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College Students Who Self-Injure: A Study of Knowledge and Perceptions of Self-Injury

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COLLEGE STUDENTS WHO SELF-INJURE: A STUDY OF KNOWLEDGE AND PERCEPTIONS OF SELF-INJURY

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COLLEGE STUDENTS WHO SELF-INJURE: A STUDY OF KNOWLEDGE AND PERCEPTIONS OF SELF-INJURY

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Archived data was utilized for the present study which examined self-injurious behaviors in a college population. College students, who engage in non-suicidal self-injury, or NSSI, were expected to evidence a higher knowledge base for the behavior than those who do not. The demographic variables of gender and sexual orientation were predicted to be over represented in the NSSI group. Further, this study examines the perceived riskiness of the behavior in individuals who self-injure, as well as their perceptions of others who engage in NSSI. The survey consisted of four sections: demographics, knowledge of NSSI, experience with NSSI, and perceptions of NSSI. Individuals who engage in or have a history of NSSI evidence a higher mean score or better knowledge of the behavior than those who do not. The NSSI population evidences disproportionate numbers of females and individuals with gay, lesbian, and questioning sexual orientations. Further, when examining the perceived riskiness of self-injury, the NSSI group views the behavior as less risky than the non self-injury group. Results are discussed in relation to the need for accurate knowledge about NSSI and additional research directions.

Introduction

To individuals who are unfamiliar with and have little to no experience with self-injury, it is a behavior that can be very worrisome, and even horrifying. Self-injury includes a broad range of behaviors from skin scratching and hair pulling to limb amputation and eye enucleation. While researchers use many different definitions to describe this behavior, this study defines and limits self-injury to the deliberate and voluntary destruction of bodily tissue, resulting in immediate tissue damage, done without suicidal intent and for reasons not socially acceptable within one's culture, nor for display (Klonsky & Muehlenkamp, 2007; Nixon & Heath, 2009). The contemporary term for this behavior is non-suicidal self-injury, or NSSI. NSSI is a behavior often seen in community samples of youth and young adults and is not a manifestation of severe psychosis or a biologically driven need. Further, the methods of self-injury in the NSSI population are less severe than those seen in the clinical setting (Simeon & Favazza, 2001). NSSI methods are often skin cutting and burning, hair pulling and/or body slamming and are carried out to cause physical harm to oneself, but not as an attempt to take one's life (Klonsky & Muehlenkamp).

NSSI is of increasing focus for research and is becoming ever more prevalently reported in the popular media. Studies have reported rates of NSSI as high as 47% in community populations and 82% in clinical populations (Lloyd-Richardson, Nock, & Prinstein, 2007). However, most research report rates from 15 to 20% in the community, or non-clinical population. When looking specifically at the college population, which is the primary focus of this study, prevalence rates are found to be between 12% and 17% (Heath, Toste, Nedecheva, & Charlebois, 2008; Whitlock, Powers, & Eckenrode, 2006).

Although the self-injury literature is certainly increasing and broadening, the college population remains an under-researched group. Much of the research on NSSI focuses on adolescents with less emphasis being placed on college students. Only recently have studies looked specifically at NSSI in the college population, and these studies focus on the prevalence, coping styles, and functions for the behavior (Heath et al., 2008; Whitlock, Powers et al., 2006). These studies do not delve deeper in the knowledge, perceptions and perceived riskiness of NSSI. From these preliminary studies, we have garnered the need for further research and a greater understanding of NSSI in college students who have a history of self-injury.

This study seeks to determine whether college students who engage in self-injury are more knowledgeable about the behavior than individuals who do not engage in NSSI. This study will also examine the prevalence rates and demographic variables of gender and sexual orientation of the individuals who engage in NSSI verses those who do not. Further, the perceived riskiness of NSSI, as well as the general perceptions of the behavior will be examined from the perspective of individuals with a history of NSSI. The following is a review of the existing research and literature on NSSI that will provide the framework for the present study.

Literature Review

Definition of Self-Injury

Many different terms are used to describe the behavior of self-injury including self-harm, deliberate self-harm, self-mutilation, self-injurious behavior, self-cutting, wrist-cutter syndrome, self-wounding, and non-suicidal self-injury (Huband & Tantam, 2000; Klonsky & Muehlenkamp, 2007; Nixon & Heath 2009; Warm, Murray, & Fox, 2003). However, in recent years researchers have recommended use of less suggestive terminology to clearly differentiate the types of self-injurious behaviors. The most commonly employed contemporary terms are self-injury and non-suicidal self-injury (NSSI). Both self-injury and NSSI are defined as the deliberate and voluntary destruction of bodily tissue, resulting in immediate tissue damage, done without suicidal intent and for reasons not socially acceptable within one's culture or for self decoration (Klonsky & Muehlenkamp; Nixon & Heath).

Simeon and Favazza (2001) constructed a classification system that organizes a broad range of self-injurious behaviors into four separate categories: Stereotypic self-injury (SI), Major SI, Compulsive SI, and Impulsive SI. Stereotypic SI includes biologically driven behaviors that are often associated with mental retardation and developmental delays, such as head banging and hair pulling. Major SI typically occurs in people suffering from severe psychosis, character disorders, or intoxication and includes severe behaviors such as castration and eye enucleation. Compulsive SI includes repetitive and impulsive behaviors such as hair pulling or skin picking. Further, Compulsive SI is most often associated with impulse disorders, such as Trichotillomania. Impulsive SI includes behaviors such as burning, skin cutting, and self-hitting. For the

purpose of this study, we will be focusing on Simeon and Favazza's third and fourth classifications, Compulsive and Impulsive SI. These two categories of SI fit within the NSSI definition used throughout this study and are behaviors often seen in normal youth and young adult self-injuring populations.

It is important to differentiate self-injury from suicide. According to Walsh (2006), the intent of suicide is to terminate consciousness, while the intent of self-injury is to modify it. Kanan, Finger and Plog (2008) point out that NSSI and suicide are distinct in terms of their intent, mode of injury, lethality, chronicity, and age of onset. Individuals who intend to commit suicide will use a much more lethal method, such as shooting themselves. On the other hand, those who engage in NSSI use less severe methods, such as cutting or burning their skin. Individuals who self-injure do not have a preoccupation with death, nor do they want to take their own lives; however, they are often just trying to feel better and cope with intense emotions (McDonald, 2006). Further, a small percentage of individuals who engage in NSSI may do so hundreds of times, while it is very rare for someone to attempt suicide at such a high rate. In terms of psychological effects, those who have suicidal ideation desire a permanent escape from deep psychological distress, while those who engage in NSSI are looking to temporarily reduce psychological distress (Walsh).

It is also important to distinguish self-decoration, such as body piercings and tattoos, from NSSI. Piercings and tattoos are typically done to express individuality and make a statement to the world and not as a way to regulate emotions. Piercing and tattoos are a norm for many youth, whereas NSSI is not (Kanan et al., 2008).

Prevalence of Non-suicidal Self-Injury

Determining an exact percentage for the prevalence of NSSI is something that researchers are unable to do for various reasons. For most individuals, self-injury is a very private and sometimes shameful personal act. Therefore, not all who engage in NSSI are willing to disclose their actions. Further, the research on NSSI has spanned across two differing populations, namely those who are in the clinical setting and those who are in the community setting. The individuals who make up these populations vary on many levels, making it difficult to translate one group's prevalence rate to the other. However, several small samples of adolescents and young adults provide some indication of the prevalence of SI in the United States in both community and clinical samples. According to a review by Heath, Schaub, Holly, and Nixon (2009), prevalence rates range from a low of 4% (Klonsky & Muehlenkamp, 2007) to a high of 47% (Lloyd-Richardson et al., 2007) in community populations. However, most studies report prevalence rates around 15 to 20% in community populations (Heath et al.). Further, individuals in the clinical setting, receiving mental health treatment, have much higher rates of NSSI than do the individuals in community settings. Prevalence rates in the clinical setting range from 12% to 82% (Heath et al.). A 1998 study of adults conducted by Briere and Gil (1998) provides a direct comparison between prevalence of NSSI in a community setting (4%) verses a clinical setting (21%).

In terms of the college population, two studies provide some guidance for the present investigation. Heath et al. (2008) studied 728 college students at a large urban university in Montreal, Canada. Of the 728 students surveyed, 85 indicated that they "hurt themselves on purpose," indicating an 11.68% prevalence rate of NSSI. Whitlock,

Eckenrode and Silverman, (2006) also studied a group of college students from two northeastern U.S. universities. The sample consisted of 2875 participants, in which 490 (17%) indicated having engaged in NSSI at least once. Due to these significant prevalence rates, NSSI in the college population is an important arena of study that warrants further investigation.

Functions of Self-Injury

Adolescents and young adults engage in NSSI for many different reasons. Self-injury serves a variety of functions, and the functions may differ from person to person. According to Klonsky and Muehlenkamp (2007), affect regulation is the most prevalent function of NSSI. Self-injury is most often a coping mechanism that aims to alleviate intense, overwhelming negative emotions. Emotions such as anger, anxiety, frustration, and stress tend to be present before self-injury occurs, and are often followed by feelings of relief or calmness. Laye-Gindhu and Schonert-Reichl (2005) also indicate that the most common reasons for NSSI include feelings of depression, feeling all alone, and negative feelings toward self. Further, these negative emotional states decrease during and after the act of NSSI (Klonsky & Muehlenkamp). Other prevalent, but less common functions of NSSI are self-punishment, interpersonal influence, antidissociation, antisuicide, sensation seeking, and testing interpersonal boundaries. Lloyd-Richardson et al. (2007) also report that an individual may engage in self-injury for many different reasons that vary over time and context. That is, one incident of NSSI may serve one function, and the next incident may serve a different function.

Methods and Frequencies of Self-Injury

There are many different ways in which individuals can engage in acts of self-injury. Skin cutting, burning, carving, hair pulling, inserting objects under the skin or in body orifices, skin picking or scratching, biting oneself, hitting oneself, head banging, body slamming and erasing skin to bleed have all been reported in the literature (Klonsky & Muehlenkamp, 2007; Laye-Gindhu & Schonert-Reichl, 2005; McDonald, 2006). According to Ross and Heath (2002), skin cutting is the most common method for NSSI. McDonald notes that self-injury can be performed with razor blades, knives, glass, needles, pins, or scissors. The most common sites for self-injury include the arms, wrists, ankles and lower legs. However, many individuals self-injure in more discreet and private areas such as the abdomen, underarm, inner thighs, under the breasts and in the genital region. In terms of duration, most individuals engage in the behavior only once or a few times, while few go on to be chronic self-injurers (Klonsky & Muehlenkamp). It is also important to note that the methods and frequency of NSSI may vary over time for an individual. People may begin by cutting their skin, and then over time change to skin burning. The method for self-injury is not always constant for the individual. Further, the frequency of NSSI may wax and wane over time for an individual. Individuals may go through a period in which they self-injure everyday and then not engage in the behavior for years.

Looking specifically at the college population, Heath et al. (2008) report that 48% of college students indicate that they engaged in the behavior between five and ten times, while only 4% reported over 100 incidents. Further, the most frequently noted method of NSSI for college students is skin cutting, followed by skin scratching, punching oneself,

and skin burning. Whitlock, Eckenrode et al. (2006) report the majority of their sample (71%) engaged in the behavior on less than three occasions. Further, the most frequently reported methods were scratching, banging, and cutting.

Co-Occurrence

In the present discussion, co-occurrence designates the presence of NSSI with Diagnostic Statistical Manual-Fourth Edition diagnoses. However, many individuals who engage in NSSI do not have any diagnosable DSM-IV psychiatric disorders but instead may just have difficulty expressing their emotions. On the other hand, some individuals who engage in NSSI evidence serious psychological disorders. Research has documented a variety of emotional problems in individuals who engage in NSSI, regardless of whether they are at a clinical degree. According to Klonsky and Glenn (2009), self-injurers are more likely to experience periods of dissociation, and have greater difficulty in dentifying or understanding their feelings and expressing their emotions than people who do not self-injure. In terms of specific psychiatric disorders, Borderline Personality Disorder may have the strongest risk for NSSI, as self-injury is considered a symptom of this disorder (American Psychiatric Association, 2000). Other diagnoses reported in NSSI populations are depression, posttraumatic stress disorder, anxiety, eating disorders, substance abuse, increased antisocial behavior, emotional distress, anger problems, and decreased self-esteem (Klonsky & Glenn; Laye-Gindhu & Schonert-Reichl, 2005; Walsh, 2006).

Gender

The literature evidences mixed findings on the relationship between gender and self-injury. According to Klonsky and Muehlenkamp (2007), many individuals believe

that women engage in NSSI more often than men. However, several recent research studies report near equal rates between males and females (Heath et al., 2009; Yates, Tracy & Luthar, 2008). According to Nixon and Heath (2009), more females engage in SI than do males in the clinical setting, but the rates in the community samples are often near equal. One explanation provided for this gender difference is that most clinical settings have a larger number of females than males as females are more likely to seek help.

It is important to note that there are definite gender differences in terms of method of self-injury. Males are more likely to burn and hit themselves while females are more likely to cut themselves (Nixon & Heath, 2009). Therefore, it is important to note that current findings support that NSSI is not a predominately female behavior, and males, although more private, are engaging in the behavior at near equal rates. Heath et al. (2008) found that 12% of college females and 9% of college males indicate a history of NSSI, and Whitlock, Eckenrode et al. (2006) found that females are two times more likely to engage in repeat instances of NSSI.

Associated Features

According to Nixon and Heath (2009), the majority of youth who engage in NSSI begin between the ages of 13 and 15, although some research suggests that there is a significant proportion of youth that begin the behavior earlier and even later. Ross and Heath's (2002) study of high school students found that 25% of their sample report engaging in NSSI before the age of 12. Although the most frequently reported age of Heath et al. (2008) college study participants for beginning NSSI was 14-16 years, 39% of participants did not begin self-injuring until after the age of 17. This vast difference in

the age of onset of NSSI further promotes the notion that self-injury in the college population is an area in need of further research. Self-injury is not a behavior limited to the young adult population, and individuals may engage in NSSI in their pre-teens and/or until later in life.

In terms of ethnicity, several studies reveal that rates of NSSI are higher in Caucasians than non-Caucasians across both clinical and community populations (Klonsky & Muehlenkamp, 2007). However, Yates et al. (2008) found a higher rate of NSSI among minorities, particularly among the Black ethnicity, than rates previously documented in other literature. Results of this study may depict a growing trend of NSSI across minority populations in the United States. However, when examining the college population, Heath et al. (2008) found a very modest significant effect for ethnicity when Caucasians were compared with all other ethnic groups. The only ethnic group that showed significantly less NSSI behavior than the Caucasian respondents was the Asian or Asian American group.

In terms of sexual orientation, youth who are gay, lesbian, bisexual, or questioning their sexual identities are disproportionately found in NSSI populations. However, these findings require further support (Heath et al., 2009). Researchers interpret this finding as a result of high stress environments and poor coping skills. Many gay, lesbian, bi-sexual and questioning youths face daily struggles with their sexual identity, and, therefore, may turn to self-injury as a way to cope. In terms of the college population, Whitlock, Eckenrode et al. (2006) found that individuals who engage in repeated instances of NSSI are more likely to be bisexual or questioning their sexual orientation than to be heterosexual.

Both physical and sexual abuse are more frequently noted in NSSI populations. For some individuals, abuse may play an important role in their self-injury, but for others it may not. Abuse may serve as a risk factor for NSSI, but not a direct cause. Not all individuals who are abused engage in NSSI, and not all individuals who self-injure have been abused (Klonsky & Muehlencamp, 2007). In terms of the college population, Whitlock, Eckenrode et al. (2006) found that 53% of college students who reported a history of self-injury also reported a history of physical, sexual, and/or emotional abuse. However, a near equal rate of college students who self-injure did not report a history of abuse. The Heath et al. (2008) college study found no significant difference between college students who self-injure and those who do not in terms of attachment difficulties, childhood trauma or abuse. Other risk factors for NSSI noted in the literature include parental alcoholism or parental depression, history of chronic illnesses with childhood hospitalization, and exposure to violence in society (McDonald, 2006).

College Population

Up to this point, studies conducted on the college population have primarily focused on the prevalence rates, method, age of onset, and frequency of the behavior. These studies report prevalence rates ranging from 12% (Heath et al., 2008) to 17% (Whitlock, Eckenrode et al., 2006). In terms of gender, it is important to note that current findings in the college population support that NSSI is not a predominately female behavior. Heath et al. found that near equal prevalence rates as 12.3% of college females and 9.4% of college males indicate a history of NSSI.

In terms of method, the most commonly reported forms of NSSI in the college population are cutting, scratching, punching and burning. The most common locations of

injury on the body are arms, hands, wrists and thighs. In terms of age of onset, the most frequently reported age reported by college students was between 14 and 16 years. The most commonly reported occurrence of the behavior is 2-5 times (33%), followed by once (25%), 6-10 times (16%), 11-20 times (10%) and more than 21 times (15%) (Whitlock, Eckenrode et al., 2006). It is important to note that the majority of individuals report engaging in the behavior between one and five times. In terms of risk factors for NSSI, Heath et al. (2008) found that college students who engage in the behavior often have difficulties with emotion regulation.

Knowledge of Self-Injury

Several investigations provide information about various professionals' knowledge of NSSI. According to Heath, Toste and Beettam (2006), many health professionals often view NSSI as severely pathological and manipulative. Further, individuals who self-injure frequently report a lack of understanding and negative interactions with these professionals. Although it has been found that training about self-injury resulted in more positive attitudes toward individuals who self-injure and more effective treatment plans, many professionals are not receiving appropriate training (Heath et al.).

Professionals who work directly with both young adult and adult populations have reported feeling ill-equipped to work with individuals who self-injure (Heath et al., 2006). It is not surprising that many professionals feel this way, as they often lack the necessary knowledge base and training to be effective in helping those who self-injure (Beld, 2007; Butts, 2008). In terms of knowledge of NSSI in the school setting, Heath et al. examined 50 high school teachers' perceptions and knowledge of self-injury. Only

20% of the teachers surveyed felt knowledgeable about self-injury, although 74% reported a personal encounter with self-injury. Further, many teachers reveal a strong desire for further knowledge and training concerning NSSI. The overriding theme from the research is that professionals need more training to be effective when working with those who self-injure (Beld; Boeckmann, 2008; Butts; Jeffrey & Warm, 2002; Smith, 2009).

Looking specifically at mental health professions, Jeffrey and Warm (2002) investigated knowledge and perceptions of NSSI in the various professions who may become involved with individuals who self-injure. The sample consisted of psychiatrists, psychologists, general practitioners, nurses, social workers and mental health support workers. The study used a questionnaire design to examine perceptions of NSSI that contained 20 statements consisting of 10 accurate perceptions and 10 myths associated with self-injury (see Table 1). Jeffrey and Warm found that medical workers and psychiatrists have a poorer understanding of NSSI than workers with psychological and social care/community training. The researchers attribute increased knowledge base to the mental health workers' development of a therapeutic relationship with people who self-injure, and their previous training. This study is important to examine as it has laid the framework for several other studies that have used the same questionnaire to assess the knowledge of various professional groups.

Table 1

Facts and Myths about Self-Injury

Accurate Statements about SI
SI is a form of communication.
SI provides a way of staying in control.
SI provides distraction from thinking.
SI can obtain feelings of euphoria.
SI is a release for anger.
SI expresses emotional pain.
SI is a coping strategy.
SI helps a person maintain a sense of identity.
SI provides escape from depression.
SI helps deal with problems.
Myths about SI
SI is a sign of madness.
People who self-injure will "grow out of it" eventually.
SI is a manipulative act.
SI is a "woman's problem"
The best way to deal with people who self-injure is to make them stop.
People who self-injure have been sexually abused.
SI is a failed suicide attempt.
SI is attention seeking.
People who self-injure should be kept in psychiatric hospitals.

Myths about SI

Everybody who self-injures suffers from Munchausen's Disease (self-inflicted injuries calculated to produce specific symptoms that will lead to medical hospital admissions).

Note. Adapted from "A study of service providers' understanding of self-harm," by D. Jeffrey and A. Warm, 2002, *Journal of Mental Health, 11*, p. 299.

Butts (2008) surveyed elementary, middle, and high school educators using Jeffrey and Warm's (2002) 20-item measure. These rural community educators evidence some knowledge of self-injury; however, their knowledge measured significantly lower than school psychologists and social community workers (see Table 2). Educators are less likely to build intimate, therapeutic relationships with their students who self-injure, which may account for their decreased knowledge. Additionally, these teachers hold many misconceptions and have problematic understandings of self-injury. However, these educators indicated an interest in seeking further knowledge and training on self-injury. Also utilizing Jeffrey and Warm's measure, Beld (2007) examined school psychologists' knowledge, perceptions and understandings of NSSI. Almost all (94%) of school psychologists indicated a desire for additional training, despite the fact that the sample evidences high knowledge about NSSI. School psychologists exhibited higher knowledge than teachers, medical workers and psychiatrists (see Table 2). Therefore, school psychologists appear to be useful resources for schools dealing with students who engage in self-injury, even though they express a need for more development in this area.

Table 2

Mean Self-Injury Knowledge Scores

Group	Mean	Standard Deviation
Psychiatrists[a]	69.78	8.76
Psychology Workers[a]	79.37	6.55
Medical Group[a]	71.00	5.98
Social Community Workers[a]	77.16	8.71
Self-Injurers[a]	79.81	6.46
Self-Injurers[b]	80.18	6.94
School Psychologists[c]	79.11	6.27
Teachers[d]	68.83	6.23
Peers[e]	61.05	8.38

[a]From "A study of service providers' understanding of self-harm," by D. Jeffrey and A. Warm, 2002, *Journal of Mental Health, 11,* p. 299. [b]From "Self-injury knowledge and peer perceptions among members of internet self-injury groups," by E. Boeckmann, 2008, Unpublished Education Specialist Project, Western Kentucky University, Bowling Green. [c]From "Self-injury in the schools: A survey of school psychologists," by A. Beld, 2007, Unpublished Education Specialist Project, Western Kentucky University, Bowling Green. [d]From "Self-injury in the schools: A survey of educators," by J. Butts, 2008, Unpublished Education Specialist Project, Western Kentucky University, Bowling Green. [e]From "Peer Perceptions of Self-Injurious Behaviors," by Fantom Shakira Smith,

2009, Unpublished Masters in Psychology Project, Western Kentucky University, Bowling Green.

In terms of peer knowledge of NSSI in the college population, Smith (2009) also used Jeffrey and Warm's measure and hypothesized that peers would have a higher level of knowledge of NSSI than health care professionals, school psychologists, and teachers. Smith (2009) hypothesized this because much of the popular media is geared towards the young adult population, and there has been a major increase in the prevalence of NSSI in the popular media. However, results of this study reveal that peers actually evidence a significantly lower mean knowledge score than that of all the professional comparison groups. Moreover, peers indicate considerable confusion surrounding NSSI and are generally not accepting of the behavior in friends. Therefore, exposure through the popular media and social networks is not enough to educate young adults on NSSI.

Another study that examined knowledge and understanding of NSSI using Jeffrey and Warm's (2002) measure was conducted by Boeckmann (2008). Boeckmann's study surveyed 101 members of online self-injury groups and found that people who belong to these self-injury groups have a fairly good knowledge of NSSI. Individuals who engage in NSSI evidence slightly higher knowledge than all professionals assessed using Jeffrey and Warm's measure. Table 2 contains each of the groups assessed with Jeffrey and Warm's measure, and their corresponding mean scores.

When examining the mean scores of the various populations assessed using Jeffrey and Warm's (2002) measure, level of knowledge appears to be greatly impacted by expectations to serve those who engage in NSSI and the extent of the professional

interactions. Of the professionals assessed, school psychologists, psychology workers, and social community workers evidence the highest levels of self-injury knowledge. These groups often interact with self-injurers and develop therapeutic relationships. Conversely, teachers, peers, and psychiatrists evidence lower knowledge of NSSI. One explanation for this is a general lack of knowledge and training in the area.

College students who engage in NSSI comprise a population that has received very little focus in the self-injury research and literature. Heath et al. (2008) examined a small sample of self-injurers in a college student sample. The prevalence rate for NSSI in the college sample was 12%, with near equal rates between men and women. However, men were significantly less willing to complete the follow-up survey, which fits the view that men are less likely to seek help for the behavior.

Smith's (2009) study gained further insight into peer knowledge and perception of NSSI within the college population. This study examined peers' perceptions of and experiences with individuals who self-injure and determined whether personal experience with self-injurers affects peers' level of knowledge. Smith found that the majority of respondents (56%) indicate they know, or have known, at least one person who self-injures. Of the respondents who indicate they know someone who self-injures, the majority (54%) reported that the person who self-injured was a close friend. Further, the peers who knew someone who has engaged in the behavior evidenced a higher level of knowledge than peers who did not. However, as a group, peers evidence a large number of inaccuracies in knowledge of NSSI. The majority of respondents endorsed the myth that NSSI is a sign of madness/mental illness and that it is an attention-seeking behavior,

and disagreed with accurate statements such as "SI can provide a way of staying in control" and "SI can provide help dealing with problems."

Smith's (2009) study also examined peers' perceptions regarding the riskiness of NSSI. Smith found that non self-injuring college students perceive the behavior of cutting oneself as equally as risky as getting drunk, smoking, speeding, and having unprotected sex. It is apparent that the peers in this study feel that NSSI is as serious and potentially harmful as these other behaviors commonly deemed risky.

The Present Study

Self-injury prevalence rates have been on the rise over the last several years, and the behavior has gained increased attention in the media and academic literature. Only recently has self-injury been investigated in college populations, and these studies have been small and focused solely on demographics and understanding of the behavior. There is also a major lack of understanding and knowledge on the part of professionals and peers who have had experience with individuals who self-injure. This lack of knowledge and understanding has been evidenced by several research studies conducted using Jeffrey and Warm's (2002) facts and myths of self-injury measure. One group that has performed considerably higher on this knowledge measure compared to professionals in the field is the NSSI group. Further, emerging patterns in the research have shown an increase of NSSI in males, minorities, and individuals who are questioning their sexuality. Therefore, the primary intent of this study is to gain insight in terms of self-injurers' knowledge of the behavior, examine the demographics and perception of riskiness of the behavior, and examine how self-injurers view others who engage in the behavior.

It is hypothesized that college students who engage in NSSI will evidence a greater knowledge of the behavior than individuals who do not (hypothesis one). Further, we expect to see a different proportionality pattern in terms of the demographic variables of gender and sexual orientation for those individuals who engage in NSSI than peers who do not (hypothesis two). It is also hypothesized that individuals who engage in NSSI will report the behavior as less risky than peers who do not engage in the behavior (hypothesis three). In addition, the present study will provide a descriptive analysis of perceptions of the behavior for those who engage in NSSI.

Method

Description of Respondents

Unanalyzed archived data from Smith (2009) was used for this investigation. The sample consists of 87 individuals aged 18 to 38 enrolled in undergraduate psychology courses at a south central Kentucky university. These 87 respondents comprise a subsample of 626 students who were originally surveyed. Due to the original survey's focus on peers' perceptions of NSSI, the students who had a history of self-injury, or currently engage in the behavior were excluded from Smith's study. These 87 participants comprise the sample for this analysis. The majority of the respondents in this study are Caucasian (82.8%), female (80.5%), in their freshman year of college (57%), and indicate their sexual orientation as heterosexual (80.2%). The remaining respondents indicate their ethnicity as African American (6.9%), Asian (2.3%), Hispanic (2.3%) and Native American (2.3%). Regarding current education level, 18.6% are college sophomores, 18.6% are college juniors, and 5.8% are college seniors. Regarding sexual orientation, 10.5% indicate they are bisexual, 3.5% are questioning their sexuality, 2.3% are gay, and 2.3% are lesbians. The current sample is comparable to the psychology department student demographics in the majority of students are Caucasian (84.5%) and female (71.8%). The remaining students enrolled in the psychology department indicate their ethnicity as African American (8.7%) or other (3.8%) (WKU Fact Book, 2008).

Instrument

The survey (Smith, 2009) consists of 54 items (including five demographic items and five background items for those that personally self-injure) that assess three separate domains. The first domain (items 12 to 21), peer knowledge, contains Jeffrey and

Warm's (2020 item measure that assesses respondent's knowledge of NSSI. Reliability of the NSSI knowledge measure is adequate, providing Cronbach's alpha coefficient of .75 (Smith, 2009) for the total sample. Additional studies using Jeffrey and Warm's measure support the reliability of the knowledge measure with coefficient alphas of .69 to .77 (Beld, 2007; Butts, 2008; Smith, 2009). Further, content validity was evidenced through factor analysis that supported the distinctions between the accurate and inaccurate perceptions of SI (Jeffrey and Warm, 2002). The second domain (items 22 to 42) examines the respondents' experiences with self-injury and contains 20 items that assess the extent and outcomes of experiences peers have engaged in with those who self-injure. The third domain (questions 43 to 54) asks about peer perceptions and contains 12 items. Smith's survey was developed using a focus group and expert reviews.

Procedure

Participants were solicited through undergraduate psychology courses. Participants in the study received either extra credit or study participation credit to meet course research requirements. Participants responded to the survey either by signing up via the Psychology Department's Study Board system or via dissemination of the survey URL (see Appendix A). All interested participants were allowed to participate in this study, and a disclaimer cautioned individuals who self-injure about the possible discomfort or triggers that may result from completing the survey. Furthermore, a helpline, a website, and a phone number to the campus counseling center on campus was provided at the top of each survey page. Once individuals elected to participate in the survey, they were first directed to a screen displaying the informed consent form. Once the individuals elected to participate in the study after reviewing the permission form,

they were directed to a screen that details the purpose of the study. From there, individuals could either continue into the website and fill out the survey or decline to fill out the survey. Once the survey was completed and submitted, participants were directed to a screen displaying the debriefing statement. The Western Kentucky University Human Subjects Review Board approved all of the procedures (see Appendix B).

Results

NSSI Sample

The incidence of NSSI (current or past) in this population was 14% (n= 87). Of the 87 individuals in the NSSI group, 84 reported engaging in the behavior in the past, while only 3 report currently engaging in the behavior. Further, 23% of individuals in the NSSI group report engaging in the behavior only once, 28% report 2-4 incidences, 16% report 5-10 occurrences, 12% report 11-20 incidences, 5% report occurrences over 21-30 times, and the remaining 15% report over 30 occurrences. In response to how long the individual engaged in NSSI, the most frequently indicated response was "only tried once" (23%).

Hypothesis One

Hypothesis one predicted that individuals who have a history of or currently engage in NSSI will have a higher knowledge base of self-injury than those who do not. The 20 item knowledge measure evidenced good item reliability with a Cronbach's coefficient alpha of .70. To address hypothesis one, an independent sample *t* test was computed to compare the mean score of the NSSI group to the mean score of the college sample obtained by Smith (2009). The reverse worded items on the measure were first recoded for consistent scaling across all items on the five-point Likert scale (1=Strongly Disagree, 2=Disagree, 3=Unsure, 4=Agree, 5=Strongly Agree). Scores were then totaled to create knowledge scores ranging from 20-100 with higher scores indicative of greater understanding. The mean score for the NSSI sample was 69.64 with a range from 47 to 84 and a standard deviation of 7.49. An independent samples *t* test compared the mean score of the NSSI group to the mean score of the college sample obtained by Smith

(2009). The test was significant [t (581) = -8.89, $p < .000$]. The mean score of the NSSI group was 69.64, which is significantly higher than the 61.13 mean score obtained by Smith (2009). The effect size was medium ($d = .48$), which indicates a medium difference between the two means. Hypothesis one was supported.

Response patterns on each of the 20 items on knowledge measure were examined to identify good, poor and problematic understanding as initiated by Beld (2007) and used by Boeckmann (2007), Butts (2008) and Smith (2009). Beld's (2007) criterion level of a 70% response rate served to differentiate good, poor, or problematic understanding. Under this criterion level, an item received a classification of *good understanding* when response rating values for agree and strongly agree or accurate understanding were evident in 70% or more of the sample. A classification of *poor understanding* was given to an item when response ratings of strongly disagree, disagree, and unsure or inaccurate understanding are equal to or greater than 70%. A classification of *problematic understanding* was for items that did not reach the 70% criterion level as either good or poor. On the 20-item knowledge measure, responses from the current sample indicated 7 good understandings, 2 poor understandings, and 11 problematic understandings of the behavior (see Table 3).

Descriptive Information for Peer Knowledge of NSSI

Additional questions were used to examine this group's knowledge of NSSI in regard to suicide, prevalence rates, age of onset, media, sources for knowledge, and evidence of NSSI within social and educational populations. When given the statement "SI is a form of suicide," the majority of the sample (70.1%) disagreed. The majority of

the sample (73.6%) also disagreed with the statement that "SI is typically followed by suicide."

Table 3

Peer Knowledge of NSSI

Level of Understanding for Items	*M*	Inaccurate	Accurate
Good Understanding of SI$_a$			
SI provides distraction from thinking	3.19	26.4	**73.5**
SI is a "woman's problem"	4.59	3.5	**96.6**
SI expresses emotional pain	4.26	6.8	**93.1**
SI is a failed suicide attempt	4.29	13.7	**86.2**
SI is a coping strategy	3.63	29.0	**71.0**
SI can provide a release for anger	4.11	9.1	**90.8**
Everybody who self-injures suffers from Munchausen's Syndrome	4.10	24.0	**75.8**
Poor Understanding of SI$_b$			
SI is a manipulative act	3.03	**71.2**	28.7
SI helps a person maintain a sense of identity	2.59	**83.7**	16.3
Problematic Understanding of SI$_c$			
SI is a form of communication	3.15	45.9	54.0
SI is a sign of madness/mental illness	3.20	59.7	40.2
SI can provide a way of staying in control	3.21	44.8	55.2
People who self-injure "will grow out of it" eventually	3.45	55.1	44.8
SI can obtain feelings of euphoria	3.44	52.8	47.1

The best way to deal with people who self-injure is to make them stop	3.21	55.2	44.8
People who self-injure have a history of sexual Abuse	3.64	45.9	54.1
SI can provide an individual with help in dealing with problems	2.95	62.0	27.9
SI is attention seeking	3.07	60.4	39.5
SI can provide escape from depression	2.80	64.3	35.6
People who self-injure need psychiatric hospitalization	3.49	44.5	53.5

Note. Accurate and inaccurate frequencies (shown as percentages) derived from rescaling the 5-point Likert scale (1=strongly disagree, 2=disagree, 3=unsure, 4=agree, 5=strongly agree) into two groups, Accurate (responses of 4 and 5) and Inaccurate (responses of 1, 2, and 3).

[a]Good Understanding of SI = Accurate frequencies $\geq$ 70%. [b]Poor Understanding of SI = Inaccurate frequencies $\geq$ 70%. [c]Problematic Understanding of SI = Inaccurate or Accurate frequencies < 70%.

For the statement, "suicide and SI are not related," 41.4% of the sample disagreed. When asked "what percentage of college aged individuals (18-22 year-olds) do you think engage in SI," the most frequent response was "16-20." When asked "at what age do most people begin to engage in SI," the majority of respondents (60.9%) indicated "13-15 years."

In terms of NSSI and the media, 46% of the respondents agreed that self-injury is evident in the popular media, 57.4% agreed that internet forums about NSSI are readily accessible, and 36.8% agreed that the media has become a mechanism for spreading

information about NSSI. When asked whether "SI can be contagious, or spread among members of a group," 43.7% or respondents agreed.

When asked "how have you learned about SI," the majority of respondents in the NSSI group stated "through personal experience" (90.8%), followed by "the media" (64.4%), and "saw someone self-injure (in person, online, in a video or movie)" (55.2%). When asked whether SI is evident in the college population, 49.4% of respondents agreed. Further, when asked whether SI is evident in the American high school population, 69% agreed.

Hypothesis Two

Hypothesis two, which predicted that the demographic variables of gender and sexual orientation for the NSSI group will be different from their peers who do not engage in NSSI, was analyzed using both descriptive and Chi square statistics. In terms of gender, 17% of females in the total college sample reported a history of NSSI, while 8% of males report a history of NSSI. In examining the college group, I found that 35.9% were male, and 64.1% were female. In terms of the NSSI group, just 19.5% are male while 80.5% are female. This indicates that the proportionality pattern of gender is different between the college group and the NSSI group. Thus, gender and self-injury status (never versus past or current) were found to be significantly related, the Pearson χ^2 (1, N= 611) = 8.25, p= .004. The odds ratio of 2.30 indicated that individuals who self injure have 2 times the odds of being female than male.

A two-way contingency table analysis was conducted to evaluate whether the other sexual orientation (gay, lesbian, bisexual and questioning) was more frequently noted in individuals who self-injure in comparison with those who do not self-injure. In

the college group, the majority indicated their sexual orientation as heterosexual (94.5%), followed by bisexual (1.7%), questioning (1.5%), gay (1.3%), and lesbian (1.0%). In the NSSI group, the majority indicated their sexual orientation as heterosexual (80.2%), followed by bisexual (10.5%), gay (3.5%), questioning (3.5%), and lesbian (2.3%). In the NSSI group, sexual orientation [heterosexual versus other (-gay, lesbian, bisexual, questioning)] and self-injury status (none versus past or current) were found to be significantly related, Pearson χ^2 (1, N = 611) = 21.534, p= .000. The odds ratio of 4.22 indicates that individuals that self-injure have 4 times the odds of having a gay, lesbian, bisexual, or questioning sexual orientation as compared to non self-injurers. Hypothesis two was supported.

Hypothesis Three

Hypothesis three, which predicted the NSSI group to report NSSI behaviors as less risky than their peers who do not engage in the behavior, was investigated using descriptive and mean group comparison statistics. Of the 13 risky behaviors listed in the survey, three dealt directly with NSSI. These NSSI behaviors were cutting oneself, burning oneself, and hitting oneself. The behaviors were rated on a five-point Likert scale (1=Extremely Risky, 2=Very Risky, 3=Risky, 4=Not Very Risky, 5=Not At All Risky). Ratings for each risky behavior group (NSSI and college) were averaged to create a mean rating riskiness score that can range from 1-5, with lower scores indicative of greater perceived riskiness (see Table 4).

Table 4

Mean Ratings and Rankings of High Risk Behaviors

Behavior	NSSI M	NSSI Ranking	College M	College Ranking
Drinking while driving	1.38	1	1.32	1
Having unprotected sex	1.87	2	1.70	4
Smoking	2.76	7	2.48	7
Doing drugs	1.92	3	1.67	3
Speeding	2.94	8	2.81	9
Cutting oneself*	2.46	6	1.65	2
Getting drunk	3.13	11	2.97	11
Burning oneself*	2.15	4	1.74	5
Cheating on an exam	3.06	10	2.87	10
Shoplifting	2.25	5	2.17	6
Lying	3.30	12	3.04	12
Skipping class	3.6	13	3.61	13
Hitting oneself*	2.99	9	2.61	8

Note. * Indicates NSSI Behaviors. Means derived from rescaling the 5-point Likert Scale (1 = extremely risky, 2 = very risk, 3 = risky, 4 = not very risky, 5 = not at all risky. N for NSSI group = 87. N for College group = 540.

An independent samples *t* test compared the mean rating of the NSSI group on the three self-injury behaviors (cutting oneself, burning oneself, and hitting oneself) to the mean rating of the same behaviors for the college sample obtained by Smith (2009). The test was significant [t (617) = -6.19, $p < .000$]. The mean score of the NSSI group is

7.60, which is significantly higher than the 6.00 mean score obtained by Smith (2009). The effect size was large (d= .75), which indicates a large difference between the two means. Those who engage in NSSI view the behavior as significantly less risky than those who never have self-injured, and the difference is large. To better understand this difference, the means for the other ten risky behavior items for the two groups were compared. The independent samples t test was also significant [t (613) = -2.27, p < .023]. The mean score of the NSSI group was 26.17, which was higher than the 24.61 mean for the college sample which indicates a less risky behavior. The effect size of .26 was medium, indicating the differences observed are of moderate size.

Perceptions of NSSI

The survey also contained several questions that sought to gauge the level and quality of experience peers have with others who self-injure, as well as their perceptions of others who engage in the behavior. The majority of respondents (87.1%) indicated they know, or have known, at least one person who also self-injures. Of the respondents who indicated they know at least one other person who also engages in the behavior, the majority (62%) indicated that the person/people they know are close friends (someone they interact with on a regular basis). The majority of the respondents indicated the individual they know was a friend prior to college (74.2%) and female (78.8%).

When examining how the participant knew that the person engages in NSSI, the majority of individuals stated that the person told them (54.5%). Other responses to how they know the person engages in NSSI included noticing scars (24.2%), being told by someone else (7.6%), and catching the person in the act (9.1%). Further, 50.6% of individuals had talked with the person about the behavior, and 36.8% had spoken with

someone else about the person and their self-injury. In response to "how long have you known that he/she self-injures," 42.2% indicated less than 1 year and 25% indicated less than 2 years. When asked about feelings regarding the issue with the friend that self-injures, the most frequent response was "somewhat distressing" (33.3%), followed by "neutral/unsure" (27%).

Additional questions asked the NSSI group about the status of their relationships after they discover that their friends engage in NSSI (see Table 5). The majority of individuals disagreed that they think less of the person (92.3%). Further, the majority disagreed that they do less with the person (83.1%) and that they feel pity for the person (63.1%). When asked whether they supported the person who engaged in NSSI, the majority agreed (73.8%), and stated that they felt closer to the person (64.7%). The majority of participants agreed that they share the same interests with the person (63.1%), but that the behavior bothers them (52.3%). Further, the majority agreed that they have tried to get him/her to stop (70.9%), and disagreed that they have aided the person in getting professional help (56.9%).

The majority (74.2%) of respondents noted that their relationship with the person did not change due to their knowledge of the behavior. For those who indicated a change in the relationships, the most frequent response was that both they and their friend initiated the change (17.2%). Only 2.3% of individuals in the NSSI group reported that they personally ended the relationship. When asked why the relationship did not change, the most frequently reported reason was that "Self Injury is just a behavior; it doesn't make the person" (26.9%), followed by "I talked with the person about the behavior" (25%), and "I decided to continue helping the person" (13.5%). Participants were asked

to indicate all thoughts and emotions they hold for self-injurious behavior. For the NSSI group, the most frequently reported thought respondents hold for SI is "They're doing what they need to in order to cope" (56.3%).

Table 5

NSSI Group Responses to Learning about a Peer's Self-Injury

Statement	SD	D	U	A	SA
I think less of the person.	**56.9**	35.4	6.2	1.5	0
I do less with the person.	**52.3**	30.8	6.2	7.7	3.1
I pity the person.	**35.4**	27.7	13.8	21.5	1.5
I support the person.	13.8	6.2	6.2	**44.6**	29.2
I feel closer to the person.	6.2	9.2	20.0	**46.2**	18.5
We're very likeminded.	4.6	18.5	29.2	**40.0**	7.7
We share the same interest.	3.1	16.9	16.9	**56.9**	6.2
I've tried to learn more about SI.	6.2	**40.0**	16.9	32.3	4.6
I've gained more tolerance for the behavior.	16.9	29.2	21.5	**30.8**	1.5
His/her behavior really bothers me.	12.3	16.9	18.5	**38.5**	13.8
I've tried to get him/her to stop the behavior.	3.2	19.4	6.5	**53.2**	17.7
I feel the person is in need of professional help.	16.9	15.4	**33.8**	27.7	6.2

Note. Peers indicate agreement by designating Strongly Disagree (SD), Disagree (D), Unsure (U), Agree (A), or Strongly Agree (SA). The highest percentage response for each item is marked in bold.

Discussion

The purpose of this study was to gain insight regarding the knowledge and perceptions of NSSI in college students who have a history of NSSI. This study sought to examine the demographic variables of gender and sexual orientation, and the perception of riskiness of the behavior. This study also sought to examine how self-injurers view others who engage in the behavior.

NSSI Sample

Smith's (2009) original sample consisted of 626 participants, of which 87 (14%) report a history of NSSI. This finding is consistent with previous college studies that indicate prevalence rates ranging from 11.68% to 17% (Heath et al., 2008; Whitlock, Eckenrode et al., 2006). Of the 87 participants, only three currently engage in self-injury, while the remaining 84 self-injured in the past. Further, over half of all individuals in the NSSI group report engaging in the behavior between one and four times, while very few self-injure at a high frequency. This finding is consistent with previous research that notes most individuals engage in the behavior only once or a few times, while few go on to be chronic self-injurers (Klonsky & Muehlenkamp, 2007). In terms of race, when the NSSI group is compared to Smith's (2009) college group, near equal ethnicity rates are found. Overall, the NSSI sample is similar to the college sample from which it was drawn, and those previously assessed in terms of ethnicity.

Hypothesis One

Hypothesis one, which predicted that college students with a history of NSSI will have a greater knowledge of the behavior than college students who do not, was supported. The NSSI group evidences a significantly higher mean knowledge score than

did Smith's (2009) college sample. However, when comparing the NSSI group's knowledge score (69.64) to the previously assessed NSSI groups, this NSSI sample received a much lower score. Jeffrey and Warm's (2002) NSSI group earned a knowledge mean score of 79.81, and Boeckmann's (2008) NSSI group earned a knowledge mean score of 80.18. This lower mean score is an interesting finding as one might initially think a college NSSI group would score higher, due to their general awareness and exposure to contemporary issues. However, the previously assessed NSSI groups were solicited from online support groups and engage in the behavior at much higher rates. For example, 95.5% of Boeckmann's (2008) sample indicated having self-injured more than 30 times, and 92% reported engaging in NSSI for over one year. The current college NSSI group evidenced just 15% reporting engaging in the behavior over 30 times, and the most frequently reported response was "I only tried it once." It appears that Boeckmann's NSSI group evidenced more severe forms of the behavior. Further the sampling of participants of online support groups may be biasing the sample toward individuals who are attempting to decrease distress associated with NSSI. These factors are felt to be contributing to the differences between the groups' knowledge of NSSI.

Analysis of the frequencies to knowledge measure for this college NSSI sample indicate that only six out of 20 items evidence good understanding, two items evidence poor understanding, and the remaining 12 items evidence problematic understanding. Smith's (2009) college study found only two out of the 20 items to evidence good understanding. These two items are "SI is a woman's problem," and "SI expresses emotional pain," and the current NSSI sample also evidenced good understanding of these items. In terms of the NSSI group, the majority of respondents agree with accurate

statements such as "SI provides a distraction from thinking" and "SI is a coping strategy." On the other hand, the majority of respondents agrees with the inaccurate statement "SI is a manipulative act," and evidence several other inaccurate understandings. The NSSI group evidences several other problematic understandings: they are unsure whether the behavior is a form of communication, a sign of mental illness, provides a way of staying in control, and obtains feelings of euphoria. Therefore, while the NSSI group does appear to have some greater knowledge of the behavior over those who do not engage in NSSI, they still evidence many inaccurate understandings.

Hypothesis Two

Hypothesis two, which predicts that the demographic variables of gender and sexual orientation for the NSSI group will be different from their peers who do not engage in NSSI, was supported. Compared to Smith's (2009) college sample, the NSSI group was composed of greater number of females than males (80.5% and 19.5%, respectively). Moreover, of the total college sample, this represents that 17% of females and 8% of males indicate a history of NSSI, while previous samples indicated the 12.8% of females and 9.4% of males indicate a history of NSSI. Therefore, while this hypothesis is supported, the current NSSI group's gender composition evidences a slight overrepresentation of females. When examining sexual orientation for the NSSI group, individuals who self-injure have four times the odds of having a gay, lesbian, bisexual, or questioning sexual orientation as compared to the college sample. This finding is consistent with the Whitlock, Eckenrode et al. (2006) study that also reported individuals who self-injure as more likely to be bisexual or questioning their sexual identity when compared to non self-injuring peers.

Hypothesis Three

Hypothesis three, which predicts the NSSI group to report self-injurious behaviors as less risky than their peers who do not engage in the behavior, was supported. Further, the NSSI group also indicated less perceived riskiness for all of the other risky behaviors. This finding is interesting to note as the NSSI group appears to view all risky behavior as less severe than their peers. When examining each risky behavior individually, both groups agree on the extreme behaviors (not at all risky, very risky), but vary on the behaviors in between. For example, both groups rate "drinking while driving" as the most risky, and "skipping class" as the least risky. The college group rates "cutting oneself" as the second riskiest behavior, while it was sixth riskiest for the NSSI group.

Perceptions of Peers

In regard to thoughts the NSSI group has concerning peers who engage in the behavior, the most frequently reported thought is "They're doing what they need to in order to cope." When the same question was asked to the college sample, the most frequently reported thought was "confusion." When given the statement, "Self Injury is just a behavior; it doesn't make the person," 26.9% of the NSSI group agreed, while just 15% of the college group agreed. Eighty seven percent of the NSSI group indicates that they know or have known at least one person who also self-injures. When we compare this number to the college sample (56.4%), the percentage is higher for the NSSI group. The majority of the respondents indicate the individual they know was a friend prior to college (74.2%) and female (78.8%). This finding is similar to Smith's (2009) study, which indicated that 77.5% of individuals who engaged in NSSI were females, and

83.8% of respondents knew the person prior to college. Overall, it appears that the NSSI group is much more aware and understanding of the behavior than the college group.

Limitations

A limitation of this study lies in the participant demographics. While the NSSI sample demographics of race, gender, and education level are comparable to those of the college sample, they are not nationally representative. This calls into question the generalizability of the findings. Another possible drawback of this study lies within the possibility of social desirability bias within participant responses to survey questions. Participants may be more willing to over report their good behavior and under report their bad behavior in order to appear more favorably through their responses.

Strengths

A strength of this study lies in the sample size. As NSSI is often an isolated and very intimate behavior, having a sample size of 87 is quite large. Previous studies on NSSI in the college population report samples ranging from 23 (Heath et al., 2008) to 464 (Whitlock, Eckenrode et al., 2006). Further, the findings are consistent with the results from similar studies. The prevalence rate of 14% is consistent with previous college studies that indicate prevalence rates ranging from 12% to 17% (Heath et al.; Whitlock, Eckenrode et al.).

Practical Implications

One implication of this study is that individuals who engage in self-injury may not evidence highly accurate knowledge of the behavior. While the majority of the NSSI group agrees with several accurate statements about self-injury, many inaccurate and problematic understandings remain. On the 20-item knowledge measure, responses from

the NSSI group indicate 6 good understandings, 2 poor understandings, and 11 problematic understandings of the behavior. As self-injury serves a variety of functions for different individuals, it may be difficult for those who engage in the behavior to understand why others may engage in the behavior. More, individuals may be very knowledgeable on certain aspects of the behavior that relate to them personally, but may be unsure about other aspects that have no personal relevance. Therefore, professionals who treat and work directly with individuals who engage in NSSI need to be aware of these common misunderstandings in order to help educate the individual. More, if individuals are further educated on the behavior, the social stigma and secret/private nature of the behavior may also decrease. All of the factors may increase the likelihood of an individual seeking help and learning positive replacement behaviors.

A second implication of this study lies in the peer perception realm of self-injury. Individuals who self-injure often know others who engage in the behavior. Therefore, increasing public awareness and education on the behavior might be beneficial on a college campus. Decreasing the social stigma attached with NSSI and creating a culture of accurate understanding may be very beneficial in the college population as all of these factors may increase help seeking behavior and a community of accurate understanding.

Further Research

While this study provides information regarding demographics, knowledge, riskiness and peer perceptions of self-injury in the college population, a more demographically varied sample is needed to further support the results. As this sample was pulled from a south central Kentucky university, it would be good to obtain similar data from a more urban setting composed with greater proportions of ethnically diverse

groups. Therefore, the results between the differing populations can be used in comparison and may guide the generalizability of these findings.

When comparing the current NSSI group to those studied in the past, this NSSI group obtained a lower mean knowledge score. The current sample was drawn from a young adult group attending college, while the previously assessed NSSI groups were drawn from young adults participating in online self-injury support groups. The differences in mean scores suggest that there may be some differences between these two NSSI groups. Further investigation may assist in understanding the differences noted.

An additional area of further research would be to further explore the ratings of riskiness of behaviors in individual who self-injure. The NSSI group rates all behaviors (including self-injury, and others) as less risky than do the college group. This finding infers cognitive distortions regarding risky behaviors. Further research is needed to substantiate this finding and to explore whether the NSSI group is minimizing all risky behaviors to be able to resolve the dissonance associated with engaging in a behavior that is risky.

Conclusions

Overall, the data from this survey supports that college students who engage in NSSI do not hold highly accurate and substantive knowledge of the behavior. While the sample did evidence some accurate knowledge of the behavior, many inaccuracies still exist. This study also informs that college students who engage in NSSI are more likely to be female, and/or gay, lesbian, bisexual, or questioning their sexual identities. Moreover, college students who engage in the behavior not only minimize the risk of

NSSI behaviors, but also view other risk taking behaviors as less risky than their college peers.

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Appendix A

Survey

***Note, the following text will appear on each screen of the survey:**

If you feel the need for assistance, please visit www.selfinjury.com <http://www.selfinjury.com/> or call 800-DONTCUT (800-366-9066).

For local assistance with self-injury, you may contact WKU Counseling and Testing Center by calling 270-745-3159.

1. In accordance with WKU's policies, you must be 18 years of age or older to participate in this survey. Please select the option below that applies to you.
    a. Yes, I am 18 years of age or older and am therefore able to participate in this survey if I so choose.
    b. No, I am not 18 years of age or older, and therefore understand that I am not able to participate in this survey at this time.

2. You understand that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.
    a. I agree/I understand
    b. I decline

3. Age:_____

4. What is your race/ethnicity?
    a. African American
    b. Asian
    c. Caucasian
    d. Hispanic
    e. Native American
    f. Other:_____

5. Please indicate your gender:
    a. Male
    b. Female

6. Indicate your current education level:
    a. College Freshman (less than 25 completed course hours)
    b. College Sophomore (25-54 completed course hours)
    c. College Junior (55-88 completed course hours)
    d. College Senior (89 or more completed course hours)
    e. Graduate Student (currently enrolled in a graduate program)

7. Indicate your sexual orientation:
    a. Gay
    b. Lesbian
    c. Heterosexual
    d. Bisexual
    e. Questioning (A fixed sexual orientation is as of yet not clear or defined.)

CAUTION: If you engage in self-injury, this survey may create some discomfort or trigger self-injurious behavior. You may stop the survey at any time or visit the URL provided above to access online support.

8. Describe any connection you may have to self-injurious behavior.
    a. I have never self-injured.
    b. I have never self-injured, but have considered it.
    c. I currently engage in self-injury.
    d. I have self-injured in the past.

9. If you self-injured in the past, how many times did you engage in the behavior?
    a. I have never self-injured.
    b. I currently engage in self-injury; I have not stopped self-injuring.
    c. Once
    d. 2-4 times
    e. 5-10 times
    f. 11-20 times
    g. 21-30 times
    h. 30+ times

10. If you self-injured in the past, how long did you engage in the behavior?
    a. I have never self-injured.
    b. I continue to self-injure.
    c. I only tried it once.
    d. 2-3 days
    e. 1 week
    f. 2-3 weeks
    g. 1 month
    h. 2-3 months
    i. 4-6 months
    j. 7-11 months
    k. 1 year
    l. 1+ year

11. If you do, or did, engage in self-injury, how often do you, or did you, engage in the behavior? (Choose only one response and indicate how many times per day for the response chosen.)
    a. I have never self-injured.
    b. Daily (_____ times per day)
    c. Weekly (_____ times per day)
    d. Monthly (_____ times per day)
    e. Less than monthly (Explain:_____)

In this survey the term self-injury will be used. Self-mutilation, deliberate self-mutilation, cutting, self-harm, and deliberate self-harm are other terms used to identify this behavior. Based on your current knowledge of self-injury, please answer the following questions:

12. Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Self-injury is a form of communication.					
Self-injury is a sign of madness/mental illness.					
Self-injury can provide a way of staying in control.					
Self-injury can provide distraction from thinking.					
People who self-injure					

will "grow out of it" eventually.					
Self-injury is a manipulative act.					
Self-injury can obtain feelings of euphoria.					
Self-injury is a "woman's problem".					
Self-injury can provide a release for anger.					
Self-injury expresses emotional pain.					
The best way to deal with people who self-injure is to make them stop.					
People who self-injure have a history of sexual abuse.					
Self-injury is a failed suicide attempt.					
Self-injury can provide an individual with help in dealing with problems.					
Self-injury is a coping strategy.					
Self-injury is attention-seeking.					
Self-injury helps a person maintain a sense of identity.					
Everybody who self-injures suffers from Munchausen's Disease (self-inflicted injuries which are calculated to produce specific symptoms that will lead to medical hospital admissions).					
Self-injury can provide escape from depression.					
People who self-injure need psychiatric hospitalization.					

Self-injury is a form of suicide.					
Self-injury is typically followed by suicide.					
Suicide and self-injury are not related.					
	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree

Self-injury includes behaviors that result in immediate harm, such as cutting, burning, skin picking, head-banging, and punching objects.

For the remainder of the survey, use the following definition when the term self-injury is used:

Self-injury is a direct, socially unaccepted behavior in which individuals purposefully harm themselves without the intention to die as a consequence.

13. What percentage of college aged individuals (18 to 22 year-olds) do you think engage in self-injury?
    a. Less than 1%
    b. 1-5%
    c. 6-10%
    d. 11-15%
    e. 16-20%
    f. 21-25%
    g. 26% or greater

14. At what age do most people begin to engage in self-injury?
    a. Below 5 years
    b. 5-8 years
    c. 9-12 years
    d. 13-15 years
    e. 16-22 years
    f. Over 23 years

15. Indicate your agreement with the following statements:

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Self-injury is evident in the popular media (internet, music, movies, TV, magazines).					
Internet forums (message boards, chat rooms, blogs) specifically about self-injury are easily accessible.					
The media (TV, movies, music, internet) has become a mechanism for spreading information about self-injury.					
Self-injury can be contagious, or spread among members of a group.					

16. Indicate how risky you find each of the following behaviors to be.

	Extremely Risky	Very Risky	Risky	Not Very Risky	Not At All Risky
Drinking while driving					
Having unprotected sex					
Smoking					
Doing drugs					
Speeding					
Cutting oneself					
Getting drunk					
Burning oneself					
Cheating on an exam					
Shoplifting					
Lying					
Skipping class					
Hitting oneself					

17. Please rate how often you engage in the following behaviors.

	Never Done	Done Once Daily	Done Occasionally	Done Often
Drinking while driving				
Having unprotected sex				
Smoking				
Doing drugs				
Speeding				
Cutting oneself				
Getting drunk				
Burning oneself				
Cheating on an exam				
Shoplifting				
Lying				
Skipping class				
Hitting oneself				

18. How have you learned about self-injury? (Mark all that apply)
    a. Peers/friends who talk about self-injury
    b. Talking with peers/friends who engage in self-injury
    c. Saw someone self-injure (in person, online, in a video or movie)
    d. Personal experience (you have engaged in self-injury at least once)
    e. Television or other popular media (i.e., news programs, World Wide Web, books/magazines)
    f. Scholarly/academic/educational outlets (i.e., scholarly websites, classrooms, lectures, published books/journals)
    g. Family members (either by talking about it or having a family member engage in the behavior)
    h. Mental health/medical professionals
    i. I have no knowledge of self-injury. (Skip to Question 20)
    j. Other:_____

19. Which two outlets selected in Question 18 are your **main** information sources for self-injury? (Mark only two)
    a. Peers/friends who talk about self-injury
    b. Talking with peers/friends who engage in self-injury
    c. Saw someone self-injure (in person, online, in a video or movie)
    d. Personal experience (you have engaged in self-injury at least once)
    e. Television or other popular media (i.e., news programs, World Wide Web, books/magazines)
    f. Scholarly/academic/educational outlets (i.e., scholarly websites, classrooms, lectures, published books/journals)
    g. Family members
    h. Mental health/medical professionals
    i. I have no knowledge of self-injury.
    j. Other:_____

20. How did you first become aware that self-injury was something that your friends do?
    a. I don't have any friends that self-injure.
    b. I saw my friends do it, either in person or online.
    c. I overheard my friend talking about it with someone else.
    d. I heard someone else talking about my friend doing it.
    e. I talked to my friend about it.
    f. I saw something my friend wrote about it.
    g. I heard about my friend self-injuring from one of his/her family members.
    h. I heard about my friend self-injuring from one of my family members.
    i. Other:_____

21. Indicate the extent to which you agree with the following statements:

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Self-injury is evident here at WKU.					
Self-injury is evident in college populations across America.					
Self-injury was evident in the high school I attended.					
Self-injury is evident in high school populations across America.					

22. How many people do you know, or have known (greater than an acquaintance), that self-injure?
    a. None that I know of.
    b. 1-2 people
    c. 3-5 people
    d. 6-10 people
    e. 10+ people

23. Of those individuals that you know, or have known (greater than an acquaintance), that self-injure, approximately how many were, or are, "close" friends (someone you interact with regularly)?
    a. I don't know anyone that self-injures.
    b. None of my close friends self-injure.
    c. 1-2 close friends
    d. 3-5 close friends
    e. 6-10 close friends
    f. 10+ close friends

24. Have any individuals within your **current** social group (those people that you interact with on a periodic basis rather than a regular basis) self-injured within the last year?
    a. Yes
    b. No
    c. I don't know

25. Indicate the number of individuals within your current social group that have self-injured within the last year.
    a. I don't know anyone in my current social group that self-injures.
    b. 1-2 individuals
    c. 3-5 individuals
    d. 6-10 individuals
    e. 10+ individuals

26. Regarding the individual(s) you know that have self-injured, have you talked with any of them about their self-injury?
    a. Yes
    b. No
    c. I don't know anyone that self-injures.

27. Have you spoken with anyone else (i.e., mutual friend, family) about the person and their self-injury?
    a. Yes
    b. No
    c. I don't know anyone that self-injures.

If you don't know anyone (either as a close friend or within your social group) that self-injures, then skip to Question 43. If you know more than one individual that self-injures, select the person you know best and respond to the following questions.

28. Indicate the gender of the individual you know that self-injures.
    a. Male
    b. Female

29. Is this someone you know from your college years or prior to college?
    a. College years
    b. Prior to college

30. How do you know the person self-injures?
    a. He/she told me.
    b. Someone else told me (i.e., roommate, friend)
    c. I caught him/her in the act of self-injury.
    d. I've noticed scars on him/her.
    e. Other:_____

31. If you indicated in the previous question (Question 30) that the person told you about their self-injury, who initiated the conversation?
    a. Him/her
    b. Me
    c. Another person
    d. He/she didn't tell me about the self-injury

32. Did your relationship with this person change due to your knowledge of the self-injurious behavior?
    a. Yes
    b. No
    c. Maybe (Our relationship changed partly due to the self-injurious behavior, but it was not the full reason)

33. Indicate your agreement with the following statements in reference to your relationship with the person after discovering he/she self-injures.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
I think less of the person.					
I do less with the person (i.e., hang out, go to dinner).					
I pity the person.					
I support the person.					
I feel closer to the person.					
We're very likeminded.					
We share the same interests.					
I've tried to learn more about self-injury.					
I've gained more tolerance for the behavior.					
His/her behavior really bothers me.					
I've tried to get him/her to stop the behavior.					
I feel the person is in need of professional help.					
I have aided the person in getting professional help.					

34. If your relationship changed, who initiated the change in the relationship?
    a. You
    b. Your friend that self-injures.
    c. Both you and your friend.
    d. The relationship did not change.

35. If you responded in the previous question that your relationship did not change, indicate the primary reason why you think your relationship did not change. (Mark only one) If you indicated that your relationship did change, skip to Question 36.
    a. I learned more about the behavior.
    b. I ignored the behavior.
    c. I talked with the person about the behavior.
    d. I can't tolerate being around people who engage in behavior I don't like or approve of.
    e. Self-injury is just a behavior; it doesn't make the person.
    f. I really liked the person.
    g. I decided to continue helping the person.
    h. Other:_____

36. Once the individual within your social group became aware of your discovery of his/her behavior, did your knowledge of the self-injury impact his/her behavior?
    a. Yes
    b. No

37. How did your knowledge of the self-injury impact his/her behavior?

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
He/she stopped doing things with me (i.e., hanging out, going out to dinner, watching movies).					
He/she avoided talking to me.					
He/she reached out to me for understanding/help.					
He/she seemed to be relieved that I knew.					
He/she pretended that I didn't know.					
To my knowledge, his/her behavior did not change.					

38. In reference to the previous question (Question 37), did the individual within your social group behave in ways other than the ones listed?

a. No
b. Yes (Please describe:_____)

39. How long have you known that he/she self-injures?
    a. Less than 1 year
    b. 1 year
    c. More than 1 year, but less than 2 years
    d. 2 years
    e. More than 2 years

40. In regard to the individual you know that self-injures, is your relationship with that person still ongoing?
    a. Yes
    b. No

41. Based on the individual you know that self-injures, which statement best describes your feeling regarding the issue that your friend self-injures?
    a. Very distressing
    b. Somewhat distressing
    c. Neutral/Unsure
    d. Not very distressing
    e. Not distressing at all

42. Based on the individual you know that self-injures, what impact does his/her self-injury have on his/her functioning?
    a. They do fine (i.e., go to classes, make good grades, have good social life); if you didn't know they self-injure, you would never see a difference.
    b. They have some problems meeting the demands of everyday life, but their functioning is only slightly different than most people's functioning (i.e., change jobs more than other people, miss more classes than most students, have trouble dealing with daily stress).
    c. They have problems meeting the demands of life in that their functioning is impaired in some way (i.e., only one of the following areas affected—school, relationships, work).
    d. Their functioning is impaired in multiple ways (i.e., more than one area affected—school, relationships, work).

43. In general, which of the following best describes your thoughts of self-injurious behavior? (Mark all that apply)
    a. Disgust
    b. Fear

c. It's a way to gain attention
d. Pity
e. Confusion
f. Shock
g. Curiosity/a need to know more, or a need to make sense, of the behavior.
h. I'm not sure how I feel about self-injury.
i. I have no thoughts regarding self-injury.
j. They're doing what they need to in order to cope.
k. I don't have a problem with it.
l. It's a good way of dealing with stress.
m. There's nothing wrong with it.
n. Everybody has a right to do what he/she wants.
o. Other:_____

44. What puzzles you about self-injury and/or what do you wish you knew about self-injury?
    a. _____

45. Have you ever spoken with anyone that does not engage in self-injury about self-injury?
    a. Yes
    b. No (Skip to Question 48)

46. If you responded yes to the previous question (Question 45), in what context did this topic occur?
    a. In a casual conversation with friends and/or family.
    b. In a classroom discussion.
    c. With a friend or family member of someone that self-injures.
    d. During a presentation/talk about self-injury.
    e. Other:_____

47. If you responded yes to Question 45, how frequently have you talked about the topic of self-injury with someone who does not engage in the behavior?
    a. Very Frequent
    b. Somewhat Frequent
    c. Not Very Frequent

48. Why do you think people who self-injure engage in the behavior? (Check all that apply.)
    a. For attention
    b. To cope with problems and/or emotions
    c. To gain control
    d. To reduce anxiety
    e. To self-punish
    f. To feel good or "alive"
    g. For the thrill or excitement
    h. I don't know why
    i. Other:_____

49. Indicate your agreement with the following statements:

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
I feel that self-injurious behavior is something that people grow out of.					
I think that people who engage in self-injury are in need of mental health services.					
I would encourage someone that self-injures to get help.					
Self-injurious behavior is something that needs to be addressed in the college population.					

50. Would you want to maintain a relationship with a friend if they divulged that they self-injure?
    a. Yes
    b. No

51. Do you think there needs to be a better understanding of self-injurious behavior within college populations?
    a. Yes
    b. No

52. What methods would be best to provide college populations with information about self-injury? (Mark all that apply)
    a. Informational talks on the subject provided to various student groups
    b. A week-long awareness project devoted to self-injury on campus (informative talks, movies, presentations)
    c. Peer Counseling
    d. Campus self-injury telephone helpline
    e. Posters with helpful resources
    f. Information tables run by professionals who can help answer questions regarding self-injurious behavior
    g. I don't think it needs to be addressed.
    h. Other:_____

53. How concerned are you about individuals your age that self-injure?
    a. Not at all concerned
    b. Not very concerned
    c. Neutral/Unsure
    d. Somewhat concerned
    e. Extremely concerned

54. In general, what impact do you think self-injurious behavior has on self-injurers as a group?
    a. They do fine (i.e., go to classes, make good grades, have good social life); if you didn't know they self-injure, you would never see a difference.
    b. They have some problems meeting the demands of everyday life, but their functioning is only slightly different than most people's functioning (i.e., change jobs more than other people, miss more classes than most students, have trouble dealing with daily stress).
    c. They have problems meeting the demands of life in that their functioning is impaired in some way (i.e., only one of the following areas is impacted—school, relationships, work).
    d. Their functioning is impaired in multiple ways (i.e., more than one area affected—school, relationships, work).

YOU ARE NOT FINISHED! YOU NOW NEED TO ANSWER THE FOLLOWING QUESTIONS IN ORDER TO RECEIVE CREDIT FOR PARTICIPATION. YOU WILL NOT RECEIVE CREDIT FOR PARTICIPATION UNLESS YOU COMPLETE THIS LAST STEP! (This information will be kept separate from your responses to the survey.)

55. Type in your WKU student ID number and last name:_____

56. Type in the name of your course instructor for the class in which you will be receiving credit or the name of your faculty advisor for the organization in which you will be receiving volunteer credit:_____

57. Type in the name and/or number of your course for which you will be receiving credit or the name of the organization you are involved in:_____

Appendix B

Human Subjects Review Board Approval Letter

WESTERN KENTUCKY UNIVERSITY
Human Subjects Review Board
Office of Sponsored Programs
301 Potter Hall
270-745-4652; Fax 270-745-4211
E-mail: Paul.Mooney@wku.edu

In future correspondence, please refer to HS10-210, March 8, 2010

Stacy Edwards Clinard
c/o Dr. Elizabeth Jones
Psychology
WKU

Stacy Edwards Clinard:

Your research project, *College Students Who Self-Injure: A Study of Knowledge and Perceptions of Self-Injury*, was reviewed by the HSRB and it has been determined that risks to subjects are: (1) minimized and reasonable; and that (2) research procedures are consistent with a sound research design and do not expose the subjects to unnecessary risk. Reviewers determined that: (1) benefits to subjects are considered along with the importance of the topic and that outcomes are reasonable; (2) selection of subjects is equitable; and (3) the purposes of the research and the research setting is amenable to subjects' welfare and producing desired outcomes; that indications of coercion or prejudice are absent, and that participation is clearly voluntary.

1. In addition, the IRB found that you need to orient participants as follows: (1) signed informed consent is not required; (2) Provision is made for collecting, using and storing data in a manner that protects the safety and privacy of the subjects and the confidentiality of the data. (3) Appropriate safeguards are included to protect the rights and welfare of the subjects.

This project is therefore approved at the Exempt from Full Board Review Level.

2. Please note that the institution is not responsible for any actions regarding this protocol before approval. If you expand the project at a later date to use other instruments please re-apply. Copies of your request for human subjects review, your application, and this approval, are maintained in the Office of Sponsored Programs at the above address. Please report any changes to this approved protocol to this office. A Continuing Review protocol will be sent to you in the future to determine the status of the project. Also, please use the stamped approval forms to assure participants of compliance with The Office of Human Research Protections regulations.

Sincerely,

Paul J. Mooney, M.S.T.M.
Compliance Coordinator
Office of Sponsored Programs
Western Kentucky University
cc: HS file number Clinard HS10-210