for other responsibilities. School health educators should incorporate self-injury into the existing mental health curriculum. According to Lieberman (2004), student education about self-injury should focus on the signs of mental stress, risk factors, coping strategies, and referring friends to trusted adults. Detailed descriptions of self-injury should be avoided to limit suggestion.

Additionally, student education about self-injury should include a component on friends acting as referral agents or “gatekeepers”. Klingman and Hochdorf (1993) suggest that peers are part of the natural support system and can serve as gatekeepers, referring their friends to counseling when they are suicidal. This same concept can be applied to self-injury. Peers can be trained via classroom education to recognize the signs and symptoms of self-injury and how to refer their friends to the school counselor. Gatekeeping strengthens students’ investment in the program and thus improves the behavioral, cognitive, and affective gains made during training (Jason and Rhodes, 1989 as cited in Klingman and Hochdorf, 1993). As only one-half of students report feeling comfortable talking to anyone on school staff about a personal problem (Armacost, 1990), friends become an especially valuable link to mental health services for self-injurers.

Self-injury education must be implemented in an age-appropriate manner. The beginning of junior high school seems to be the most appropriate time to begin self-injury prevention education. A majority of school counselors (67%) identified 7-9th

grade as the most likely grade level for students to begin to self-injure. This is consistent with the literature that after puberty is the most common time to report the onset of self-injury (Conterio & Lader, 1998). Thus prior to this time, education about self-injury needs to begin. In earlier grades, it would be appropriate for teachers to address topics such as body satisfaction, coping skills, communication, and self-esteem that are related to the prevention of self-injury.

Community connections. Quality referrals were of great concern to counselors. Sixty-six participants (20%) listed referrals as a needed support. They wanted to know who in the community is qualified to work with self-injurers. Referring students outside the school for treatment is one of the most important roles of today's school counselor (Baker, 1992) and the task "making referrals" is the most essential service students reported they want from a school counselor (Wiggins & Moody, 1987). School counselors are the "first line of defense" in screening concerns that require additional time and more specialized treatment than the school professionals can provide (Ponec, Poggi, & Dickel, 1998, p. 263). They are in a particularly ideal position for communicating to parents the necessity of additional support and then to collaborate with the therapist to assist treatment efforts at school and home (Ponec, Poggi, & Dickel). Unfortunately, many counselors are unfamiliar with the therapists they refer student to. Ritchie and Partin (1994) reported that counselors were least likely to be familiar with professionals outside the school system, such as family therapists, and that many counselors never meet face to face with the therapists to whom they make referrals. Interaction between the school

counselor and the professional therapist encourages the use of alternative coping strategies and interventions during the school day (Lieberman, 2004).

A need for networking with fellow counselors who have experience with self-injurers or having a mentor counselor was mentioned frequently ($n = 25$, 8%). This is consistent with the finding that the most frequent source of information about self-injury is other counselors (77%). Counselors would also like to have contact with recovering or recovered self-injurers to discuss what actions were of help to them.

Tangible support. Support, in the form of time, money, and staff were frequently reported as needed supports ($n = 75$, 23%). School counselors are asked to do more tasks in less time today. Although the recommended student to counselor ratio is 250-to-1, the national average is now 477-to-1 ("School Counselors", 2004). In addition to counseling and educational planning duties, almost all counselors (86%) report responsibility for non-counseling duties such as filing, reception, or requesting records (Burnham & Jackson, 2000). In order to successfully work with self-injurers, counselors reported they would need more time or more personnel. Personnel requests ($n = 37$, 11%) included school nurses, school psychologists/psychiatrists, school social workers, and health teachers. Counselors also reported they either needed be relieved of non-counseling duties, such as course scheduling, or be given clerical help in order to have time to successfully work with self-injurers ($n = 31$, 9%). They also requested personnel development days to attend training. All of this takes funding, which counselors would also like to have more of. They requested funding to purchase materials, attend trainings or conferences, hire more staff, and pay for referral services.

Cooperation. Finally, counselors requested cooperation to alleviate barriers in work with self-injurers ($n = 34$, 10%). They requested collaboration from the self-injurers' therapists, hospitals, parents, and school administrators. From parents, counselors responded that they needed parents to meet with them, follow-up on referrals for therapy, and be involved with their child's treatment. From the administrators, counselors are looking for tangible support and coordination among school services such as the nurse, the counselor, and principal, and the school psychologist. Comments such as "let counselors counsel" and "recognize self-injury as a counseling problem" are representative of these comments.

DISCUSSION

Based on counselors' statements, school administrators have many options for improving counselors' ability to work with self-injurers. The most obvious route is to first provide opportunities for counselor training. For schools, this may mean the provision of funding for trainings, books, or videos. The greatest request was for in-service trainings, but first some type of in-service training must be developed and made widely available at an affordable price, given the strained budgets of many districts today. Until then, the provision of media and time to consume this media must be made available (see Table 2.3). Counselors who are knowledgeable and confident will then be able to educate school staff and parents about self-injury. Once school health educators are trained, they will be able to disseminate information about self-injury to students via the health curriculum.

Table 2.3

Resource list for self-injuryBooks

Bodily Harm: The Breakthrough Healing Program for Self-Injurers by Karen Conterio and Wendy Lader (with Jennifer Kingson Bloom) (Hyperion, 1999)

The Scarred Soul: Understanding and Ending Self-Inflicted Violence by Tracy Alderman (New Harbinger Publications, 1997)

Cutting: Understanding and Overcoming Self-Mutilation by Steven Levenkron (W.W. Norton & Company, 1999)

Secret Scars: Uncovering and Understanding the Addiction of Self-Injury by V. J. Turner (Hazelden Publishing and Educational Services, 2002)

Self-Injury: When Pain Feels Good. Resources for Changing Lives by Edward Welch (P & R Publishing, 2004)

Hotline

Self Abuse Finally Ends Treatment 1-800-DON'T-CUT

Videos

Self-Injury: From Suffering to Solutions Distributed by SVE & Churchill Media

Websites

Self Abuse Finally Ends Treatment, www.selfinjury.com

Deb Martinson, <http://www.palace.net/~llama/psych/injury.html>

Linkages between schools and qualified, competent community-based therapists are essential in order for school counselors to provide appropriate resource referrals. Counselors are least likely to have complaints about professional therapists, such as the therapist being ineffective or failing to communicate, when they have previous contact with the therapist (Ritchie & Partin, 1994). Working as a team helps to provide a continuum of care and integrated services (Ritchie & Partin). This team approach could take many forms; telephone contact, consultation at the school, qualified therapists working in school-based health clinics, or a school-based mental health center (Porter, Epp, & Bryant, 2000). School-based mental health centers are the solution of choice for the American Academy of Pediatrics. Their Committee on

School Health is urging the development of three levels of in-school mental health service, including prevention and education programs, targeted services for students with identified mental health needs, and services for students with severe mental health problems (American Academy of Pediatrics, 2004).

School policy, tangible support, and cooperation within the school building are the supports school administrators are most able to affect. The development of policy and procedures simplifies the school counselor's job and may protect the school from liability (Grebow, Greene, Harvey, & Head, 2000). This is a simple, concrete step to initiate the school's commitment to supporting counselors in their work with self-injurers. The cooperation between and among school staff may be facilitated by delineation of roles within the school's policy on self-injury. Guidelines for contact with and inclusion of parents in the counseling and referral process are also useful within the policy.

Limitations. Strengths of this study include the large number of counselors surveyed ($n = 443$) and the nationwide, random sample. Also, to our knowledge, this is the first study to address the school's response to self-injury. The study is limited as the respondents are all members of the American School Counselor Association. Generalizability outside that population may be unjustified. Also, of the 1,000 randomly selected members, 443 returned usable questionnaires. Those who did not respond may be less familiar with self-injury and thus less likely to respond. It may also be the case that counselors with particularly heavy workloads were less likely to respond due to time constraints. The timing of the questionnaires may have impacted

responses. Questionnaires were mailed in mid-April, thus counselors with greater year-end responsibilities may have been unable to respond.

Conclusion. Students who self-injure create new and serious challenges for school administration. Although school counselors are not the appropriate personnel for treating self-injury, they are an important early contact in helping self-injurers get the professional therapy they need. The counselor's actions may determine if and when the student receives further assistance (Froeschel & Moyer, 2004). When school administrators facilitate this process by creating an environment that supports counselors, they become an important part of the solution. School administrators can also encourage communication with and education of students' families, create time for counselors to work with self-injurers, and foster a spirit of cooperation among school staff. When school administrators work to improve awareness and create appropriate policy to respond to self-injurers in the school setting, students' physical and psychological welfare can be maintained (Lieberman, 2004). Policy adoption may also protect schools from potential litigation (Grebow, Greene, Harvey, & Head, 2000). Administrators can also work to create closer ties to the community, raising awareness about self-injury and encouraging links with local professional therapists. Recent research interest in self-injury is encouraging and must be sustained to ensure schools are playing an adequate and appropriate role in the prevention, identification, and treatment of self-injurers.

ARTICLE 3: An ecological approach to identifying and reducing self-injury in the schools

ABSTRACT

The purpose of this paper is to describe an ecological approach to self-injury where school personnel work in separate and complementary roles to best identify, refer, and educate students about self-injury. This paper will propose that the two main roles of the school counselor are to provide education to school staff and parents and to act as a conduit through which self-injurers are identified and referred to professional therapy. A model delineating roles of school personnel is presented and suggestions are made to improve the education of counselors, school staff, parents, and students. Data are presented on the presence of self-injury in school curriculum, school counselors' perception of teachers' and students' knowledge about self-injury, and knowledge levels of school counselors. Participants were randomly drawn from a list of 7,110 members of the American School Counselor Association. They were asked to complete a 46-item questionnaire on their experiences with students' self-injurious behaviors. Of the 1,000 randomly selected counselors, 443 (44%) returned usable questionnaires.

INTRODUCTION

Self-injury is a serious mental health concern gaining recognition among school professionals. Defined as a "volitional act to harm one's own body without intention to cause death" (Yaryura-Tobias, Neziroglu, & Kaplan, 1995, p. 33), self-injury has become increasingly common among today's adolescents and young adults.

It is estimated that 700 in every 100,000 people self-injure (Dunkle, 1990). Among adolescents and young adults the number may be as high as 14% (Suyomoto & Kountz, 2000; Ross & Heath, 2002). The school-age years are the most common for the onset of self-injurious behaviors, usually soon after the onset of puberty. Few self-injurers seek professional therapy until their mid-twenties, by this time the self-injurer has an average of 93 scars (Favazza & Conterio, 1988; Bach-y-Rita, 1974).

Theories abound on the reasons for self-injury: the body focused culture, body alienation, emotional deprivation, abuse, divorce, and biology, but none alone adequately explain why people injure themselves and why suddenly there is an increase in reports of this behavior. The increase is most likely due to an “epidemic of disclosure” due to the media attention given to self-injury via television shows such *Beverly Hills, 90210* and *Seventh Heaven*, and disclosures of self-injury by celebrities such as Angelina Jolie, Johnny Depp, and Princess Diana. Despite the interest of the mainstream culture in self-injury, little empirical research exists. Much of the existing research consists of case studies (Solomon & Farrand, 1996) and when research has been conducted, much of it involves clinical samples with psychiatric disorders such as Borderline Personality Disorder, making this literature difficult to extrapolate to other populations (Herpetz, 1995). There are no published studies analyzing self-injury in community samples and only one analyzing self-injury among adolescents in the school setting (Ross & Heath, 2002).

Recent education literature has addressed legal and ethical challenges in working with students who self-injure (Froeschle & Moyer, 2004) and strategies for counseling and responding to students who self-injure (White Kress, Gibson, &

Reynolds, 2004; Lieberman, 2004), but literature has yet to clearly identify the role the school counselor can play in reducing the prevalence of self-injury among adolescents. As the most likely scenario for successful treatment of self-injury is professional therapy, the goal of schools when encountering a self-injurer should be to facilitate the transition to therapy while supporting the student academically. This paper will propose that the main role of the school counselor is to act as a conduit through which a self-injurer is identified and referred to professional therapy. To facilitate identification and referral, the counselor must provide education to school staff, students (via the school health educator), and parents. These groups, when properly informed about the topic of self-injury, can inform the counselor of students who self-injure, further facilitating the referral process.

METHODS

Participants for the study were randomly drawn from a membership list of the American School Counselor Association, which represents 12,000 of the approximately 100,000 school counselors in the United States. The initial list contained 7,110 names of current school counselors. Approximately 5,000 members' names had been excluded from the list by ASCA because they were retirees or counseling students. An additional four hundred and fifty possible participants were determined ineligible for reasons such as living outside the United States, identification as a university professor, identification as a school board member, or identification as a counselor in private practice. Of the remaining 6,660 possible participants, 1,000 were randomly selected to receive a confidential questionnaire on

self-injurious behaviors in the school setting. Non-respondents were sent a second questionnaire four weeks after the first questionnaire. Questionnaires were initially mailed in mid-April and again in mid-May to allow participants to report behaviors for the majority of the 2002-2003 school year.

The questionnaire was developed by the author based on a comprehensive review of literature. Information on six demographic variables was collected on the questionnaire: age, gender, level of education, number of years as a counselor, work responsibilities, and grade level of the students with whom the counselor worked. Also included on the questionnaire were six background and attitude questions: self-perceived confidence in working with self-injury, self-perceived knowledge about self-injury, personal experience in working with students who self-injure, identification of the most appropriate school personnel to work with self-injurers, how they found out about students who self-injure, and how students were assisted. There were 19 general knowledge questions about self-injury, one question listing nine potential sources of information, four demographic questions about self-injurers with whom they had worked, and eight questions describing their school.

In order to assure participants' responses were referring to the same set of behaviors, a definition of self-injury was included at the beginning of the survey ["deliberate destruction of body tissue, not including suicide attempt or overdose on alcohol or drugs", based on Favazza (1996)]. A definition of counseling was also included to assure that all responses regarding counseling referred to helping behaviors and not treatment behaviors. The definition used ("meeting with students to

help them resolve or cope constructively with their problems”) is from the American School Counselor Association (ASCA) (1999).

Descriptive statistics, *t* tests, chi-squares, and correlations were used in data analysis. Data analysis was performed using SPSS 12.0 for Windows. A 2-tailed *p* value of .05 or less was considered statistically significant.

RESULTS

School counselors were asked if they were the most appropriate person within the school to provide consultation to a self-injurer and if they were the most likely person a self-injurer would be sent to by other school staff. Overwhelmingly, school counselors reported that they were both the most appropriate contact (75.39%) and the most likely contact (76.75%). Seven percent reported that the school nurse was the most likely contact. Six percent identified the school psychologist as a more appropriate contact than the counselor.

Knowing counselors consider themselves the most likely and appropriate contact for self-injurers is a first step in delineating roles for school personnel to work successfully with self-injury, but many questions remain. For example, what should counselors do when they learn a student is self-injuring? What can be done to better identify students who self-injure? Who else should be involved in prevention and identification? How can parents be involved? Where do these responsibilities fit in an already busy counseling agenda? These questions will be addressed by looking at the school counselors' roles from an ecological perspective, examining how the school

counselor can affect the other environments a self-injurer interacts with and examining how other school personnel can contribute to the success of the school counselor.

Role One: Education

Education of counselors. There are three primary groups school counselors should ensure education is provided to: school staff, students, and parents. Prior to becoming the main information source on self-injury, the school counselor must become the local expert. Currently, few counselors would consider themselves experts on the topic. When asked to self-report their knowledge of self-injury only 6% of counselors identified themselves as highly knowledgeable; 74% identified themselves as moderately knowledgeable; and 20% identified themselves as not very knowledgeable. In order to increase the knowledge level of school counselors, state and national counseling conferences can feature speakers on self-injury, in-service trainings can be provided, self-injury can be featured in counseling publications, book/website lists can be provided by professional organizations, and information can be included in school counselor preparation programs. A focused effort to arm school counselors with the information they need about self-injury must begin.

The development of a training program to equip school counselors to work with self-injurers would be the ideal solution. The program could be similar to Project SOAR (Suicide, Options, Awareness, and Relief), an intensive suicide training program for school counselors (King & Smith, 2000). This program incorporates activities to help counselors examine personal attitudes toward suicide, strengthens empathy and active listening skills, and develops crisis intervention skills through training to identify students at risk, counsel those students, document contacts, and

appropriately refer students to outside mental health counseling (King & Smith).

After participating in Project SOAR training, 56% of participants believed they could recognize a suicidal student, compared to 38% in a national sample of non-participants. Counselors scoring high on knowledge of intervention steps were seven times more likely than low scoring counselors to have received SOAR training in the past three years (King & Smith). King and Smith also recommend counselor training include role plays and mock scenarios to increase counselors' confidence in interacting with students in crisis. All of these components would be appropriate to include in school counselor training for self-injury prevention, intervention, and referral.

Fewer than half (41.97%) of the counselors reported learning about self-injury in their college coursework. Counselors with fewer years of experience (1-5 years) were significantly more likely to have learned about self-injury in their pre-service training than counselors with six or more years experience, yet only 65% of first-year counselors reported self-injury being addressed in their counselor training programs (see Table 3.1) ($t(423) = -4.16, p = .00$). All accredited counseling degree programs include coursework in eight core areas: human growth and development; social and cultural diversity; relationships; group work; career development; assessment; research and program evaluation; and professional identity (ACSA, 1999). There are no data, however, identifying whether topics such as self-injury or other mental health topics are included in a particular program's coursework. Counseling preparation programs must recognize the growing need for training in self-injury and update their

curriculum accordingly. It is difficult for counselors to find time and funding for further training once in the field, thus they must enter the field prepared.

Table 3.1

Percent of counselors reporting training in self-injury in their graduate programs by number of years experience

Years experience	Number reporting training of total number in category	Percent
1 year	22/34	64.71%
2-5 years	86/173	49.71%
6-10 years	45/108	41.67%
11-15 years	13/52	25.00%
16-20 years	11/31	35.48%
20+ years	6/38	15.79%

Education of school staff. Once counselors are sufficiently knowledgeable, they can in turn, train the school staff. This is not a new role for counselors as they are often the heads of crisis intervention teams and are looked to for information on a variety of mental health topics. School staff, especially teachers, nurses, and coaches, need to recognize warning signs and risk factors for self-injury. This can be accomplished through repeated in-service training and written materials. Content should include the causes of self-injury, how to identify self-injurers, and to refer self-injurers to the school counselor. School staff should be trained to report all known or suspected cases of self-injury to the counselor for further screening and referral. This centralized referral ensures that all self-injuring students have follow-up. This educational piece is essential as junior high and senior high school counselors describe school staff as having low to moderate knowledge levels about self-injury ($M = 2.89$ on a scale of one to seven, $SD = 1.25$). Elementary school counselors rated their

teachers even lower ($M = 2.62, SD = 1.23$). Junior high and senior high school counselors perceived their students to be significantly more knowledgeable about self-injury than their teachers ($M = 3.64, SD = 1.50, t(330.94) = -5.08, p = .00$).

Education of students. Education of students should be performed by the school health educator, after training by the school counselor on self-injury. It is the role of the teacher, not the counselor, to deliver and evaluate course content. Training teachers, and then assigning them to disseminate the information to students, delineates roles and frees the counselor for other responsibilities. School health educators should incorporate self-injury into the existing mental health curriculum. According to Lieberman (2004), student education about self-injury should focus on the signs of mental stress, risk factors, coping strategies, and referring friends to trusted adults. Detailed descriptions of self-injury should be avoided to limit suggestion.

Additionally, student education about self-injury should include a component on friends acting as referral agents or “gatekeepers”. Klingman and Hochdorf (1993) suggest that peers are part of the natural support system and can serve as gatekeepers, referring their friends to counseling when they are suicidal. This same concept can be applied to self-injury. Peers can be trained via classroom education to recognize the signs and symptoms of self-injury and how to refer their friends to the school counselor. Gatekeeping strengthens students’ investment in the program and thus improves the behavioral, cognitive, and affective gains made during training (Jason and Rhodes, 1989 as cited in Klingman and Hochdorf, 1993). As only one-half of students report feeling comfortable talking to anyone on school staff about a personal

problem (Armacost, 1990), friends become an especially valuable link to mental health services for self-injurers.

Few schools (10.61%) reported including self-injury in their curriculums. Not surprisingly, junior high and senior high schools were more likely to include self-injury in their curriculums than elementary schools [$F(2)310 = 6.12, p = .00$, Tukey's HSD = .01 and .01, respectively]. Junior high and senior high schools with health educators on staff were significantly more likely to include self-injury in the curriculum than schools with no health educator, [$t(197) = -3.43, p = .00$]. Self-injury was also more likely to be included in the curriculum of the 88 junior high and senior high schools where a Coordinated School Health Program was in place compared to the 127 schools where a program did not exist, [$t(143) = -2.93, p = .00$].

Education of family. Schools must develop supportive school-family partnerships. Schools should inform parents about the school's self-injury education activities and enlist parental support where possible. Self-injury prevention materials should be provided to parents including information on the causes of self-injury, symptoms, steps for contacting a therapist, and information on what the school counselor can do for a self-injuring student. This could be accomplished via a parent awareness meeting or included in other parent-school contacts. The education of parents is essential for three reasons. One, it makes parents more likely to notice self-injurious behaviors in their children. Two, it informs them of what to do when they notice these behaviors. Three, it informs them that the school has a plan for this behavior and can be of assistance.

Role 2: Referral

Conduit to therapy. The counselor's role in education creates environments where self-injury is more likely to be identified by school staff, students, and parents. Once the student has been identified and the school counselor notified, the counselor's second role begins. The job of the school counselor is not intended for or amenable to providing in-depth counseling. In many cases, school counselors need to refer students to professional counselors outside the school (Remley & Sparkman, 1993; Sheeley & Herlihy, 1989). Thus, for mental health concerns, such as self-injury, the counselor's main function is to serve as a conduit to professional therapy. In order to fulfill this role, they must be able to both identify self-injurers in need of mental health services and be prepared to make appropriate referrals. School counselors can then coordinate with the professional therapist and parents to ensure appropriate interventions and responses from school personnel (Lieberman, 2004).

Referring students outside the school for treatment is one of the most important roles of today's school counselor (Baker, 1992) and the task "making referrals" is the most essential service students reported wanting from a school counselor (Wiggins & Moody, 1987). As certification or licensure in therapy does not necessarily qualify a therapist to practice in all areas, counselors must be familiar with the specialty of the professional therapist to whom they refer students. Unfortunately, many counselors are unfamiliar with the therapists they refer students to. Ritchie and Partin (1994) reported that counselors were least likely to be familiar with professionals outside the school system, such as family therapists, and that many counselors never meet face to face with the therapists to whom they make referrals. As counselors were more likely

to have complaints, such as ineffective therapy, about therapists who they were unfamiliar with, it is imperative for counselors to familiarize themselves with local therapists to ensure they are making appropriate referrals (Ritchie & Partin).

After a student is referred, the school counselor maintains the “conduit” role between the school and professional therapy. This may involve being available during the school day if the student needs to talk, providing a safe space in an office if a student feels the need to be alone, arranging tutoring, speaking with the student’s family, teachers, and friends to address concerns, and preparing a Section 504 plan, if necessary. These actions work to maintain the student’s mental health while facilitating the student’s academic success.

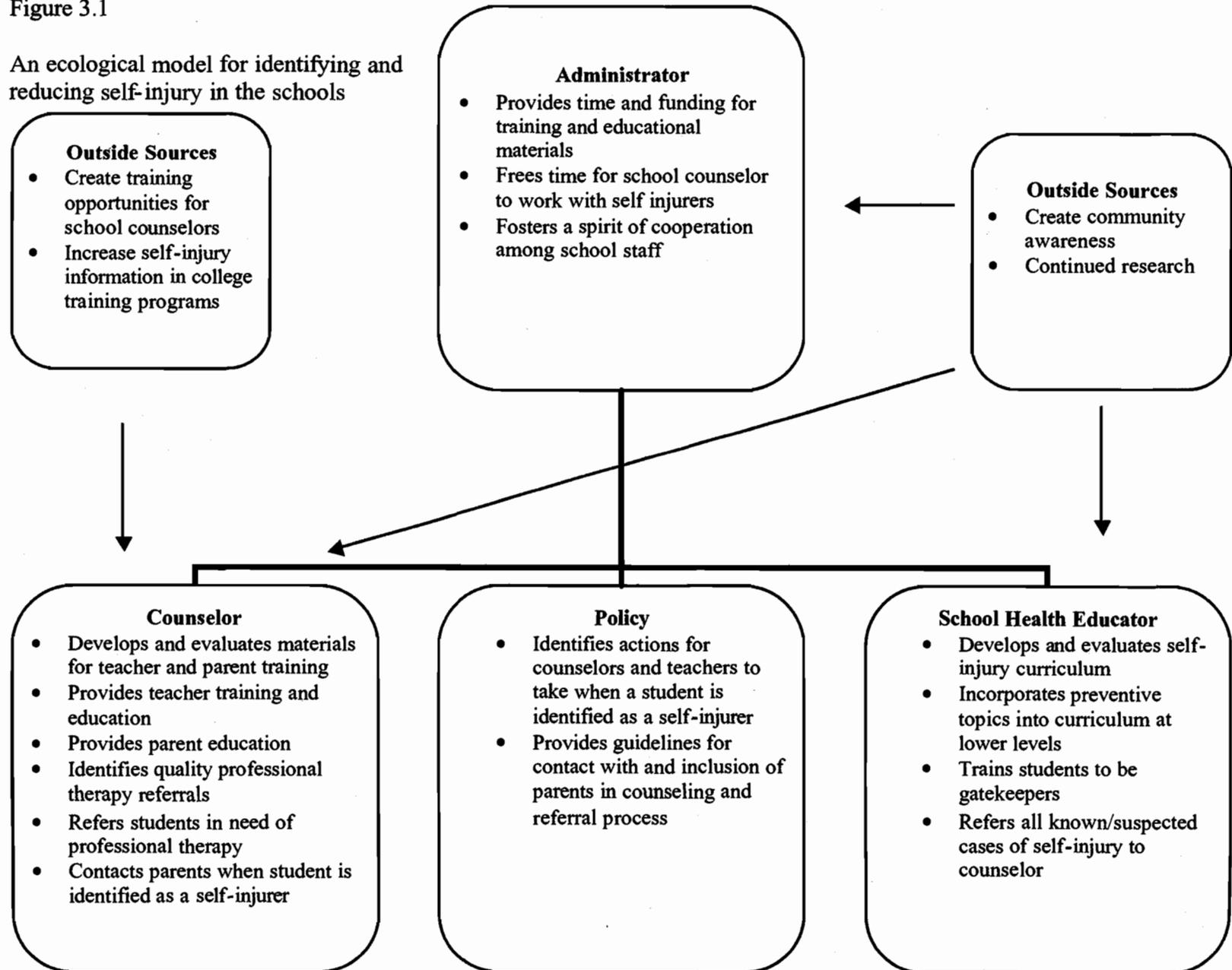
Linking the systems. The conduit role of the school counselor allows him or her to link the many environments in which the self-injurer simultaneously exists. The systems perspective analyzes a person in the context of his situation and evaluates patterns within and between systems, such as home, school, friends, community, or therapy (Lambie and Rokutani, 2002). By fulfilling their roles as an educator and a conduit, school counselors link these systems together. Through educating parents, the home and school are more likely to interact if self-injury is present. Self-injury is also more likely to be discovered by the parents due to the school’s involvement. Educating school staff creates a school environment which is a safer, more understanding place, and where symptoms are more likely to be reported to the school counselor. When school health educators teach students and train them to be gatekeepers, friends know what symptoms to look for and know the school has plans in place to help, making disclosure more likely. If a student is referred to an

appropriate therapist and the counselor works closely with that therapist, healing begins and academic progress can continue. Thus, approaching self-injury from an ecological perspective allows more opportunities for identification, referral, and treatment. All three environments are bolstered by the previously outlined education plan. This education plan improves the likelihood that the student will enter therapy early by educating and empowering each environment.

Figure 3.1 shows diagrammatically the role of the school counselor and other school personnel in cases of self-injury. The school administrator must create a school environment where counselors are able to successfully fulfill their role. Counselors must provide training and make quality referrals, but in order to do this, outside sources must create opportunities for them to be trained. School health educators must take the information they learn from counselors and deliver it to their students to create a culture of awareness. All of these roles will be continually strengthened as the community becomes more aware of the problem of self-injury among adolescents and as current questions are answered by future research.

Figure 3.1

An ecological model for identifying and reducing self-injury in the schools



DISCUSSION

Limitations. Strengths of this study include the large number of counselors ($n = 443$) surveyed and the nationwide, random sample. Also, to our knowledge, this is the first study to address the school's response to self-injury. The study is limited as the respondents are all members of the American School Counselor Association. Generalizability outside that population may be unjustified. Also, of the 1,000 randomly selected members, 443 returned usable questionnaires. Those who did not respond may be less familiar with self-injury and thus less likely to respond. It may also be the case that counselors with particularly heavy workloads were less likely to respond due to time constraints. The timing of the questionnaires may have impacted responses. Questionnaires were mailed in mid-April, thus counselors with greater year-end responsibilities may have been unable to respond.

Conclusion. Adolescent self-injury is a particularly challenging behavior to deal with in the school setting for a variety of reasons. First, the behavior is generally secretive. Most self-injurers hide their wounds and scars behind long sleeves and pants and make excuses for their wounds or scars when questioned (Conterio & Lader, 1998). Second, adolescents are possibly the most challenging therapeutic population (Church, 1994; Hanna, Hanna, & Keys, 1999). They are often hesitant to enter into a helping relationship and have little motivation to change (Rutter & Rutter, 1993; Sommers-Flanagan & Sommers-Flanagan, 1995) and developmentally, they are looking to assert their autonomy, rather than feel controlled (Miller & Rollnick, 1991). Add to these challenges that self-injurers have difficulty trusting others and have

difficulty forming therapeutic relationships (Levenkron, 1998). For these reasons, this is a particularly challenging population to both identify and to initiate into therapy.

Without appropriate training, the school counselor is ill-equipped to identify self-injurers or refer them to professional therapy. Once educated, the counselor is in a position to disseminate this knowledge to school staff and parents, creating a wide network of trained observers. After training, school health educators can, in turn, educate students. The more informed, the better able each group is to identify self-injurers and then notify the school counselor. Education of these three environments is key to the early identification and future treatment of self-injurers. Using an ecological approach strengthens the links between these environments and increases knowledge and communication, helping to facilitate the early referral of self-injurers to professional therapy.

CHAPTER 5

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Discussion

The purpose of this study was to determine the frequency with which school counselors work with students who self-injure, their knowledge regarding self-injury, and their confidence level in working with self-injurers. Additional goals included determining the supports school counselors need in order to work effectively with this population and indirectly estimating the prevalence of self-injury in adolescents based on school counselors' reports. Although recent education literature has addressed legal and ethical challenges in working with students who self-injure (Froeschle & Moyer, 2004) and strategies for counseling and responding to students who self-injure (White Kress, Gibson, & Reynolds, 2004; Lieberman, 2004), the literature has yet to explore whether or not counselors are adequately prepared for this role.

Results of this study show that although almost all counselors were familiar with self-injury (98%) and that most had worked with a self-injurer during their careers (81%), few (17%) described themselves as highly confident in their skills for working with this population. Price, Desmond, Price, and Mossing (1990) reported similar low levels of confidence in school counselors regarding eating disorders. Despite being well-informed about eating disorders (a majority were able to identify 12 of 14 symptoms of anorexia and bulimia), only 11% reported feeling highly competent in helping students with eating disorders. King and Smith (2000) found school counselors were also relatively well-informed on the topic of suicide (a majority were able to identify 9 of 16 risk factors), but only 38% were confident they

could recognize a student at risk for suicide. As confidence in working with students who self-injure was positively correlated with knowledge about self-injury ($r_s = .80, p = .00$), raising knowledge levels may be one means of increasing confidence in working with students who self-injure.

Overall, self-reported knowledge levels about self-injury were low to moderate. In a composite score of the three knowledge measures (root causes of self-injury, symptoms of self-injury, and treatment of self-injury), 6% of counselors identified themselves as highly knowledgeable in working with self-injurers (a score of 6 or 7, on a scale of 1 to 7); 74% identified themselves as moderately knowledgeable (a score of 3, 4, or 5, on a scale of 1 to 7); and 20% identified themselves as not very knowledgeable in their ability to work with self-injurers (a score of 1 or 2, on a scale of 1 to 7) ($M = 3.60, SD = 1.24$). To increase school counselors' knowledge of other health topics, training programs have been developed. McClanahan, McLaughlin, Loos, Holcomb, Gibbons, and Smith (1998) developed a training project to prepare school counselors to work in prevention, early detection, and appropriate referral of students at high risk for substance abuse. Participants in the training reported greater perceived self-efficacy, comfort, confidence, and competence in working with students at risk of substance abuse. A school counselor training program has also been developed on the topic of suicide. Project SOAR (Suicide, Options, Awareness, and Relief) participants were seven times more likely to be able to identify steps to intervene during a suicide attempt than school counselors who had not participated in the training (King, Price, Telljohann, & Wahl, 2000).

Counselors used a variety of resources to learn about self-injury. Contact with professional colleagues (76.8%), reading professional journals (71.1%), and personal experiences (63.5%) were the most common sources of information. Those who had worked with self-injurers reported using a wider variety of learning sources ($M = 6$ types of resources vs. 4, respectively). The need for training and education about self-injury was the most commonly reported barrier to successfully working with students who self-injure.

Currently, accredited counseling degree programs require coursework in eight core areas: human growth and development; social and cultural diversity; relationships; group work; career development; assessment; research and program evaluation; and professional identity (ACSA, 1999), but inclusion of mental health topics, such as self-injury, is at the discretion of individual programs. Fewer than half (42%) of the counselors reported learning about self-injury in their college coursework. Counselors with fewer years of experience (1-5 years) were significantly more likely to have learned about self-injury in their pre-service training than counselors with six or more years experience, yet only 65% of first-year counselors reported self-injury being addressed in their counselor training programs [$t(423) = -4.16, p = .00$].

Counselors who had worked with a self-injurer in the 2002-2003 school year reported working with an average of three students per year. However, junior high and senior high school counselors estimated that about 2% of their entire student body engages in self-injury. The discrepancy between the number of self-injuring students they worked with and their estimates of the prevalence of self-injury highlights the

hidden nature of this behavior and suggests that a majority of self-injurers are not being identified and are not receiving services from school personnel. This estimate is also far lower than Ross and Heath's (2002) finding that almost 14% of adolescents report having self-injured at least once, emphasizing that most counselors fail to recognize how widespread self-injury is.

The majority who were identified and had received services from school counselors were female (69%), White, non-Hispanic (87%), and were more likely to attend higher-income schools (based on the percentage of students receiving free and reduced lunch benefits). These findings are consistent with Favazza and Conterio's (1988) description of the typical self-injurer being female, White, and middle to upper-middle class.

Despite recognizing the presence of self-injurers in the school, few school counselors reported information about self-injury being included in the school curriculum (15% of junior high schools and 13% of senior high schools). In junior high and senior high schools with health educators on staff, self-injury was significantly more likely to be included in the curriculum compared to schools with no health educator, [$t(197) = -3.43, p = .00$]. This finding highlights the importance of utilizing trained school health educators to educate students about self-injury. It is the role of the teacher, not the school counselor to deliver this information to the students. Education about self-injury should begin early in the junior high school years, as counselors identified grades seven through nine as the most likely time for self-injury to begin. This is most likely an accurate estimate as early adolescence/beginning of

puberty has been identified in the literature as the typical onset for self-injurious behavior (Favazza, 1996).

In addition to the absence of self-injury in the curriculum, few school counselors (23%) reported the existence of an identified policy or plan for self-injury compared to other health concerns such as suicide attempt (90%), alcohol use (87%), physical or sexual abuse (98%), sexual harassment (95%), or weapons on school grounds (99%). Of the seventeen policies queried, more school counselors responded to both “no policy” (55%) or “I don’t know” (22%) regarding self-injury than all other policies. The number of self-injurers with which a school counselor had ever worked was the only significant predictor of whether or not a school had a policy on self-injury [$\chi^2(1, N = 346) = 4.7, p = .030, Exp(B) = 1.05$].

This study describes for the first time the experience, knowledge, and needs of school counselors in relation to students’ self-injurious behaviors. The descriptive nature of the study yielded a comprehensive view of the counselors’ actions when working with self-injurers and their abilities to effectively work with this population. Results revealed the need for additional training and support for school counselors in their work with self-injurers.

Conclusions

The frequency with which counselors reported encountering self-injuring students necessitates their familiarity and confidence in working with them as well as the ability to identify additional students who self-injure. Yet, school counselors believed that they are poorly prepared for this role. They reported low to moderate

levels of knowledge and confidence. They also reported having few opportunities for gaining knowledge due to the lack of attention given to self-injury in professional journals, conferences agendas, and university pre-service programs. School counselors who are inadequately trained and lack opportunities for training cannot ensure that schools are playing an adequate and appropriate role in the prevention, identification, and treatment of self-injurers.

In addition to the need for training, another major implication of the results of this study is the need for an ecological approach to working with self-injurers in the schools. School counselors need to work in tandem with many other personnel. It is important for school administrators to create environments where school counselors can work successfully by implementing policy and providing needed resources. School health educators play the important role of disseminating information about self-injury to students. Students, in turn, become gatekeepers, referring friends to the school counselor in order to get the help they need. Parents, after being educated by the school counselor via a parent awareness meeting or through other parent-school contacts, can watch for behaviors indicative of self-injury, and contact the school counselor or a professional therapist, when needed. Professional therapists can function, not as a separate entity, but as a partner with the school counselor to promote the healing and academic success of the student. These systems, when combined in an integrated community-school approach, can work together to identify self-injurers early, giving them the best chance for successful treatment and recovery.

Recommendations

First and foremost, school counselors' knowledge levels of self-injury must increase. In order to increase knowledge among counselors, state and national counseling conferences should feature speakers on self-injury; if a local expert can be identified, in-service trainings should be provided; articles on self-injury should be featured in school counseling publications; resource lists should be provided by professional organizations; websites devoted to working with self-injurers should be developed; and information specific to working with self-injurers should be included in school counselor college preparation programs. Counseling preparation programs must recognize the growing need for training in self-injury and update their curriculums accordingly. New counselors must enter the field prepared, as it is difficult to find time and funding for further training once they enter the field.

For counselors already in the field, an in-service training should be developed. It must be widely available and affordable given the strained budgets of many school districts today. One option is a program similar to Project SOAR (Suicide, Options, Awareness, and Relief), an intensive suicide training program for school counselors (King & Smith, 2000) that incorporates activities to help counselors examine personal attitudes toward suicide, strengthens empathy and active listening skills, and develops crisis intervention skills through training to identify students at risk, counsel those students, document contacts, and appropriately refer them to outside mental health counseling (King & Smith). To make this training widely available and accessible, one option would be to offer it via the Internet. An on-line training program would

eliminate barriers such as travel expenses, high-cost conference registration fees, and the need to miss a school day in order to attend training.

Once trained, school counselors must disseminate their knowledge to school staff, students, and parents. By educating these three groups, the probability of early identification of a self-injurer is increased exponentially. This allows for early intervention and referral to therapy, increasing the likelihood of successful treatment. To provide education, counselors will need to hold in-services for school staff, develop educational materials for parents, and work with the school health educator to integrate self-injury information into the school curriculum. Within the school, administrators need to provide counselors with a school policy on self-injury, tangible support in the form of time and resources, and cooperation within the school building.

Teachers, nurses, and coaches, especially need to be trained to recognize warning signs and risk factors for self-injury, such as wearing long sleeves and pants in warm weather, unexplained injuries, and depressed mood. This information can be delivered through repeated in-service training and written materials. Content should include the causes of self-injury, how to identify self-injurers, and to refer self-injurers to the school counselor. Information should also be included on how social factors, such as parental divorce and constructs of gender impact self-injury. School staff should be trained to report all known or suspected cases of self-injury to the counselor for further screening and referral. This centralized referral ensures that all self-injuring students have follow-up.

Student education on self-injury should be performed by the school health educator, after any needed training by the school counselor. Training teachers, and

then assigning them to disseminate the information to students, delineates roles and frees the counselor for other responsibilities. School health educators should incorporate self-injury into the existing mental health curriculum, focusing on the signs of mental stress, risk factors, coping strategies, and referring friends to trusted adults. Additionally, student education about self-injury should include a component on friends acting as referral agents or “gatekeepers”. Peers can be trained via classroom education to recognize the signs and symptoms of self-injury and how to refer their friends to the school counselor. School health educators should also address topics such as body satisfaction, coping skills, communication, and self-esteem that are related to the prevention of self-injury.

The links between school counselors and local professional therapists must be strengthened. Counselors need to identify local therapists who are qualified to work with self-injurers in advance of needing to refer a student. This will allow the school counselor to become a conduit to therapy, so healing can begin and academic progress can continue. In order to prepare counselors to work cooperatively with local therapists, training can be included at the pre-service level. As part of their academic preparation, school counselors could learn how to build partnerships with local therapists and how to determine if a therapist is a good match for a particular student’s needs. This type of preparation would help to eliminate many of the complaints counselors have about professional therapists, such as ineffectiveness or failure to communicate (Ritchie & Partin, 1994). Counselors should also gather and record feedback from students, parents, and other school counselors about their experiences with professional therapists to evaluate therapists in a systematic manner.

After supports, such as counselor training, have been implemented, evaluation must be conducted to determine if training has been effective. It will also be important to document the actions taken by trained counselors to assist self-injuring students and the outcomes of those actions to determine the most effective strategies. Based on these outcomes, best practice guidelines can be determined for counselor training, as well as policy and program implementation in schools.

More research related to self-injury in the schools must be done to continue the work of this project. These descriptive statistics give the first picture in the literature of the interactions between school personnel and self-injurers. The data gathered for this project can serve as a foundation for further study on this topic and as a starting point for exploring self-injury in the school setting from additional perspectives. The findings highlight many actions that need to be taken to improve the ability of school counselors to work with self-injurers. Future research should focus on what strategies school counselors are using when working with self-injurers and determining what actions are most effective. All future research and actions must honor the ecological nature of this behavior, studying the self-injurer in the context of his or her situation and evaluating the patterns within and between systems, such as home, school, friends, community, or therapy (Lambie and Rokutani, 2002). By approaching self-injury from an ecological perspective, opportunities for identification are multiplied, thus increasing the likelihood of early identification, referral, and successful treatment.

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APPENDICES

APPENDIX A**Questionnaire**

THE SCHOOL COUNSELOR SELF-INJURY SURVEY
by Susan Roberts Dobie, M.A. and Rebecca Donatelle, Ph.D.

DIRECTIONS: For the purpose of this survey, "SELF-INJURY" (also called self-mutilation, self-inflicted violence, or cutting) is defined as **THE DELIBERATE DESTRUCTION OF BODY TISSUE** (e.g. cutting, burning, breaking bones, sticking needles into the skin, interfering with the healing of wounds). This definition **DOES NOT INCLUDE SUICIDE ATTEMPTS OR AN OVERDOSE ON DRUGS OR ALCOHOL**. The term "COUNSELING", as defined by ASCA, refers to "MEETING WITH STUDENTS TO HELP THEM RESOLVE OR COPE CONSTRUCTIVELY WITH THEIR PROBLEMS". **THIS DOES NOT INVOLVE PROVIDING TREATMENT.**

Q1. Are you currently employed as a school counselor? (Circle one number.)

- 1 YES
2 NO → PLEASE RETURN THE QUESTIONNAIRE IN THE POSTAGE-PAID ENVELOPE PROVIDED—THANK YOU.

Q2. Have you ever heard of, read about, or seen cases of self-injury? (Circle one number.)

- 1 YES
2 NO → GO TO QUESTION 5.

Q3. Have you learned information about self-injury from any of the following resources? (Circle one number for each line.)

	<u>YES</u>	<u>NO</u>
a. PROFESSIONAL JOURNAL	1	2
b. SESSION AT A PROFESSIONAL CONFERENCE	1	2
c. IN-SERVICE TRAINING OR CONTINUING EDUCATION	1	2
d. CONTACTS WITH PROFESSIONAL COLLEAGUES	1	2
e. I KNOW OF SOMEONE WHO SELF-INJURES	1	2
f. MASS MEDIA (TV, NEWSPAPERS, MAGAZINES)	1	2
g. INTERNET	1	2
h. COLLEGE CLASSES	1	2
i. TEXTBOOKS	1	2
j. OTHER: (PLEASE DESCRIBE) _____	1	2

Q4. How knowledgeable are you about self-injury on a scale of 1 to 7, where '1' means 'not at all knowledgeable' and '7' means 'extremely knowledgeable'? (Circle one number for each.)

a. How knowledgeable are you about the root causes of self-injury?
 NOT AT ALL EXTREMELY
 KNOWLEDGEABLE 1 2 3 4 5 6 7 KNOWLEDGEABLE

b. How knowledgeable are you about the symptoms of self-injury?
 NOT AT ALL EXTREMELY
 KNOWLEDGEABLE 1 2 3 4 5 6 7 KNOWLEDGEABLE

c. How knowledgeable are you about the treatment of self-injury?
 NOT AT ALL EXTREMELY
 KNOWLEDGEABLE 1 2 3 4 5 6 7 KNOWLEDGEABLE

Q5. If a student in your school is identified as a self-injurer (BY SOMEONE OTHER THAN YOU), who is the most likely person within the school he/she would be sent to for consultation? (Circle one number.)

- 1 ME, THE SCHOOL COUNSELOR
- 2 ANOTHER SCHOOL COUNSELOR → 2A. WHY THIS COUNSELOR AND NOT YOU? _____
- 3 SCHOOL NURSE
- 4 SCHOOL SOCIAL WORKER
- 5 SCHOOL PRINCIPAL
- 6 OTHER: (PLEASE DESCRIBE) _____

Q6. In your opinion, who is the most appropriate person within your school to provide consultation to a student who is identified as a self-injurer? (Circle one number.)

- 1 ME, THE SCHOOL COUNSELOR
- 2 ANOTHER SCHOOL COUNSELOR → 2A. WHY THIS COUNSELOR AND NOT YOU? _____
- 3 SCHOOL NURSE
- 4 SCHOOL SOCIAL WORKER
- 5 SCHOOL PRINCIPAL
- 6 OTHER: (PLEASE DESCRIBE) _____

Q7. How confident do you feel in providing the following services on a scale of 1 to 7, where '1' is 'not at all confident' and '7' is 'extremely confident'? (Circle one number for each.)

- a. Identifying students who self-injure?
 NOT AT ALL EXTREMELY
 CONFIDENT 1 2 3 4 5 6 7 CONFIDENT
- b. Providing individual counseling to students who self-injure?
 NOT AT ALL EXTREMELY
 CONFIDENT 1 2 3 4 5 6 7 CONFIDENT
- c. Providing group counseling to students who self-injure?
 NOT AT ALL EXTREMELY
 CONFIDENT 1 2 3 4 5 6 7 CONFIDENT
- d. Following-up with a student after identification as a self-injurer?
 NOT AT ALL EXTREMELY
 CONFIDENT 1 2 3 4 5 6 7 CONFIDENT
- e. Providing counseling to friends of students who self-injure?
 NOT AT ALL EXTREMELY
 CONFIDENT 1 2 3 4 5 6 7 CONFIDENT
- f. Referring students who self-injure to outside resources?
 NOT AT ALL EXTREMELY
 CONFIDENT 1 2 3 4 5 6 7 CONFIDENT
- g. Providing information to faculty and staff about the topic of self-injury?
 NOT AT ALL EXTREMELY
 CONFIDENT 1 2 3 4 5 6 7 CONFIDENT
- h. Providing information to parents about the topic of self-injury?
 NOT AT ALL EXTREMELY
 CONFIDENT 1 2 3 4 5 6 7 CONFIDENT

Q8. In your career as a school counselor, have you ever worked with a student who self-injured? (Circle one number.)

- 1 YES → (IF YES, HOW MANY SELF-INJURERS HAVE YOU WORKED WITH?
 _____ STUDENTS)
- 2 NO

Q9. During the current 2002-2003 school year, have you worked with a student in your school who self-injures? (Circle one number.)

- 1 YES
2 NO → (ANSWER QUESTION 9A, AND THEN GO TO QUESTION 19.)

→ **Q9a. In the future, if you worked with a student in your school who self-injures, would you take any of the following actions? (Circle one number for each line.)**

	<u>YES</u>	<u>NO</u>
a. I WOULD TAKE NO ACTION	1	2
b. CONTACT THE STUDENT'S PARENT/GUARDIAN	1	2
c. PROVIDE INDIVIDUAL COUNSELING	1	2
d. PROVIDE GROUP COUNSELING	1	2
e. REFER STUDENT TO THE SCHOOL PRINCIPAL	1	2
f. REFER STUDENT TO A SCHOOL NURSE	1	2
g. REFER STUDENT TO A SCHOOL SOCIAL WORKER	1	2
h. REFER STUDENT TO AN OUTSIDE SOCIAL WORKER OR CHILD PROTECTIVE SERVICES	1	2
i. RECOMENDED STUDENT VISIT AN OUTSIDE PSYCHIATRIST OR PSYCHOLOGIST	1	2
j. RECOMENDED STUDENT VISIT A PHYSICIAN	1	2
k. OTHER: (PLEASE DESCRIBE) _____	1	2

Go to
question
19.

Q10. During the current 2002-2003 school year, have you taken these actions when working with students in your school who self-injure? (Circle one number for each line.)

	<u>YES</u>	<u>NO</u>
1 I HAVE TAKEN NO ACTION	1	2
2 CONTACTED THE STUDENT'S PARENT/GUARDIAN	1	2
3 PROVIDED INDIVIDUAL COUNSELING	1	2
4 PROVIDED GROUP COUNSELING	1	2
5 REFERRED STUDENT TO A SCHOOL NURSE	1	2
6 REFERRED STUDENT TO THE PRINCIPAL	1	2
7 REFERRED STUDENT TO A SCHOOL SOCIAL WORKER	1	2
8 REFERRED STUDENT TO AN OUTSIDE SOCIAL WORKER OR CHILD PROTECTIVE SERVICES	1	2
9 RECOMENDED STUDENT VISIT AN OUTSIDE PSYCHIATRIST OR PSYCHOLOGIST	1	2
10 RECOMENDED STUDENT VISIT A PHYSICIAN	1	2
11 OTHER: (PLEASE DESCRIBE) _____	1	2

Q11. In general, how would you describe the level of knowledge/awareness of self-injury by the teachers in your school building on a scale of 1 to 7, where '1' means 'not at all aware' and '7' means 'extremely aware'? (Circle one number.)

NOT AT ALL
AWARE 1 2 3 4 5 6 7 EXTREMELY
AWARE

Q12. In general, how would you describe the level of knowledge/awareness of self-injury by the students in your school building on a scale of 1 to 7, where '1' means 'not at all aware' and '7' means 'extremely aware'? (Circle one number.)

NOT AT ALL
AWARE 1 2 3 4 5 6 7 EXTREMELY
AWARE

Q13. In the current 2002-2003 school year, approximately how many students who self-injure have you worked with? (Write in a number.)

_____ STUDENTS

Q14. During the current 2002-2003 school year, approximately what percent of the self-injurers who you have worked with were female? (Write in a percentage.)

_____ % FEMALE

Q15. During the current 2002-2003 school year, approximately what percent of the self-injurers who you have worked with were recent immigrants (within the last 2-3 years) to the United States? (Write in a percentage.)

_____ % RECENT IMMIGRANTS

Q16. During the current 2002-2003 school year, how would you describe the approximate ethnic split of the self-injurers who you have worked with? (Write a percentage on each line.)

_____ % AMERICAN INDIAN OR ALASKA NATIVE
 _____ % ASIAN
 _____ % BLACK OR AFRICAN AMERICAN
 _____ % HISPANIC OR LATINO
 _____ % NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
 _____ % WHITE, NON-HISPANIC

Q17. During current 2002-2003 school year, have you learned of students in your school who self-injure by any of the following ways? (Circle one number for each line.)

	<u>YES</u>	<u>NO</u>
a. STUDENT WHO SELF-INJURES APPROACHED YOU	1	2
b. INFORMED BY A FELLOW STUDENT	1	2
c. INFORMED BY A CLASSROOM TEACHER OR COACH	1	2
d. INFORMED BY THE SCHOOL NURSE	1	2
e. INFORMED BY A SCHOOL SOCIAL WORKER	1	2
f. CONTACTED BY A STUDENT'S PARENTS	1	2
g. YOU RECOGNIZED SIGNS AND SYMPTOMS IN STUDENT	1	2
h. OTHER: (PLEASE DESCRIBE) _____	1	2

Q18. During the current 2002-2003 school year, did you document incidents of self-injury in the students' record or student file? (Circle one number.)

- 1 YES, WITH ALL STUDENTS THAT I WORKED WITH WHO SELF-INJURED.
- 2 YES, WITH SOME STUDENTS THAT I WORKED WITH WHO SELF-INJURED.
- 3 NO, WITH NO STUDENTS THAT I WORKED WITH WHO SELF-INJURED.

Q19. At what grade level do you think students are at greatest risk for starting to self-injure? (Circle one number.)

- 1 K-3RD GRADE
- 2 4TH-6TH GRADE
- 3 7TH-9TH GRADE
- 4 10TH-12TH GRADE

Q20. Is information on self-injury included in any part of your school's curriculum? (Circle one number.)

- 1 NO → (GO TO QUESTION 21.)
- 2 I DON'T KNOW → (GO TO QUESTION 21.)
- 3 YES → (ANSWER QUESTION 20A, THEN GO TO QUESTION 21.)

→ **Q20a. Describe in which courses self-injury is covered and approximately how much time is devoted to it (e.g. in a guidance, health, or psychology class).** _____

Q21. Does your school have a health educator on staff? (Circle one number.)

- 1 NO
- 2 YES

Q22. Does your school have a Coordinated School Health Program? (Circle one number.)

- 1 NO
2 YES

Q23. Please indicate your opinion about each of the following statements about self-injury. 'SD' is 'strongly disagree', 'D' is 'disagree', 'N' is 'neither disagree or agree', 'A' is 'agree', and 'SA' is 'strongly agree'. (Circle one answer for each line.)

- | | | | | | |
|---|----|---|---|---|----|
| a. SELF-INJURY IS ASSOCIATED WITH A HISTORY OF PHYSICAL ABUSE. | SD | D | N | A | SA |
| b. SUBSTANCE ABUSE IS COMMON IN PEOPLE WHO SELF-INJURE. | SD | D | N | A | SA |
| c. SELF-INJURY IS A PREDICTOR OF FUTURE SUICIDE ATTEMPTS | SD | D | N | A | SA |
| d. SELF-INJURY IS A MENTAL ILLNESS. | SD | D | N | A | SA |
| e. SELF-INJURY IS CAUSED BY A CHEMICAL IMBALANCE. | SD | D | N | A | SA |
| f. SELF-INJURY IS A COPING MECHANISM FOR STRESS. | SD | D | N | A | SA |
| g. SELF-INJURY IS AN ACCEPTABLE MEANS OF SELF EXPRESSION. | SD | D | N | A | SA |
| h. SELF-INJURY IS AN ATTENTION SEEKING BEHAVIOR. | SD | D | N | A | SA |
| i. A PERSON FEELS BETTER AFTER SELF-INJURY. | SD | D | N | A | SA |
| j. SELF-INJURY IS A MEANS OF SELF-STIMULATION. | SD | D | N | A | SA |
| k. A PERSON FEELS PHYSICAL PAIN DURING SELF-INJURY. | SD | D | N | A | SA |
| l. SELF-INJURY IS ASSOCIATED WITH A HISTORY OF SEXUAL ABUSE. | SD | D | N | A | SA |
| m. A PERSON WHO SELF-INJURES IS LIKELY TO INJURE OTHERS. | SD | D | N | A | SA |
| n. SELF-INJURY IS ADDICTIVE. | SD | D | N | A | SA |
| o. SELF-INJURY IS A WAY TO MAINTAIN CONTROL. | SD | D | N | A | SA |
| p. SELF-INJURY IS A WAY TO REGULATE UNCOMFORTABLE FEELINGS. | SD | D | N | A | SA |
| q. EATING DISORDERS ARE COMMON IN PEOPLE WHO SELF-INJURE. | SD | D | N | A | SA |
| r. SELF-INJURY IS ASSOCIATED WITH A HISTORY OF EMOTIONAL ABUSE. | SD | D | N | A | SA |
| s. DEPRESSION IS COMMON IN PEOPLE WHO SELF-INJURE. | SD | D | N | A | SA |

Q24. What is your best 'educated guess' of approximately how many TOTAL students in your school self-injure? (Write in a number.)

_____ STUDENTS

Q25. What is your best 'educated guess' of the approximate percent of students who know someone who self-injures? (Write in a percent.)

_____ % OF STUDENTS

Q26. What state is your school located in? (Write in state.)

THE STATE OF _____

Q27. How would you describe your school setting? (Circle one number.)

- 1 INNER-CITY
2 URBAN
3 SUBURBAN
4 RURAL

Q28. Does your school (or school district) have identified policies or plans for the following health concerns? (Circle one number for each line.)

	<u>YES</u>	<u>NO</u>	<u>I DO NOT KNOW</u>
a. SELF-INJURY	1	2	3
b. SUICIDE ATTEMPT	1	2	3
c. SUICIDE THREAT	1	2	3
d. EATING DISORDERS	1	2	3
e. ALCOHOL USE	1	2	3
f. ALCOHOL ABUSE	1	2	3
g. DRUG USE (INCLUDING STEROIDS)	1	2	3
h. SEXUAL HARASSMENT	1	2	3
i. PREGNANCY	1	2	3
j. SEXUAL ASSAULT	1	2	3
k. abuse (physical, sexual, emotional or neglect)	1	2	3
l. BULLYING	1	2	3
m. WEATHER RELATED DANGERS (E.G. TORNADOS)	1	2	3
n. BOMB THREATS	1	2	3
o. WEAPONS ON SCHOOL GROUNDS	1	2	3
p. STRANGERS ON SCHOOL GROUNDS	1	2	3
q. TERRORIST ATTACK	1	2	3

Q29. Is your school publicly or privately funded? (Circle one number.)

- 1 PUBLIC
 2 PRIVATE (WITH RELIGIOUS AFFILIATION)
 3 PRIVATE (WITH NO RELIGIOUS AFFILIATION)

Q30. What percent of the students in your school qualify for free or reduced lunch benefits? (Write in a percent.)

_____ % OF STUDENTS

Q31. What is the approximate demographic make-up of your school? (Write a number on each line.)

- _____ % AMERICAN INDIAN OR ALASKA NATIVE
 _____ % ASIAN
 _____ % BLACK OR AFRICAN AMERICAN
 _____ % HISPANIC OR LATINO
 _____ % NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
 _____ % WHITE, NON-HISPANIC

Q32. Approximately what percent of the students in your school are recent immigrants (within 2-3 years) to the United States? (Write in a percent.)

_____ % OF STUDENTS

Q33. Approximately how many students are enrolled in your school? (Write in a number.)

_____ STUDENTS

Q34. Approximately how many students do you serve in your position as school counselor? (Write in a number.)

_____ STUDENTS

Q35. Which best describes the grades which you serve as counselor? (Circle one number.)

- 1 ELEMENTARY ONLY
- 2 JUNIOR HIGH ONLY
- 3 HIGH SCHOOL ONLY
- 4 ALL GRADES (ELEMENTARY, JUNIOR HIGH, AND HIGH SCHOOL)
- 5 ELEMENTARY AND JUNIOR HIGH
- 6 JUNIOR HIGH AND HIGH SCHOOL

Q36. How many school counselors (including you) work with the SAME GRADE LEVELS you work with? (Circle one number.)

- 1 1 (I AM THE ONLY SCHOOL COUNSELOR FOR THESE GRADE LEVELS.)
- 2 _____ COUNSELORS (INCLUDING ME)

Q37. How would you describe your work responsibilities as a school counselor? 'Educational Planning' includes activities such as scheduling, college and career preparation activities, or testing. (Circle one number.)

- 1 ONLY EDUCATIONAL PLANNING AND NO COUNSELING
- 2 MOSTLY EDUCATIONAL PLANNING AND SOME COUNSELING
- 3 EQUALLY SPLIT BETWEEN EDUCATIONAL PLANNING AND COUNSELING
- 4 MOSTLY COUNSELING AND SOME EDUCATIONAL PLANNING
- 5 ONLY COUNSELING AND NO EDUCATIONAL PLANNING

Q38. How long have you worked as a school counselor? (Write in a number.)

_____ YEARS

Q39. How old are you?

_____ YEARS

Q40. Which best describes your highest level of education? (Circle one number.)

- 1 UNDERGRADUATE DEGREE
- 2 UNDERGRADUATE DEGREE PLUS HOURS TOWARD A MASTER'S DEGREE
- 3 MASTER'S DEGREE
- 4 MASTER'S DEGREE PLUS HOURS TOWARD AN ADVANCED DEGREE
- 5 DOCTORAL DEGREE

Q41. What is your gender? (Circle one number.)

- 1 MALE
- 2 FEMALE

Q42. What measures could schools take to decrease the prevalence of self-injury?

Q43. What strategies or interventions have you used to help students who self-injure?

Q44. What kinds of supports would help you to work with students who self-injure?

Q45. What are the most effective ways to reach school counselors with information about self-injury?

Q46. How far would you be willing to travel to learn more about self injury?

- 1 I AM NOT INTERESTED IN LEARNING MORE ABOUT SELF-INJURY.
- 2 I WOULD TRAVEL UP TO _____ MILES.

Thank you for your time and help.

Please return to:
Susan Roberts Dobie, Oregon State University
256 Waldo Hall Corvallis, Oregon 97333-9967
541-737-3839

APPENDIX B**Cover letter for first mailing**

April 2, 2003

Dear School Counselor,

Enclosed is a survey being conducted by Dr. Becky Donatelle and Susan Roberts Dobie of the Department of Public Health at Oregon State University in order to better understand school counselors' experiences with self-injury. Through your responses, this project will identify the frequency of contact counselors have with self-injurers, as well as paint a picture of who school counselors are working with and what supports are being offered. If you have not yet worked with a self-injurer, your responses are still important to help determine school counselors' awareness of self-injury. Results from this study will be provided to the American School Counselor Association early in 2004. After May 15, 2003, please visit <http://fp.uni.edu/dobies/selfinjury>. On this website, you will find information on self-injury and updates about the progress on this research project.

We would greatly appreciate you taking 20 minutes to respond to the enclosed questionnaire and returning it in the postage-paid envelope provided **before April 18, 2003**. Your participation in this study is voluntary and you may refuse to answer any question. **Your responses will be combined and used for statistical summaries only.** Only a small portion of American School Counselor Association members will receive this questionnaire, so your participation is crucial to the success of this study.

The answers you provide will be kept confidential to the extent permitted by law. Special precautions have been established to protect the confidentiality of your responses. The number on your questionnaire will be removed once your questionnaire has been returned. The number is used to contact people who have not returned their questionnaire, so we do not burden those who have responded. Your questionnaire will be destroyed once the responses have been tallied. Your returned questionnaire implies your consent to participate in this research project.

If you have any questions about the survey, please contact Susan at (319) 273-5930 or susan.dobie@uni.edu. If no one is available when you call, please leave a message and your call will be returned. If you have questions about your rights as a research participant, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator at (541) 737-3437 or IRB@oregonstate.edu.

Thank you for your help. We appreciate your time and cooperation.

Sincerely,

Becky Donatelle, Ph.D.
Primary Investigator

Susan Roberts Dobie, M.A.
Student Researcher

APPENDIX C**Follow-up postcard**

Dear School Counselor,

Last week a questionnaire about your experience with students' self-injurious behaviors was mailed to you. You were sent this questionnaire because your name was drawn in a random sample of members of the American School Counselor Association. Your participation in this survey is voluntary.

If you have already completed and returned the questionnaire to us, please accept our thanks. If you have not returned it, please do so today. Because the questionnaire was mailed to only a small portion of the ASCA membership, your responses are extremely important to ensure the results are representative of all ASCA members.

We appreciate your time and effort.

Sincerely,

Becky Donatelle, Ph.D.
Primary Investigator

Susan Roberts Dobie, M.A.
Student Researcher

APPENDIX D

Cover letter for second mailing

May 8, 2003

Dear School Counselor,

About four weeks ago we sent you a questionnaire regarding your experiences with students who self-injure. As of today, we have not received your completed questionnaire.

We are conducting this study with the sincere belief that school counselors play a vital role in the mental health needs of today's students. Your input, as one of the few school counselors randomly selected to participate, is necessary to determine how frequently school counselors are working with self-injurers and the level of mental health services currently provided to these students.

We are contacting you again because each questionnaire is significant to the usefulness to this study. Your name was drawn from the American School Counselor Association membership list through a random selection process. In order for the results of this study to represent all members of ASCA, it is essential that each person return his or her questionnaire.

Please be assured that the answers you provide will be kept confidential to the extent permitted by law. Special precautions have been established to protect the confidentiality of your responses. Your name will never be placed on the survey or in the data set. This survey is voluntary and you may skip any question you choose not to answer. In the event that your questionnaire has been misplaced, a replacement is enclosed. Please return your completed questionnaire in the postage-paid envelope provided **before May 31, 2003**.

If you have any questions about the survey, please contact Susan at (319) 273-5930 or susan.dobie@uni.edu. If no one is available when you call, please leave a message and your call will be returned. If you have questions about your rights as a research participant, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator at (541) 737-3437 or IRB@oregonstate.edu.

Your cooperation is greatly appreciated.

Sincerely,

Becky Donatelle, Ph.D.
Primary Investigator

Susan Roberts Dobie, M.A.
Student Researcher