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School Counselors' Training, Knowledge, and Perceptions of Non-Suicidal Self-Injury

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SCHOOL COUNSELORS' TRAINING, KNOWLEDGE, AND PERCEPTIONS OF NON-SUICIDAL SELF-INJURY

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This investigation examined school counselors' perceptions and levels of knowledge in regard to nonsuicidal self-injury (NSSI), existing school prevention and protocol, resources and training opportunities available, as well as identified training needs. NSSI is the socially unaccepted, deliberate, self-inflicted harm of an individual's body to reduce psychological distress with out the intention to die as a consequence (Simeon & Favazza, 2001). As a mental health professional in the schools, school counselors are often salient figures in adolescents' educational environment. They are also many times the most appropriately qualified individuals to work with self-injuring adolescents in the school setting. While existing studies have identified some needs of school counselors, no studies have looked at the existing knowledge and the quality of knowledge (Kibler, 2009; Roberts-Dobie & Donatelle, 2007). The purpose of this study was to conduct a survey of practicing school counselors in order to obtain information about their knowledge, training opportunities, resources, and school responses in regard to NSSI. On a knowledge measure based on Jeffrey and Warm's (2002) myths and accurate statements about NSSI, school counselors performed no differently than school psychologists, but evidenced significantly greater knowledge than teachers. Qualitative analysis on individual survey items indicated that respondents evidenced good

understanding of 60% of items, problematic understanding of 40%, and poor understanding of no items. While the sample generally evidenced high knowledge of most items, several inaccuracies were present, specifically in regarding to the association of NSSI to psychopathologies, environmental risk factors, and functions of the behavior. Additionally, respondents indicated a lack of training specific to NSSI, limited presence of school response plans specific NSSI, and an expressed need for more training and resources on the topic.

Introduction

Self-injurious behavior has been well-documented in clinical populations for many decades (e.g., Ballinger, 1971; Favazza, 1987; Klonsky, 2007; Klonsky, Oltmanns & Turkheimer, 2003; Lester 1972; Walsh & Rosen, 1985). In recent years, there has been growing concern about self-injury in community (non-clinical) populations, specifically with mainstream visibility of this behavior in adolescent and young adult populations (Aizenman & Conover-Jensen, 2007; Kibler, 2009; Roberts-Dobie & Donatelle, 2007; Ross & Heath, 2002). Although this behavior is not considered to be suicidal in intention, it still presents serious potential health risks, including permanent scarring, infection of wounds, disfigurement, and fatality. Not only does it present serious risks in regard to physical health, but it also suggests the presence of significant maladaptive coping mechanisms and personal distress. Much of the research about the prevalence on self-injurious behavior in community populations is still in it's infancy, though a great number of professionals in community and educational settings report frequent contact with adolescents and young adults without a clinical diagnosis who engage in these behaviors (Kibler, 2009; Roberts-Dobie & Donatelle, 2007). The potential physical and mental health risks coupled with the more predominant mainstream presence makes self-injury a vital topic to understand for professionals who may come in contact with individuals who self-injure.

The presence of self-injury in community samples has left many professionals in educational settings concerned and struggling to understand, respond and provide adequate treatment to students who self-injure (Kibler, 2009; Roberts-Dobie & Donatelle, 2007). Investigations of teachers, school counselors, school psychologists, and social

workers knowledge and experience in regard to self-injury indicate the need for more training. Further, the existing knowledge of these professionals evidences the presence of beliefs about that are inconsistent with current research (Beld, 2007; Butts, 2008; Heath, Toste, & Beettam, 2006; Jeffrey & Warm, 2002).

A great deal of research on self-injury is centered on clinical populations (e.g., cognitive disability, autism, mood and depressive disorders, psychosis), making it difficult to gain an understanding of the contextual and functional differences between clinical and community samples. The research and practice focus on clinical self-injury has not appropriately addressed distinctions between self-injury in the two populations and has spawned many misconceptions about self-injury in community samples. Further, it has also left many youth who seek treatment dissatisfied, misunderstood and frustrated, which has been known to reinforce negative feelings and perpetuate the cycle of harming oneself (Clarke & Whittaker, 1998; Jeffery & Warm, 2002).

As self-injury becomes an increasing concern in adolescent populations, it becomes necessary to evaluate where accessible resources for help may be put into place (Roberts-Dobie & Donatelle, 2007; Kibler, 2009). Often times the self-injuring adolescent's first line of contact will be a professional in the educational setting/context. The current study will investigate school counselors' existing practices and knowledge levels, as well as needs in regard to training and resources. As a mental health professional in the schools, school counselors are often salient figures in adolescents' educational environment. They are also many times the most appropriately qualified individuals to work with self-injuring adolescents in the school setting. The following

literature review will provide an overview of NSSI, public and professional knowledge, and individual and school response in regard to self-injury.

Literature Review

Overview of NSSI

Definition. The term self-injury can be used to describe a broad variety of behaviors that range greatly in severity and quality. The term includes behaviors as severe as castration, eye enucleation, or limb amputation, as well as the less severe skin picking, nail biting or hair pulling behaviors (Klonsky et al., 2003). It is important to note that the more extreme forms of self-injury are seen in a low incidence population of individuals who have diagnosable developmental and clinical disorders (e.g. autism, cognitive disability, borderline personality disorder), severe psychosis, or in some cases intoxication. A population of self-injurers who do not have a co-occurring clinical diagnosis and only engage in mild to moderate forms of self-injury will be the focus of the current investigation. Mild and moderate forms of self-injury have been most commonly reported to include behaviors such as cutting or burning skin, self-hitting, hitting body parts on objects, scratching, or hair pulling (Carlson, DeGreer, Deur, & Fenton, 2005; Klonsky et al., 2003; Warm, Murray & Fox, 2003; White Kress, 2003; Whitlock, Powers, & Eckenrode, 2006). These mild and moderate injuries are deliberate, usually self-inflicted in an area of the body that is easily hidden by clothing, and not carried out with the intention to die as a consequence.

Various terms are used to describe this moderate form of self-injury, including superficial-moderate self-mutilation, self-injurious behavior, parasuicide, self-destructive behaviors, self-cutting, common self-injury, nonsuicidal self-injury and self wounding (Klonsky et al., 2003; Zila & Kiselica, 2001). Various definitions accompany these moderate self-injury terms. For the purposes of this study, the term nonsuicidal self-

injury (NSSI) will be adopted, and the following definition will be used: nonsuicidal self-injury is the socially unaccepted, deliberate, self-inflicted harm of an individual's body to reduce psychological distress with out the intention to die as a consequence (Simeon & Favazza, 2001). This definition has been previously used by Butts (2008) and Beld (2007) in their research on educators' knowledge of NSSI. This definition of NSSI makes distinctions about NSSI that are crucial for understanding the nature and scope of the behavior, such as differentiating between socially deviant and socially sanctioned self-injury, self-injury and suicide, as well as noting the self-injurers' psychological state and intentions (Aizenman & Conover-Jensen, 2007; Kanan, Finger, & Plog, 2008; Leiberman, 2004; White Kress, 2003).

Although the given definition of NSSI may seem clear-cut, there have been many discrepancies regarding what researchers have considered NSSI in the past. For this reason, it is necessary to make further distinction about what NSSI is, and what NSSI is not. NSSI is distinct from suicide. Most individuals who engage in NSSI report emotional regulation as the primary function of their actions, not death (Favazza, 2006; Leiberman, 2004; Nock & Pristein, 2005). However, it should be noted that, statistically speaking, individuals who engage in NSSI are more likely attempt suicide (Whitlock & Knox, 2007).

Body alteration (e.g., tattooing and piercing) is another act that is important to differentiate from NSSI. Although both body alteration and NSSI involve deliberately damaging body tissues, body alteration is motivated by a need for self-expression, social group identification, or appearance enhancement, while NSSI is largely motivated by the need to regulation negative emotions (Aizenman & Conover-Jensen, 2007).

It is also important to distinguish NSSI from cultural and ritual acts that involve self-harm. Clarke and Whittaker (1998) stress that these acts of self-injury can be viewed very differently from culture to culture, and that some cultures view acts of self-mutilation as rites of passage (e.g., African tribes sporting decorative facial scars). Clarke and Whittaker (1998) also note that those who engage in cultural or ritual acts of self-injuring do not use self-injury in the same manner, do not possess the same psychological characteristics, and that these rituals are primarily intended for rite of passage traditions, promoting social group membership, or spiritual healing/enlightenment. NSSI is primarily motivated by an individual's need to regulate and cope with negative emotions (Aizenman & Conover-Jensen, 2007).

Classification. One of the most widely accepted and used systems of classification for self-injury was first developed by Favazza in 1987. It is still currently considered one of the most useful systems of classification, and is composed of four types of self-injurious behavior: Major, Stereotypic, Compulsive, and Impulsive (Favazza, 1987; Favazza, 2006; Walsh, 2006; White Kress, 2003).

The type of self-injurious behavior classified as Major is associated with psychosis, severe character disorders and intoxication. This type of self-injury includes extreme acts such as eye-enucleation, autoamputation, and autocannibalism. Major self-injurious behavior results in the most invasive physical damage, and is most often seen in individuals with more severe and life-course persistent clinical diagnoses. Stereotypic self-injurious behavior is associated with organic and pervasive mental disorders such as autism, cognitive disability, or Tourette's syndrome. This includes fixed and repetitive acts such as self-biting, hair-pulling or head-banging (Favazza, 2006; White Kress,

2003). Compulsive self-injurious behavior is typically associated with the disorders, trichotillomania or stereotypic movement disorder with self-injurious behavior.

The Impulsive classification of self-injurious behavior is associated with various mood and personality disorders such as borderline personality disorder, major depressive disorder, histrionic personality disorder and post-traumatic stress disorder. This classification includes acts such as cutting, burning or carving of the skin, or self-hitting, and can occur habitually or episodically. Episodic incidents only occur a limited number of times throughout an individual's life, whereas habitual occurrences in this classification are observed to have almost an addictive quality and be highly incorporated into an individual's life. It is this type of individual that may even identify him or herself as a "cutter" (Favazza, 2006; White Kress, 2003).

It may be difficult to conceptualize how Favazza's (2006) Compulsive and Impulsive classifications of self-injury are different; however, one should note that the Impulsive classification is associated with various mood disorders, while the Compulsive classification does not have this mood component. It is important to note that individuals who engage in NSSI often report both impulsive and compulsive features in their self-injuring. While Favazza's categories cover a wide range of behaviors, there is no clear place in this system for individuals without a clinical diagnosis. Thus, contemporary researchers utilize this classification to put NSSI into a broad frame of reference. The definition adopted for this study encapsulates an emerging definition of self-injury that would be considered a milder form of Favazza's Impulsive and Compulsive categories.

Prevalence. Recent investigations of NSSI in community populations have stated prevalence rates ranging from 4% to 46.5.5% (Briere & Gil, 1998; Klonsky et. al, 2003;

Laye-Gindhu & Schonert-Reichl, 2005; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Ross & Heath, 2002; Whitlock, Eckenrode, & Silverman, 2006; Yates, Tracy, & Luthar, 2008). When limiting prevalence to adolescent populations, Ross & Heath (2002) found that 13.9% of high school youth in their survey sample reported engaging in self-injury at some point in time. In a sample of 424 high school students, Laye-Gindhu and Schonert-Reichl (2005) found that 42% reported having self-harm ideation, and 15% reported actually engaging in self-harm.

Yates et al. (2008) examined a cross-sectional sample of approximately 1,000 9th to 12th grade students from an upper-middle class, suburban, west coast high school. They found that 7.7% reported in engaging in at least one incident of self-injury, while 29.5% reported engaging in self-injury more than once.

Reported incidence rates of self-injury vary from study to study. Research findings have reported rates as low as 4% (Briere & Gil, 1998) and as high as 46.5% in community samples, (Lloyd-Richardson et al., 2007), and as high as 82.4% in clinical samples (Heath, Schaub, Holly, & Nixon, 2009). While some of the studies noted suggest that prevalence rates of NSSI in community samples are alarmingly high, determining exact rates of self-injury, and whether or not it has been increasing over time in community populations, has been a subject of disagreement. One problem with determining exact prevalence rates and trends is because of variances in NSSI definitions. These inconsistencies in methodology likely contribute to the variability in research findings regarding prevalence of NSSI; as well as make it difficult to ascertain exactly what these reported prevalence rates are measuring, and if in fact they are measuring the same behavior. Regardless of disagreements, one thing is clear: this physically harmful

and maladaptive coping mechanism is present in community populations and there is a need for future research dedicated to understanding this behavior in order to develop effective care.

Another issue to take into account when considering the prevalence rates of NSSI is that research documents that self-injurious behavior has a tendency to spread throughout a population, as if contagious. Walsh and Rosen (1985) conducted a study in which they tracked self-injurious behavior of 25 individuals in a residential facility. This study found that these behaviors occurred in time clusters, suggesting that one self-injurious act was triggering the next. This phenomenon suggests the presence of a social variable, and lends credibility to the contagion effect. Another incident of self-injury contagion was documented and discussed by Fennig, Carlson, and Fennig (1995), and took place in a public school. This incident occurred among a group of students with no obvious psychopathology. The instigators of the phenomena were noted to be a few students with more severe pathologies who were influencing more passive students within the same group of peers. Kibler (2009) concurs with the notion of contagion, and equates it to social modeling. Nock and Pristein (2005) also support the presence of a contagion effect, and note that many adolescents who engage in self-injury also have a friend who does the same.

Another consideration to make in regard prevalence rates and trends is in regard to the rise in self-injury presence in the media. In recent years, numerous movies, television programs, and musical artists have covered this topic, and a large number of internet websites and forums are dedicated to sharing information promoting self-injury. Television series such as *Will and Grace*, *Grey's Anatomy*, and *Seventh Heaven* have all

included self-injury as subject matter in their storylines; Actors such as Christina Ricci, Angelina Jolie, and Johnny Depp have all publicly shared information about their current or previous usage of self-injuring as method of coping (Whitlock & Knox, 2009). This increased exposure to self-injury in the mainstream media may produce a number of effects. One such effect may be that the increased mainstream presence of self-injury has resulted in the false perception that self-injurious behavior is increasing in incidence, when in actuality, rates may be remaining fairly stable over time.

While there is no doubt that the media has a powerful effect on our perceptions, assuming that the increased mainstream presence of self-injury is simply media induced trickery would make light of the problem. The fact remains that contagion is a very real and well documented characteristic of self-injurious behavior. Researchers theorize that the media may actually be fuel for the contagion affect, and, therefore, a contributor to NSSI prevalence rates (Whitlock & Knox, 2009).

Associated Features and Risk Factors. Although no single profile applies to every individual who self-injures, there is a culmination of characteristics and factors that many self-injurers are likely to share. Most researchers agree that the age of onset of NSSI is during adolescence, between the age of 13 and 15, and persists through the individual's 20s before declining (Heath et al., 2009). There is some evidence, however, that some individuals begin self-injuring earlier. For example, Ross and Heath (2002) found that 25% of their survey sample began self-injuring before the age of 12. This early onset of self-injuring is most often associated with a life-course prevalent trend of self-injury, and is more frequently encountered in clinical populations in individuals with associated psychopathologies. Adolescent-limited self-injury occurs most often in

community samples, and may not necessarily be accompanied by psychopathology, and will be the focus of this discussion.

It has been traditionally thought that self-injury was primarily a female affliction (Clarke & Whittaker, 1998; Crick & Zahn-Waxler 2003). Recent research by Laye-Gindhu and Schonert-Reichl (2005) suggest that gender differences are actually much smaller than what was originally thought. Laye-Gindhu and Schonert-Reichl suggest that rates appear to be higher for females because they are more likely to seek help from outside sources. Another explanation they offer for the gender difference is that methods of self-injury chosen by males are more likely to resemble an accident or a haphazard "male" behavior, and therefore may be dismissed as such (e.g., punching objects resulting in injury, risk-taking behavior).

There are several other features that have been commonly linked to NSSI. Aizenman and Conover-Jensen (2007) found, in their survey of college students about self-injury, tattooing and body piercing, that those who reported sexual abuse, physical abuse or eating disorders also reported significantly higher incidences of self-injury. Froeschle and Moyer (2004) also note the link between having a history of abuse and eating disorders and the likelihood of engaging in NSSI. Klonksy and Glenn (2009) agree that a history of abuse is linked to a higher likelihood of self-injury, but use the general term "early invalidating environments" (p. 47). This term includes many things, such as neglect, stifled emotional expression, and physical or sexual abuse. They note that many studies have reliably linked self-injury to childhood trauma and abuse and that self-injurers often report an overall lower quality of family life. In fact, most research that addresses associated features and risk factors of NSSI has pinpointed quality of

childhood environment (or lack thereof) as the biggest predictor of NSSI, and more specifically, it is linked to a history of abuse or neglect (Gratz & Roemer, 2004; Klonksy & Glenn, 2009).

Klonsky and Muehlenkamp (2007) note several clinical disorders that are associated with NSSI, including: borderline personality disorder, post-traumatic stress disorder, disassociative identity disorder, major depressive disorder, obsessive-compulsive disorder, antisocial personality disorder, and a variety of psychoses. Lofthouse, Muehlenkamp, and Adler (2009) note that, due to lack of agreement about NSSI definitions and a failure to differentiate NSSI from suicidal self-injury, much of the research on the comorbidity and covariance of NSSI with clinical disorders has not been documented consistently and accurately. Therefore, it can only be concluded that NSSI may at some point in time be related to a psychiatric diagnosis, and that there may not necessarily be a currently co-occurring psychiatric diagnosis.

It is important to clarify that, while these variables may be linked to self-injury, there is no evidence of a causal relationship between these variables, not all self-injurers have experienced abuse, trauma or poor quality family lives, there are many self-injurers that do not possess any these associated features or risk factors. It is also important to clarify that NSSI affects all races, genders, cultures and socioeconomic backgrounds (Lieberman, 2004).

Functions of NSSI. There are several researchers that address the functions of NSSI. Klonsky (2007) conducted an analysis of 18 studies on the functions of self-injury, and concluded that self-injury is most often performed to alleviate negative affect. Klonsky places the function of alleviating negative after under the broader function of

affect-regulation, which is any strategy employed to alleviate and regulate powerful negative emotional buildup. The research by Klonsky (2007) also strongly supports the presence of self-punishment as a function of self-injury. Most individuals who self-injure for this reason do so in order to express anger toward themselves or punish themselves which results from low self-esteem or body dissatisfaction (Klonsky & Muehlenkamp, 2007). Moderate support is provided for several other possible functions, one of these being antidissociation, which is defined as self-injuring in order to stop the numbing feelings of dissociation from oneself, and generate some kind of feeling, even if it is pain. This function may overlap with affect-regulation, as often times this feeling of dissociation is generated from the intense emotions felt by the individual.

Klonsky (2007) also notes anti-suicide as a function of self-injury. Individuals who report antisuicide as a function of their self-injury claim that it alleviates the intense negative emotions that they feel would lead them to suicide. Hence, they harm themselves in order to avoid doing something much worse (Klonsky & Muehlenkamp, 2007). Other less common functions of NSSI reported by Klonsky & Muehlenkamp include interpersonal influence, sensation seeking, interpersonal boundaries.

Lloyd-Richardson, Nock, and Pristein (2009) present another conceptualization of self-injury functions. They propose that behavioral functions of NSSI differ along two dichotomous dimensions. They propose that reinforcement for a behavior is either positive (followed by a desired stimulus/event) or negative (an aversive stimulus/event is removed), and that the consequences are either automatic (intrapersonal) or social (interpersonal). With these dimensions in place, Lloyd-Richardson et al. (2009) suggest that functions of NSSI will fall under one of four functions: automatic-negative

reinforcement (to stop undesirable cognitive or emotional state), automatic-positive reinforcement (to generate a desired internal state), social-positive reinforcement (to gain attention from others or access some sort of social resource), and social-negative reinforcement (to escape from interpersonal demands or tasks).

Another proposed function of self injury is that it is motivated primarily by endorphin levels or other physiological influences. Osuch and Payne (2009) address this perspective and verify that variables such as lower levels of serotonin and dopamine are linked to suicide attempts and self-aggressive behaviors. They also address the theory that abnormal or fluctuating levels of opioids can lead to addiction to certain opioids and increased tolerance to painful stimuli, suggesting that self-injury itself produces an effect on individuals that simulates addiction, subsequently making self-injury a reoccurring habit. Shaw, Pembroke, and Thomas (2007) refute this theory, and state that the research on the biological etiology of self-injury has been with subjects who has been diagnosed as having learning disabilities, autism, or with a life-course persistent mental or personality disorder. They state that these individuals may not use self-injury for the same reasons, or with the same intent. They also state that individuals would not be able to go months and years without self-injuring if it were truly a result of an addiction to the high released by endorphins.

Overall, most individuals report that their self-injuring behaviors are a way to alleviate anxiety and cope with emotional difficulties; though it is important to elucidate that each case of self-injury is different. Often times the function this act serves is multiple, complex and very personal. There is no “one-size-fits-all” profile of self-injuring.

Professional Knowledge about NSSI. Much of NSSI research is still in its infancy, making it likely that dissemination to practicing professionals has not occurred. Therefore, practitioners may hold some misconceptions about what self-injury actually is, the function it serves, and effective treatment approaches. These misconceptions and lack of knowledge lead to the maintenance of negative attitudes towards self-injurers and the substandard and potentially harmful treatment of individuals who seek help for self-injury. Professionals who come in contact with individuals who self injure should hold themselves responsible for evaluating their own attitudes and beliefs toward self-injury and inform themselves on current and appropriate conceptualizations and treatment approaches for self-injury.

Research suggests that education and training about self-injury has increased the quality of care received by those who seek help for their self-injurious behavior. Crawford, Turnbull, and Wessely (1998) found that training programs provided to accident and emergency hospital employees improved the staffs' ability to conduct quality psychosocial assessments of deliberate self-harmers. Results indicate that training increases medical staffs' knowledge, and improves treatment practices within the hospital. Huband and Tantum (2000) found that attitudes of medical staff with prior training in counseling or psychotherapy varied significantly from medical staff that did not have prior training. Staff with prior training in counseling or psychotherapy felt that self-injurers had less control over their actions than did the staff without prior training. The notion that self-injury is entirely controllable and that self-injuring is an avoidable, conscious decision made by the individual is a common misconception. Thus, Huband and Tantum's research suggests that staff with previous training and education in

counseling or psychology may be better equipped to provide appropriate treatment to those who seek help for self-injury.

Warm, Murray, and Fox (2002) conducted a survey of self-harmers' levels of satisfaction with help received from various professionals for their self-injurious behavior. Results indicated that 42.3% of individuals who sought help for their self-injury from counselors were dissatisfied or very dissatisfied with the treatment. Approximately 44% were dissatisfied or very dissatisfied when seeking help from a psychologist, 39.7% were dissatisfied or very dissatisfied when seeking help from a social worker, and over half of all individuals who sought help from a psychiatrist, doctor, or nurse were dissatisfied or very dissatisfied with their treatment. Not surprisingly, the professionals who received the highest marks in treatment satisfaction by patients were self-harm specialists; 44% rated their treatment by the specialist as very satisfactory or satisfactory, only 5.6% were dissatisfied, and 0% were very dissatisfied. This study illustrates how levels of knowledge about self-injury impact a professional's ability to provide appropriate care.

One reason for the lack of adequate support for self-injurers is that many professionals lack formal training and education in this area, which opens the door to misconceptions and clouded judgment and understanding (Huband & Tantum, 2002). A study by Jeffrey and Warm (2002) investigated current beliefs and misconceptions held by professionals via survey containing 10 accurate statements and 10 myths about self-injury, which are shown in Table 1 as follows:

Table 1

Accurate Statements and Myths about Self-Harm

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

Table 1 (cont.)

Myths about Self-Harm (cont.)
People who self-harm should be kept in psychiatric hospitals.
Everybody who self-harms suffers from Munchausen's Disease (self-inflicted injuries which are calculated to produce specific symptoms that will lead to hospital admission).

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. 229.

Jeffrey and Warm's study included psychiatrists, psychologists, medical workers (general practitioners and nurses) and social/community care workers, as well as a group of individuals who self-harm. Psychiatrists' and medical workers' ability to identify accurate and false statements about self-harm was poorer than the others who completed the survey while psychologists, self-harmers, and social/community workers all performed similarly and demonstrated a view of self-harm that is more consistent with existing research. All groups demonstrated some lapse in understanding, and demonstrated that they hold some misconceptions about self-harm (Jeffrey & Warm, 2002).

Butts (2008) used Jeffrey and Warm's (2002) 20-item questionnaire to investigate NSSI knowledge of teachers from a rural Kentucky community. Butts found that teachers' levels of NSSI knowledge were significantly lower than school psychologists' and social community workers' levels of knowledge, indicating a need for training and instruction for school personnel. Beld (2007) also used Jeffrey and Warm's survey to

examine school psychologists' knowledge of NSSI, and found that they had a higher level of understanding about NSSI than teachers, medical works and psychiatrists; nonetheless, the great majority (93.6%) still expressed the desire for additional training.

Heath et al. (2006) developed their own survey about NSSI knowledge in order investigate high school teachers' perceptions of self-injury, and found that 50% of teachers reported not feeling knowledgeable about NSSI, 48% found the idea of self-injury to be horrifying, and an overwhelming majority expressed that they did not feel equipped to help a student who self-injures. A survey of school counselors about NSSI and found that while 81% of counselors have worked with students engaging in NSSI, most still felt a need for more training in order to be successful (Roberts-Dobie and Donatelle, 2007). The results of Kibler's (2009) survey of school counselors' NSSI knowledge also indicated that more training would be beneficial, as responses to questions regarding some basic and factual characteristics of NSSI indicated the presence of several inconsistencies in beliefs. Taken together, these studies highlight the need for training and education on NSSI for our school personnel, regardless of professional title.

School Response to NSSI. Schools have an obligation to protect and support their students. Leiberman, Toste, and Heath (2009) suggest that prevention is the first step to providing this support. While there are no existing evidenced-based psychoeducational programs that specifically address NSSI prevention, there are many other evidence-based prevention programs that may be effective. Such programs include information on topics such as health risks, depression, suicide, bullying, and substance abuse (Leiberman et al., 2009). It is possible that it is no coincidence that a program specifically addressing NSSI is not yet in existence. Research on NSSI and its contagious nature has noted that

bringing direct awareness to the "how and why" of self-injury may actually lead an increase in NSSI. It may be more beneficial to indirectly educate students about coping skills and seeking help, as directly discussing the "how and why" of NSSI could actually lead to a contagion effect (Kibler, 2009).

Most professional opinions agree with this indirect approach to universal prevention directed toward the entire staff and student body (Onacki, 2005). Often, the first person to discover a student's self-injuring behavior is not a psychologist, counselor, or other professional who may be equipped to handle the issue, but more likely teachers or other school staff who may be less likely to be trained in matters of mental health. Leiberman et al. (2009) rightly suggest that prevention efforts should be focused on training all staff and personnel who may come in contact with youth who self-injure. Leiberman et al. (2009) also suggest integrating a response to NSSI protocol into school crisis plans. This response plan should outline how to assess suicide risk, notify parents, collaborate with community support, and work with students in the school setting (Kanan et al., 2008).

While this type of response and support suggested by Leiberman et al. (2009) is ideal, research suggests that most schools do not provide this level of support for their staff. In Beld's (2007) survey of school psychologists, almost half of respondents indicated that their most recent NSSI was either more than 10 years ago, or never. Additionally, 30% indicated that their school did not have any school response plan for NSSI, and of the remaining 70% that did report having a school response plan, only 37% indicated it specifically addressed NSSI or was developed with the assistance of mental health professionals.

School Counselor Response to NSSI

Most studies investigating knowledge of NSSI highlight the need for training and education on NSSI for all school personnel, regardless of professional title (Beld, 2007; Butts, 2008; Heath et al., 2006; Jeffrey & Warm, 2002; Kibler, 2009; Roberts-Dobie & Donatelle, 2007). Studies specifically addressing school counselors' NSSI knowledge indicate that the majority of counselors' are working with students who self-injure, report a need for more training, and may hold beliefs about NSSI that are inconsistent with current research (Kibler, 2009; Roberts-Dobie & Donatelle, 2007). Because school counselors are often one of the few professionals in schools who are specifically trained in matters of mental health, it is necessary to ensure that they have the resources, knowledge and confidence to provide services to students who self-injure.

A survey of 443 school counselors regarding their experiences with students who self-injure, found that, while counselors felt they were the appropriate people to work with students who self-injure, they indicated a need for more training on the topic (Roberts-Dobie & Donatelle, 2007). Obstacles identified that kept the school counselors from being more confident and successful in working with students who engage in NSSI included a lack of training, lack of school policy on the topic, and lack of school personnel cooperation.

While it is clear that NSSI has more mainstream visibility in adolescent populations, it is not clear whether or not NSSI incidence is truly increasing, or if professionals working with this population have adequate understanding of NSSI functions, accompanying features, and treatment approaches. Also, school responses to NSSI are often poorly described and understood by those who would implement them,

leaving many professionals unprepared to provide adequate care to a self-injuring student. The present investigation plans to further the literature knowledge of NSSI on one mental health provider in the schools – school counselors.

Purpose

The current investigation was designed to investigate school counselors' perceptions and levels of knowledge in regard to NSSI, existing school prevention efforts and protocol, resources and training opportunities available, as well as identify training needs. While there are existing studies that have identified some needs of school counselors, no studies have looked at the existing knowledge and the quality of knowledge. Studies specifically investigating school counselors' training and resource needs indicate and are limited in number, and indicate limited resources and training opportunities, and a reported desire for more training (Kibler, 2009; Roberts-Dobie & Donatelle, 2007).

A survey was utilized in order to gain information about school counselors in regard to levels of knowledge, school response and protocol, resources and training opportunities available, and training needs. Levels of knowledge were assessed using the 20-item questionnaire developed by Jeffrey and Warm (2002), which contained statements reflecting facts and myths about self-injury. Additionally, individual items were classified as good, problematic, or poor in order to provide further qualitative information about levels of knowledge about NSSI. Jeffrey and Warm report adequate reliability for this measure, noting a Cronbach's Coefficient Alpha of .75. Additionally, subsequent studies utilizing this questionnaire as a measure of NSSI knowledge also reported adequate reliability, as Beld's (2007) survey of school psychologists reports a

Cronbach's Coefficient Alpha of .69, and Butt's (2008) survey of teachers reports a Cronbach's Coefficient Alpha of .71.

This investigation purported that school counselors would evidence higher levels of knowledge than school psychologists (Beld, 2007) and teachers (Butts, 2008). School counselors will evidence greater knowledge of NSSI than school psychologists because they generally spend a greater percentage of time in direct contact with students, making it more likely that they have had experience working with a student who self-injures. While school psychologists also spend time in direct contact with students, their position requirements are generally not centered primarily on direct counseling intervention services as is the case with school counselors (Froeschle & Moyer, 2004; White Kress, 2004; White Kress, 2006). The research questions and hypothesis are as follows:

1. How knowledgeable are school counselors about NSSI?
    a. *Hypothesis One*: School counselors will evidence greater knowledge of NSSI than school psychologists (Beld, 2007) and teachers (Butts, 2008).
2. What are the training needs of school counselors in regard to NSSI?
3. How do schools respond to NSSI?

Method

Participants

A total of ninety school counselors completed this survey. Of the 90 returned, 73 were complete and usable. Table 2 contains descriptive statistics for selected demographic variables. Most participants were Caucasian (84.9%) and hold an M.A., M.S., or M.Ed. as their highest degree in school counseling (93.2%). Participants received his or her highest degree in school counseling from 1980 to 2010. Most participants report having obtained their degree within the last 10 years (68.5%). Approximately half (51.4%) of the respondents were 21 to 40 years old (n = 37), with the remainder of the participants falling between 41 and 67 years of age (n = 35). Most respondents (82.2%) reported five or less years of experience. Respondents reported being with their current district from a range of less than one year to 38 years, with an average of 8.8 years. The respondents practice in 15 states, with cities ranging from metro areas to rural areas. Most participants (93.2%) work in public schools, three participants work for a private school, one for a combination of both public and private schools, and one is retired. Respondents estimated the student population of their district, and the largest response category (35.6%) was less than 5,000 students.

Procedure

Participants for this study were school counselors who hold a membership with the American School Counselor Association (ASCA). The 190 ASCA members listed as Kentucky residents were directly contacted via email. A direct link to the survey was also posted to ASCA's SCENE professional networking forum, which is an electronic networking forum affiliated with the ASCA, intended for use by school counselors

Table 2

Demographic Characteristics of Participants

Characteristic	Sample % (n)
Total	100% (73)
Age	
20-30	20.8% (15)
31-40	30.6% (22)
41-50	20.8% (16)
51-60	26.4% (19)
61+	1.4% (1)
Race	
African American	9.6% (7)
Caucasian	84.9% (62)
Hispanic	2.7% (2)
Asian	1.4% (1)
Years experience	
0-5	82.2% (60)
16-20	5.5% (4)
21-30	12.3% (9)

Table 2 (cont.)

Characteristic	Sample % (n)
Degree	
M.A., M.S., or M.Ed.	93.2% (68)
Ed.S.	5.5% (4)
Ed.D.	1.4% (1)
School Population	
Less than 5,000	35.6% (26)
5,001-15,000	17.8% (13)
15,001-25,000	17.8% (13)
25,001-35,000	6.8% (5)
35,001-45,000	2.7% (2)
Over 45,000	16.4% (12)
Location of school	
Metro	17.8% (13)
Urban large	16.4% (12)
Urban middle	9.6% (7)
Town large	19.2% (14)
Town small	24.7% (18)
Rural	11% (8)

seeking to share information regarding issues that arise within the profession. This forum is moderated by the ASCA Director of Communication to ensure that content is relative and appropriate to the ASCA and school counselors.

The Director of Communications of the ASCA assured the appropriateness of using the ASCA member directory and ASCA's SCENE professional networking forum to solicit members' participation (see Appendix A). Further, the Western Kentucky University Institutional Review Board approved all procedures that were a part of this investigation (see Appendix B). Members listed as Kentucky residents (N = 190) were sent an email containing a link to the survey, which was electronically posted to a web-based survey tool located at www.SurveyMonkey.com. Three weeks were allotted for the collection of survey data. On day one, after the survey was posted to the web, participants received an initial email (see Appendix C) notifying them of the opportunity to participate in the research. On day seven, after the initial email, participants received their first reminder email (see Appendix D) about the survey research opportunity. On day 19, participants received their final reminder email (see Appendix E) about the survey research opportunity. Access to this survey was also posted to the SCENE, a school counselor networking forum sponsored by ASCA. As incentive to participate, respondents were offered the chance to win a raffle drawing of a $50 gift certificate from www.Amazon.com. If respondents chose to participate in this raffle drawing, they were given the opportunity to email the researchers and provide their name and address, with the assurance that it would be kept separate from their survey responses.

Instrument

The survey consists of 47 items, and contains four sections: demographics, knowledge of self-injury, experience and training in working with youth who self-injure, and knowledge of school response plans regarding self-injury. The survey is a modification of the survey used by Beld (2007) and Butts (2008). As Beld and Butts conducted surveys with school psychologists and teachers, minor modifications were made to some of the survey questions to ensure its appropriateness for use with school counselors. Questions 1 through 12 assess demographics, and specifically ask for age, years of experience, highest degree obtained in the field, age group/setting the counselor works with, and the location and size of the school district in which they are employed. Questions 13 through16 assess knowledge of self-injury, and utilizes Jeffrey and Warm's (2002) 20-item questionnaire containing facts and myths about the causes and nature of self-injury. Jeffery and Warm cite a sufficient internal consistency on this measure of NSSI knowledge, with a reported Cronbach's alpha coefficient of .75 and a split-half reliability of .84. Subsequent studies using Jeffrey and Warm's (2002) measure of NSSI also report adequate levels of internal consistency, with coefficient alphas of .69 (Beld, 2007) and .71 (Butts, 2008). Questions in this section cover topics such as psychopathology, suicide, and associated features, and are formatted on five-point Likert-type Scale (*strongly agree, agree, unsure, disagree, and strongly disagree*). Beld (2007) added several more questions to those developed by Jeffrey and Warm (2002) to reflect more current understandings, these questions address the topics of age of onset, prevalence, media influence, and relationships to psychopathology. These questions are formatted on the same five-point Likert-type scale used for the Jeffrey and Warm items.

Questions 17 to 36 are intended to assess experience and training in working with youth who self-injure, and questions 37 to 47 assess knowledge of school response plans regarding self-injury.

Results

This section presents the survey data and analyses addressing the hypothesis and research questions one, two, and three. It provides descriptive statistics and analysis of demographic variables addressing training, knowledge, experience and school response patterns. Additionally, hypothesis one's mean group score is compared to the mean group score for school psychologists (Beld, 2007) and teachers (Butts, 2008).

Response Rate

The first email survey invitation was sent the last week of May 2010 to 190 Kentucky resident ASCA members who comprised the pool of potential respondents. A total of 25 emails were undeliverable, due to invalid email addresses, leaving 165 potential respondents. One week later a reminder about the survey invitation was sent, and the following week respondents received a final reminder about the survey invitation two days prior to the survey's closing. Data collection ended on June 11th, 2010. A total of 90 respondents returned a survey. Several returned surveys were unusable, 14 were excluded due to lack of response on the Jeffrey and Warm items, and three were excluded because respondents indicated they were students, and had no experience working as a school counselor. Of the remaining 73 remaining usable surveys, 40 respondents (54.8%) indicated they resided and worked as a school counselor in a state other than Kentucky, while 33 respondents (45.2%) indicated they resided and worked as counselor in Kentucky. The 33 respondents from Kentucky were used to determine response rate, as these were the individuals who received a personal email invitation to participate in the survey, while the remainder of respondents accessed the survey through ASCA's SCENE

forum. The response rate for the survey is 20% with 33 participants out of 165 returning a completed and valid survey.

Hypothesis One

To test the first hypothesis, that school counselors will evidence greater level of knowledge about NSSI than school psychologists and teachers, a knowledge score was computed based on responses to the first 20 items included in question 16 which are the knowledge items used by Jeffrey and Warm (2002). A knowledge score was computed for these items by assigning a value to the Likert-type scale responses (1-*strongly disagree*, 2-*disagree*, 3-*unsure*, 4-*agree*, 5-*strongly agree*). Possible scores could range from a minimum of 20, to a maximum of 100, with higher scores reflecting more accurate knowledge. To control for the response set, 10 items within the set were reverse scaled and recoded so that all accurate responses resulted in high scores. A reliability analysis for this measure yielded strong results, with a Cronbach's alpha of .718. School counselors' knowledge scores ranged from 64 to 93, with a mean knowledge score of 76.9. An independent samples *t*-test compared the school counselor mean knowledge score to the mean knowledge scores obtained by school psychologists (Beld, 2007) and teachers (Butts, 2008). Table 3 contains descriptive data for sample and comparison groups knowledge scores. The sample mean of 76.9 (*SD* = 5.87) for school counselors was not significantly different from the school psychologist mean of 78.08 (*SD* = 6.11), $t(62) = -1.58$, $p = .117$. An independent samples *t*-test was also computed for school counselor and teacher mean knowledge scores. The sample mean of 76.9 (SD = 5.87) was significantly higher than the teacher mean of 68.83 (SD=6.23), $t(62) = 10.91$, $p = .01$. The computed Cohen's *d* for this mean difference was 1.33, indicating a large effect

size. School counselors evidenced greater levels of knowledge about NSSI than teachers, although their knowledge scores were not significantly different from school psychologists; therefore, the hypothesis is partially supported.

Table 3

Descriptive Statistics of Knowledge Score

Group	Knowledge Score Mean	Range	Standard Deviation
School Counselors (*n* = 73)	76.9	64-93	5.87
School Psychologists (*n* = 173)	78.08	67-95	6.11
Teachers (*n* = 578)	68.83	52-89	6.23

Note. Knowledge score was derived by summing responses to Jeffrey and Warm's 20 questions on NSSI (1-strongly disagree, 2-disagree, 3-unsure, 4-agree, 5-strongly agree) with a potential score range of 20-100.

To investigate the NSSI knowledge of respondents, the response patterns on Jeffrey and Warm's 20-item knowledge measure of accurate statements and myths about NSSI were individually examined. Myth items within this measure were recoded, so that response codes of 4 and 5 reflected an accurate understanding of NSSI, and response codes of 1, 2, or 3 reflected inaccurate or unsure understanding of NSSI. The groups' knowledge of each item was then classified as good, problematic or poor. A 70% criterion set by Beld (2007) was used. An item evidencing 70% accurate understanding

was classified as evidencing good understanding, items evidencing 70% inaccurate understanding was classified as poor, and items that did not reach 70% accuracy were classified as problematic. Eight items (40%) were classified as problematic, indicating that the sample evidenced some inaccuracies in NSSI understanding regarding these items. Items classified as problematic included statements regarding psychopathology, functions of NSSI, and associated features/risk factors of NSSI. A total of 12 items (60%) were classified as good, indicating that the sample evidenced an accurate understanding of NSSI regarding these items. No items were classified as poor, indicating that the sample evidenced at least 30% or greater accurate responses to all items. Table 4 contains the accuracy percentages and classification for all statements on the Jeffrey and Warm 20-item knowledge measure.

Table 4

Accuracy of Understanding of NSSI

Question	Mean	Understanding	
		Inaccurate[a]	Accurate[b]
Good Understanding of NSSI[c]			
SI is a form of communication.	4.14	8.2%	91.8%
SI can provide a feeling of staying in control.	4.27	2.7%	97.2%
SI can provide a distraction from thinking.	4.10	2.8%	90.4%
People who self-injure can obtain feelings of euphoria.	4.07	15.3%	83.6%

Table 4 (cont.)

Question	Mean	Understanding: Inaccurate[a]	Understanding: Accurate[b]
SI is a woman's problem.	4.37	4.1%	95.9%
Good Understanding of NSSI[c] (cont.)			
SI can provide a release for anger.	4.17	6.8%	90.4%
The best way to deal with people who self-injure is to make them stop.	3.96	19.2%	80.8%
SI is an expression of emotional pain.	4.36	1.4%	97.3%
SI is a failed suicide attempt.	4.24	8.3%	90.4%
SI can provide the individual with a way to deal with problems.	3.81	20.8%	78.0%
SI is a coping strategy.	4.17	4.2%	94.5%
Self-injurers suffer from Munchausen's Disease (self-inflicted injuries performed to produce specific symptoms that will lead to hospital admissions).	3.81	30.0%	70.0%
Problematic Understanding of NSSI[d]			
Self-injury is a sign of madness/mental illness.	3.51	41.1%	58.9%
People who self-injure will eventually grow out of it.	3.75	34.7%	64.4%
Self-injury is usually a manipulative act.	3.26	53.4%	46.6%
People who self-injure have been sexually abused.	3.52	42.5%	57.5%

Table 4 (cont.)

Question	Mean	Understanding: Inaccurate[a]	Understanding: Accurate[b]
Problematic Understanding of NSSI[d] (cont.)			
Self-injury is attention seeking.	2.89	67.1%	32.9%
Self-injury helps a person maintain a sense of identity.	3.30	53.5%	45.2%
Self-injury provides escape from depression.	3.23	52.1%	48.0%
People who self-injure need psychiatric hospitalization.	3.65	36.1%	63.1%

Note. Frequencies derived from rescaling the 5-point Likert-type scale (1-strongly disagree, 2-disagree, 3-unsure, 4-agree, 5-strongly agree) into two groups, Inaccurate and Accurate.

[a]Inaccurate (responses 1, 2, or 3)

[b]Accurate (responses 4 or 5)

[c]Good Understanding of NSSI = Accurate frequencies ≥ 70%.

[d]Problematic Understanding of NSSI = Inaccurate or Accurate frequencies <70%

Research Question Two

To address research question two (What are the training needs of school counselors in regard to NSSI?), descriptive statistics were used to analyze and look for

patterns. Survey questions 20 to 35 inquired about respondents perceived levels of knowledge, experience, confidence, and comfort, as well as training needs and school response to NSSI.

Perceived Experience and Knowledge. Questions 20 to 27 inquired about participants' experiences in working with individuals who engage in NSSI, as well as their perceptions about their own levels of knowledge in regard to NSSI. The largest response category (41.1%) indicated that they first became aware of self-injury through experience working with a student who engaged in the behavior. Other ways participants reported first becoming aware of self-injury were through a lecture/training session (19.2%), the media (15.1%), acquaintance/colleagues (13.7%), journal/professional newsletter (2.7%), and students or youth (2.7%). One participant reported having no prior knowledge of self-injury.

When reporting primary sources of obtaining information about self-injury, 32.9% reported lecture/training sessions, 20.5% reported journal/professional newsletters, and 24.7% reported experience working with youth who self-injure. Less frequently reported methods of obtaining information included acquaintances/colleagues (9.6%), the media (8.2%), and students or youth (2.7%). One individual reported his or her primary source of information was books about self-injury.

More than one-third (34.2%) of respondents reported never having a student directly report self-injury within the last school year (2008-2009). All participants report at least one instance of being contacted by another person about a youth engaging in self-injury. One-quarter of respondents reported being contacted 1-2 times, more than 60% report being contacted 3 to 5 times, and 15% report being contacted 6 or more times

about a youth engaging in self-injury. Table 5 provides descriptive statistics regarding types of self-injury seen by or reported to participants. The methods of self-injury participants most report seeing are cutting (86.3%) and scratching (64.4%). Figure 1 illustrates participants' rankings of the three most common types of self-injury seen or reported, and the largest response categories rated cutting as the most common, and scratching as the second most common.

When self-rating levels of knowledge, over 90% of respondents indicated being somewhat knowledgeable or knowledgeable about self-injury, and that they are aware of it in the popular media, may have talked with other professionals about self-injury, may have read scholarly work on the topic, attended a training, and/or had experience working with someone who self-injures. Only 4% of respondents indicated they "know nothing" about self-injury, and conversely, 4% indicate being "very knowledgeable" in that they have attended multiple trainings, and read extensively on the topic.

Additionally, the majority of participants (72.6%) indicated they would be able to recognize the signs of self-injury in a student. One respondent indicated that he or she would not be able to recognize the signs of self-injury, while 26% indicated they were unsure about being able to recognize the signs of self-injury in a student. When respondents indicated whether they felt they had the knowledge to know how to assist a youth who self-injures, over 93% indicated having the knowledge or abilities to do so, though they report they would likely seek additional supports. Two participants (2.7%) indicated that they didn't feel they had any knowledge at all, while only three participants (4.1%) indicated they had enough knowledge to assist a youth who self-injures.

Perceived Knowledge, Confidence, and Comfort. Questions 28 to 32 inquired about participants' perceived levels of confidence and comfort in working with individuals who engage in NSSI. When asked to consider how confident they would feel in working with someone who self-injures given their current levels of knowledge, 56.2% of respondents indicated they were only somewhat confident. Approximately 15% reported that they were "not confident at all." Approximately 20% reported being "confident," and only 8% reported being "very confident." When asked to consider

Table 5

Forms of Self-Injury Seen By or Reported to Participants

Form	N	Percent
Cutting	63	86.3
Scratching	47	64.4
Burning	25	34.2
Punching, hitting (self or objects)	25	34.2
Breaking bones	3	4.1
Pulling out hair	21	28.8
Picking at scabs to interfere with healing	32	43.8
Banging body parts on objects	8	11.0
Ingesting harmful materials	5	6.8
Other: Branding	1	1.4

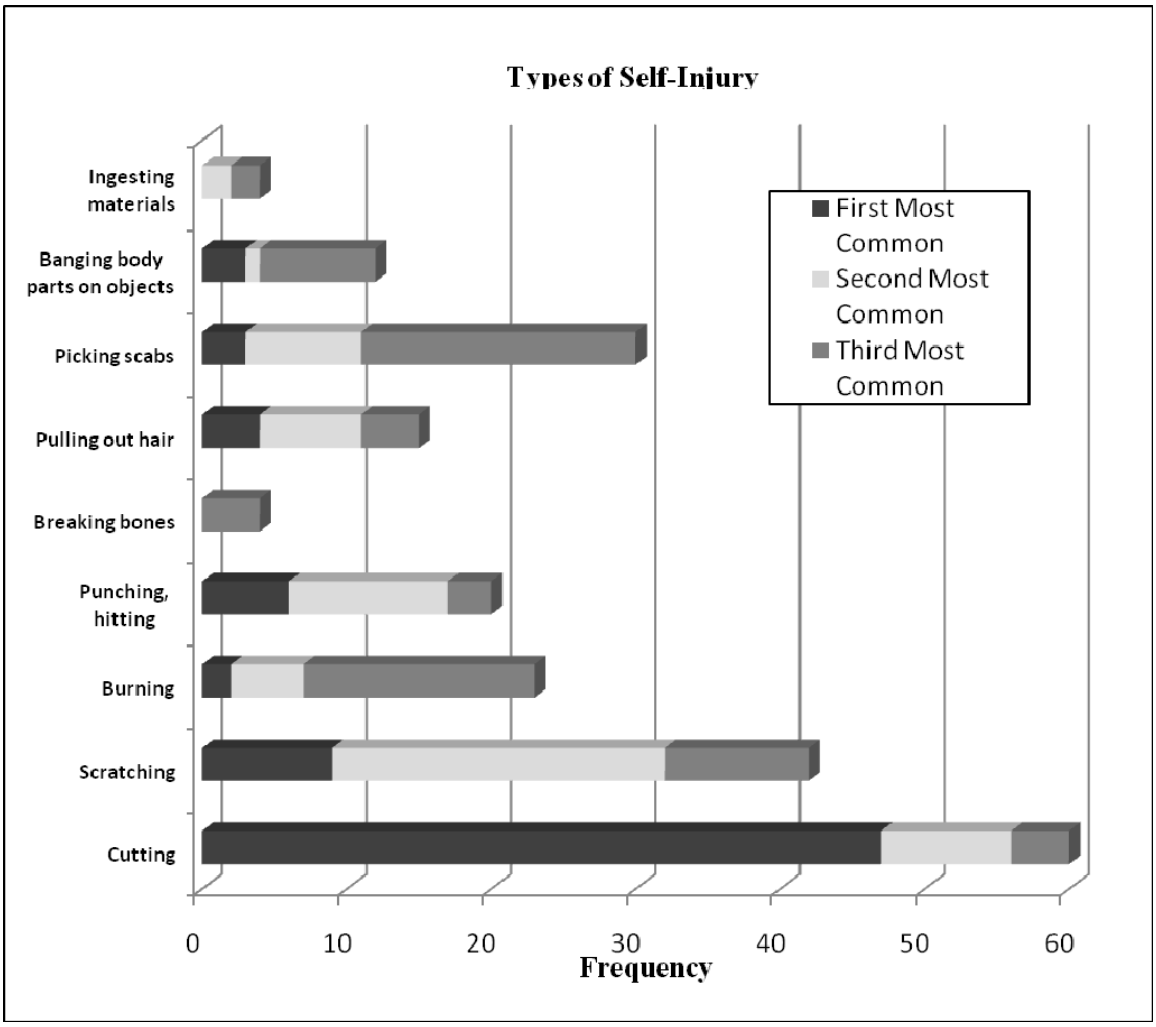

Figure 1. Rankings of common types of self-injury encountered by participants, ranked as first most common, second most common, and third most common (n = 73).

comfort level in working with someone who self injures, approximately 90% indicated feeling "comfortable" or "very comfortable" in working with someone who self-injures. Over 90% of respondents also reported being "comfortable" or "very comfortable" with the thought of self-injury, and that thinking or talking about the topic does not cause distress or discomfort. Just over half (54.8%) of respondents reported that they would be "confident" or "very confident" if asked to do an initial interview with a student referred for self-injury. Only three participants indicated that they would not be at all confident, while the remainder of the sample (41.1%) reported being only "somewhat confident" if conducting an initial interview. When asked what may help them to feel more confident in working with youth who self-injure, the majority (52.1%) indicated that more training on the topic would be most beneficial. Figure 2 provides more descriptive statistics regarding resources participants indicated would assist in increasing confidence in working with youth who self-injure.

Training Needs. Questions 33 to 35 inquire about participants' recent training, current resources, and perceptions of training needs. When asked to report on resources available in the schools, approximately three-quarters of respondents indicated having general crisis response training, training in general psychological issues, reading books on general psychological issues, reading articles about self-injury, having access to outside resources (e.g., local treatment groups, credible websites) and/or having access to

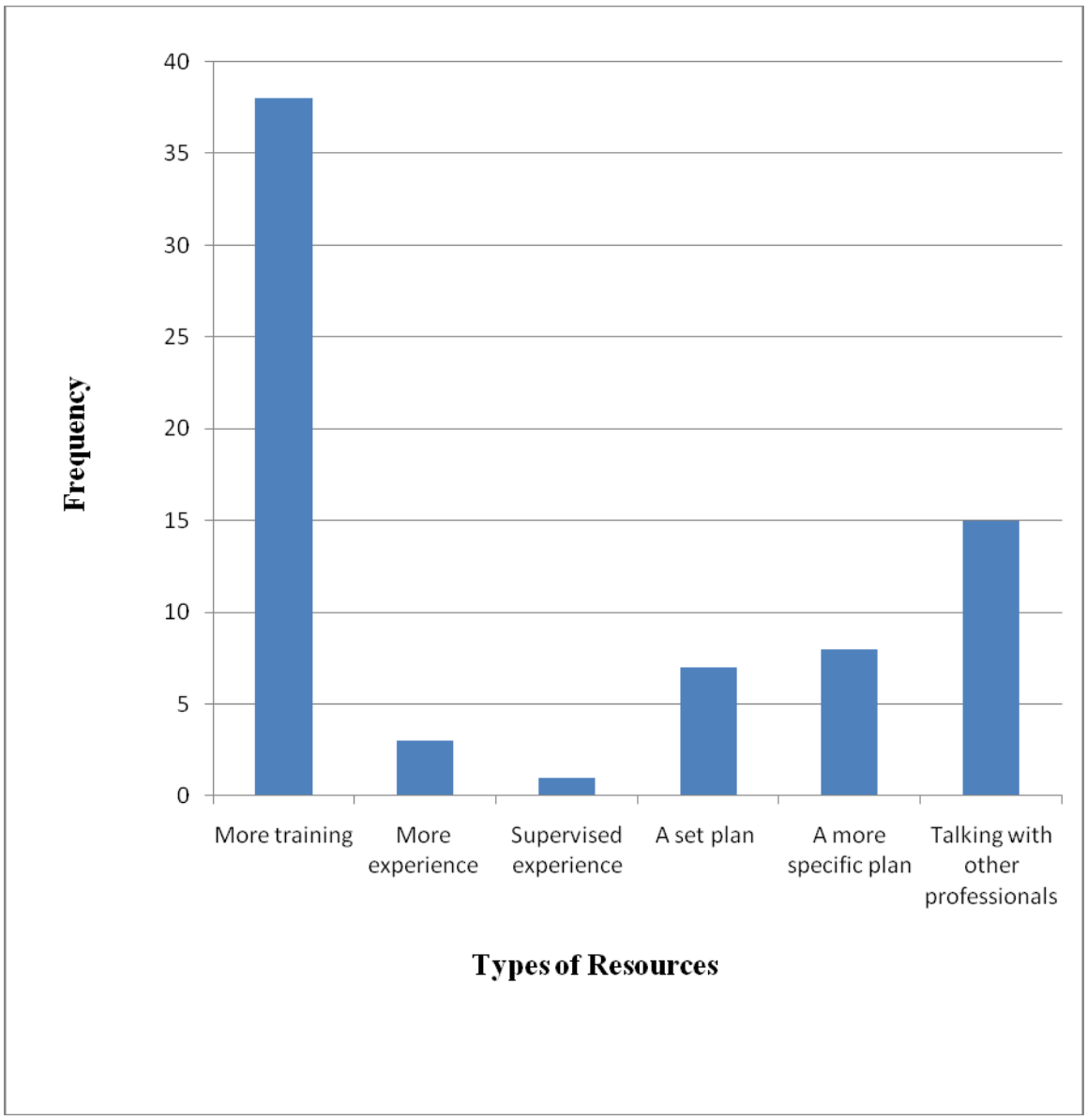

Figure 2. Resources identified by participants that would assist increasing confidence when working with youth who self-injure.

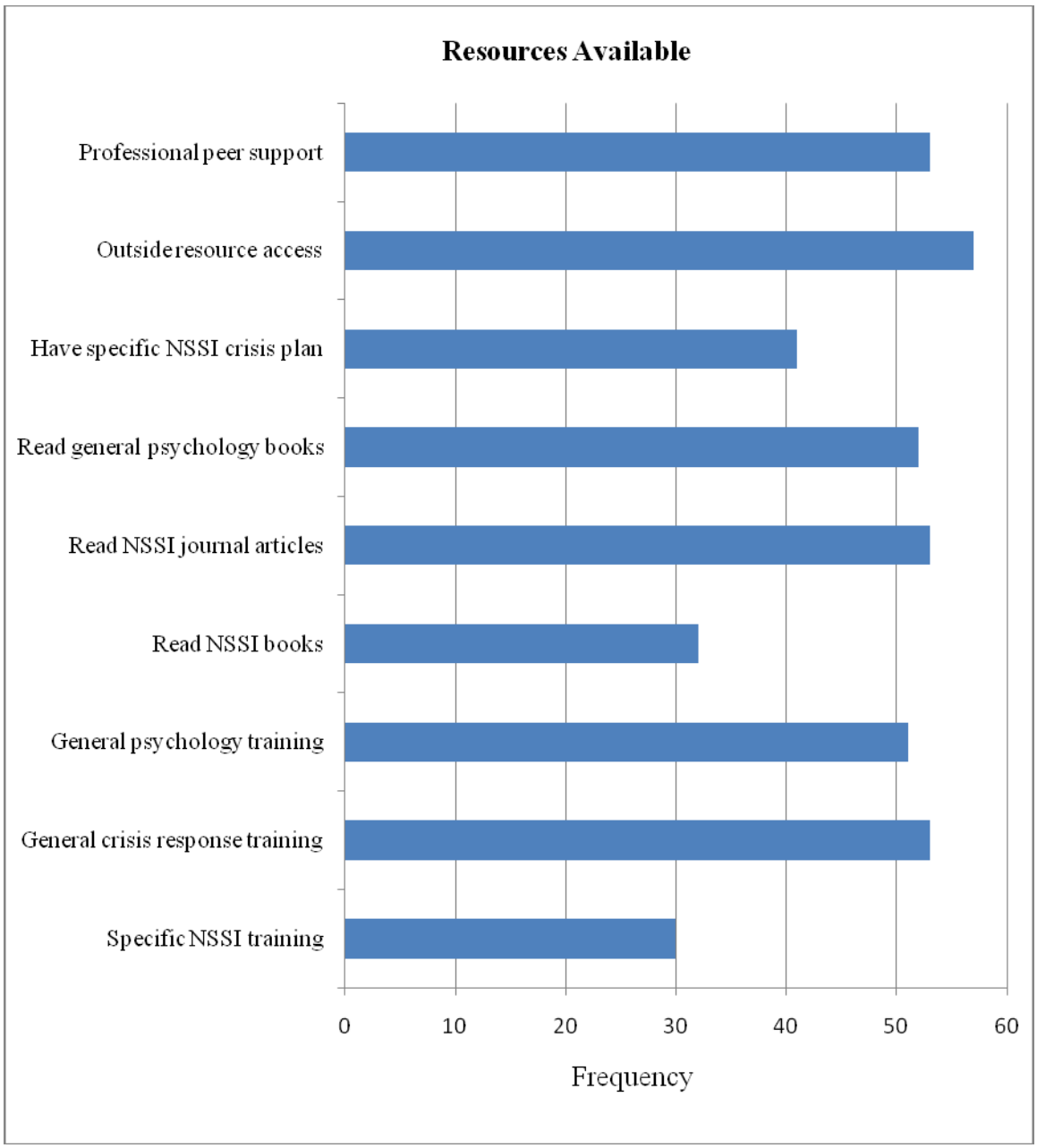

Figure 3. Training/Resources on NSSI currently available to participants (n = 73).

professional peer support. Figure 3 provides descriptive statistics regarding the types of training and resources respondents report are available to them in their schools.

In regard to recent training, approximately half of respondents report attending a training about self-injury within the last five years (19.1% within the last calendar year, 32.4% between one and five years ago). Over one-third (39.7%) of respondents report never having attended a training on self-injury. Figure 4 provides information about the most recent NSSI training attended by participants. When asked to provide information regarding interest in obtaining more training on the topic, the majority of respondents (65.7%) indicated being either "interested" or "very interested," 27.4% indicated being "somewhat interested," and only 6.8% indicated they were "not interested" in receiving training about NSSI.

Research Question Three

To address research question three (How do schools respond to NSSI?), descriptive statistics were again analyzed to identify trends and patterns. Survey questions 36 to 47 inquired about school response, professional response, protocol and policy, resources, and training opportunities in regard to NSSI. When participants were asked about the frequency of self-injury referrals they received, the majority (69.9%) indicated this occurs "very rarely" or "never," 17.8% reported receiving monthly referrals, and only 4.1% reported receiving weekly referrals. When asked about the primary role they play in working with students who self-injure, the largest response category (42.2%) was "refer student to a professional in the community." Respondents also reported contacting parents (21.9%), providing individual counseling (18.8%), and developing supports within the school (10.9%). Four respondents reported having no role

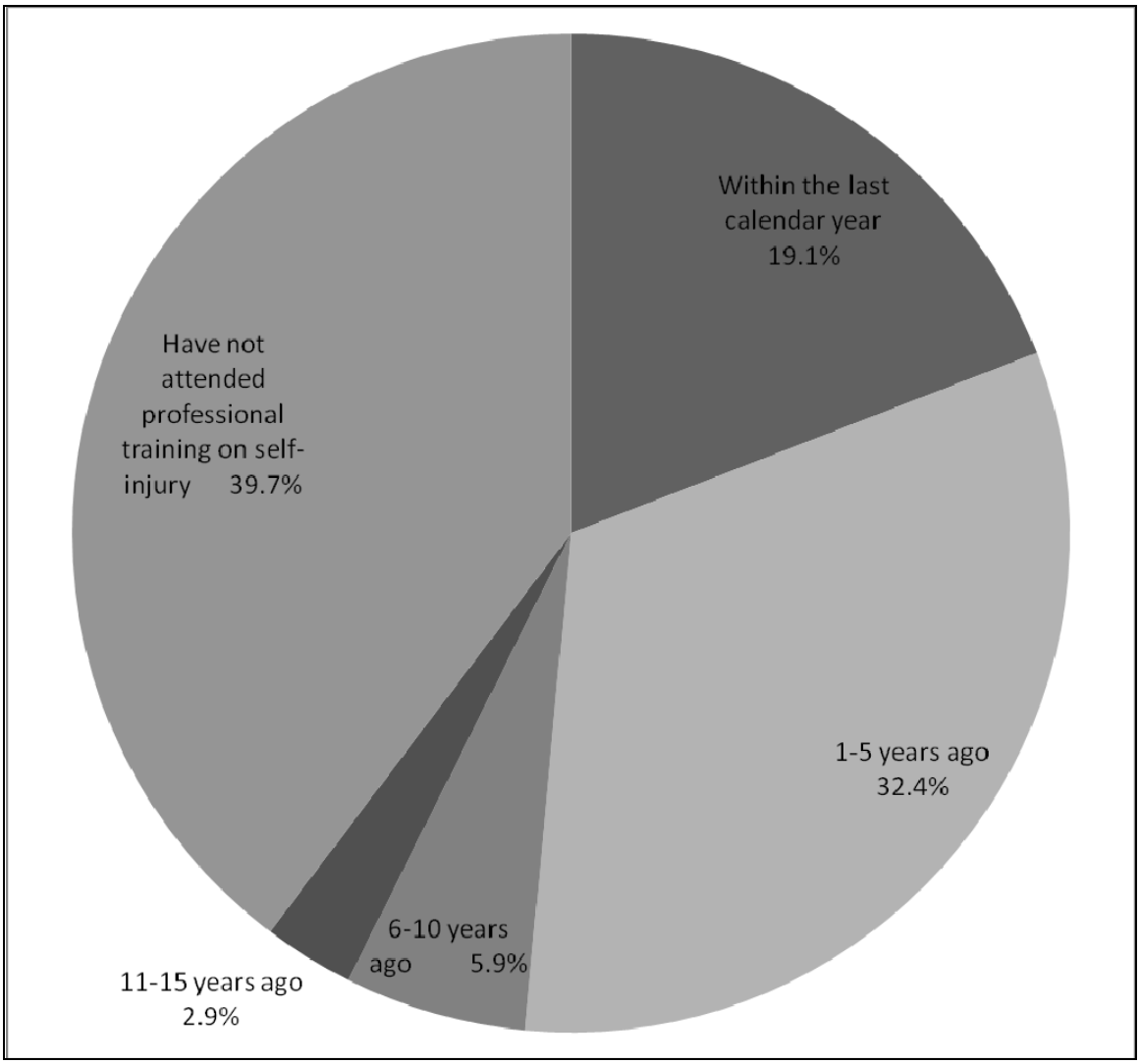

Figure 4. Most recent training on NSSI reported by participants (n = 68).

in working with students who self-injure. When reporting on what other professionals within their school play a role in working with students who self-injure, about half (50.7%) reported that there are no other professionals involved. Of those respondents who indicated that other professionals were involved in working with students who self-injure, the largest number of participants reported that school psychologists (30.1%) were involved, followed by school social workers (20.5%), school nurses (16.4%), another school counselor (9.6%), and school therapists (6.8%). Four respondents (5.5%) indicated they did not know what other professionals in their school were working with students who self-injure.

In regard to the type of response plan districts have for students who self-injure, half of the respondents indicated that they did not know if their district had, or did not have a plan. Only 4.8% indicated that their district had a specific response plan for students who self-injure, and the remaining 44.4% indicated that a generic crisis response plan was in place. Of those respondents who indicated having a specific NSSI response plan, 18.8% indicated they had created on their own, and 29.7% indicated it was created by the school/district. Of those who reported using a response plan designed by the school, 17.2% indicate it was design by a school committee with mental health involvement, and 5.2% indicate it was designed by another individual. Another 5.2% of respondents report that this plan was designed by a school committee without any mental health involvement, and 17.2% of respondents do not know who designed their response plan. When reporting on the actions included in these response plans, the most often reported components included assess/talking to the student (60.3%), calling

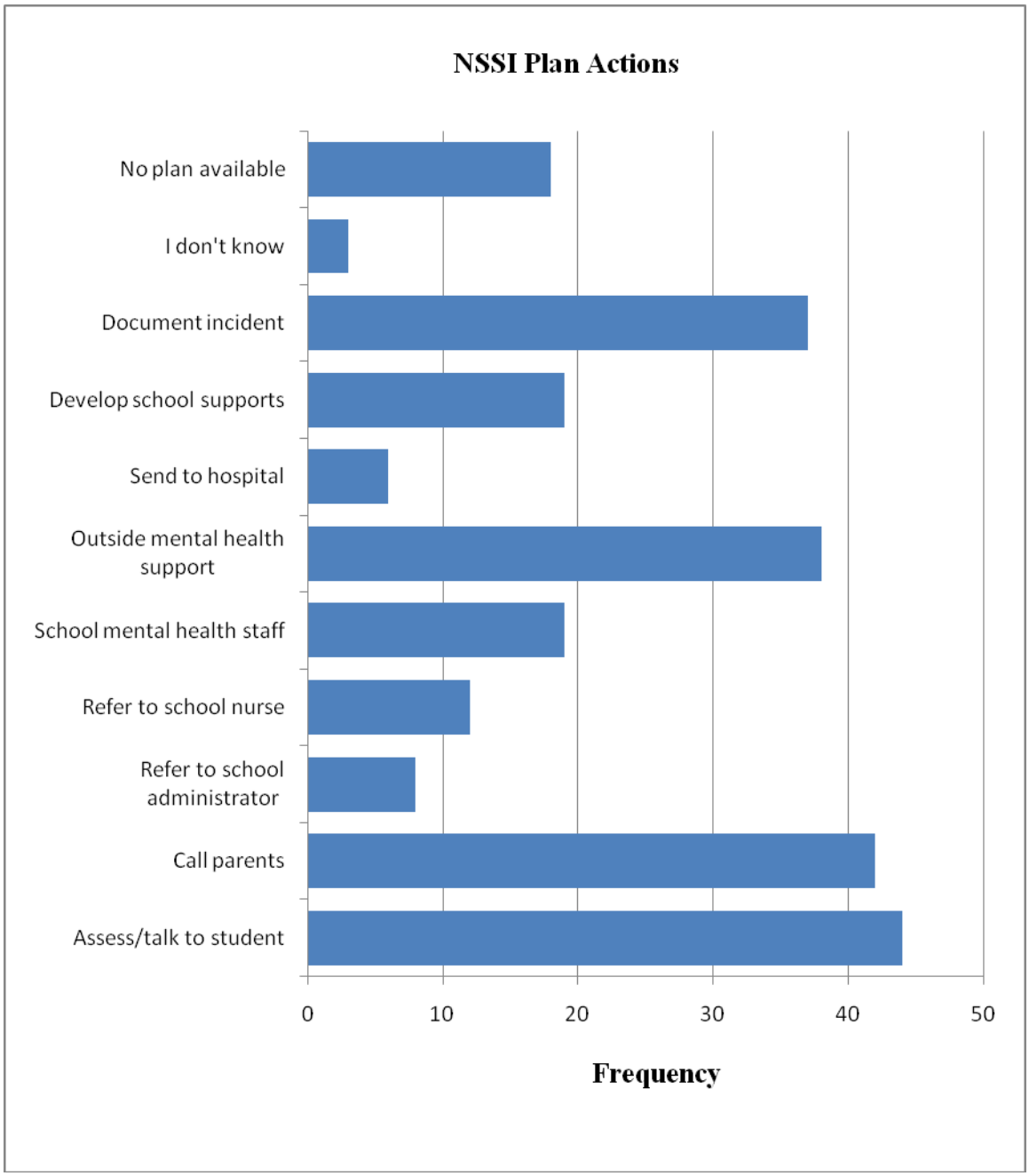

Figure 5. Actions included in school NSSI response plans.

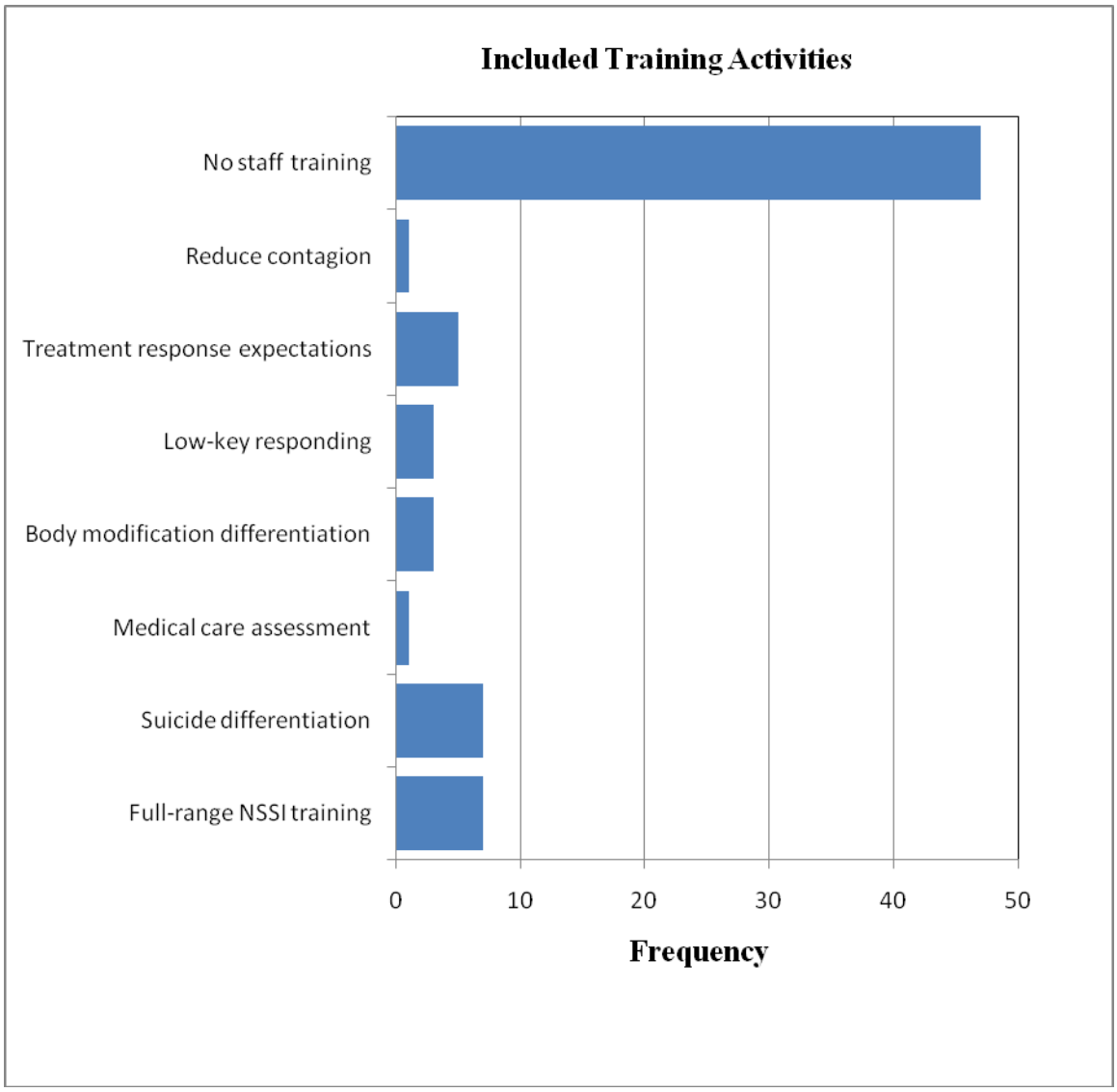

Figure 6. Activities included in schools' NSSI training.

parents (57.5%), encouraging outside mental health support (52.1%), and documenting the incident (50.7%). Figure 5 includes which actions participants indicated are a part of their school NSSI response plan. When reporting activities included in staff training on self-injury, the majority (64.4%) reported that there had been no staff training on self-injury. Only 9.6% of respondents report receiving a full range of training on self-injury. Figure 6 includes the activities participants indicated are a part of their school NSSI training.

In regard to training on reducing contagion, the majority of participants (94.0%) again report no such training, while only 6.0% report training on how to reduce communication about self-injury among peers. No respondents reported training regarding reducing public exhibition of wounds, or how to approach individual or group therapy.

The last item on this survey was an open response question which inquired about any additional issues school counselors felt were relevant or important to comment on. Comments provided by respondents expressed the need for more training in this area (including universal training for all staff), and more specific plans developed by individuals with mental health training; as well as concern about NSSI becoming more prevalent, presenting at earlier ages, the contagious nature of the behavior, and a lack of research of NSSI in regard to gender.

Discussion

The current investigation examined school counselors' perceptions and levels of knowledge in regard to NSSI, existing school prevention efforts and protocol, and resources and training opportunities available.

Hypothesis One

The hypothesis stated that school counselors will evidence greater level of knowledge about NSSI than school psychologists and teachers. This was tested by comparing the knowledge score obtained by school counselors to the knowledge score of school psychologists (Beld, 2007) and teachers (Butts, 2008). The hypothesis was partially supported in that the school counselor knowledge score was significantly higher than the teacher knowledge score, but not the school psychologist knowledge score.

One explanation for the outcome of the hypothesis is that school counselors and school psychologists have similar levels of knowledge on this topic, and may have similar content included in their program curriculums, field experience, and/or professional development requirements and opportunities. The Hypothesis rationale stated that because school counselors' primary role tends to involve direct intervention and counseling services, they spend a greater percentage of time in direct contact with students, thus making it more likely that they have had experience working with a student who self-injures. While school psychologists also spend time in direct contact with students, their position requirements are generally not centered primarily on direct counseling intervention services as is the case with school counselors (Froeschle & Moyer, 2004; White Kress, 2004; White Kress, 2006). The current finding does not

support this rationale, and rather, supports the two groups as holding similar levels of knowledge about NSSI.

Another possible explanation for school counselors and school psychologists obtaining similar knowledge scores could be due to the small school counselor sample size. A total of 73 school counselors returned completed and usable surveys, which was much lower that the school psychologist (n = 173) and teacher sample sizes (n = 578). Scores obtained from this small sample of school counselors may not be a reflective of the general school counselor population. Additionally, this sample was not a random sample of counselors, and there may have been a self-selection bias present for the school counselor sample that accessed the survey through the SCENE network.

There were also several characteristics of this sample that may have had bearing on the obtained knowledge score. One such characteristic was the reported years of experience. This sample of school counselors reported being relatively new to the field of school counseling, in that 82.2% reported have five or less years of experience. Although Beld (2007) notes this was a characteristic shared by the school psychologist sample, the number of school counselors who reported having five or less years of experience was much greater than the 34.9% of school psychologists who reported five or less years of experience. The school psychologist sample was overall more experienced than the school counselor sample, as such; the obtained knowledge scores for these groups may have been reflective of these sample characteristics. Additionally, because the years of experience reported by this sample were highly homogenous, it may not be reflective of the years of experience generally held by the school counselor population.

When considering the qualitative information obtained by sorting items into good, problematic, and poor classifications, school counselors' response patterns and classifications were fairly similar to those of school psychologists. School counselor responses did not indicate that there was a poor understanding of any items, while school psychologists' answers indicated a poor understanding for only one item. School counselors' answers indicated good understanding of 12 items, and problematic understanding of 8 items. School psychologists' answers indicated good understanding of 14 items, and problematic understanding of five items.

Research Question One

The first research question was intended to investigate how knowledgeable school counselors were about NSSI, and investigated what inaccuracies, if any, they held about the topic. While school counselors did not obtain a score significantly higher than school psychologists in Beld's (2007) study, school counselors still performed relatively well on the knowledge measure. The sample mean score was similar to the mean score Beld (2007) obtained for school psychologists (school counselor mean = 76.9; school psychologist mean = 78.08). The sample mean score was also similar to the mean scores obtained by Jeffrey and Warm (2002) for psychology workers (79.37), social/community workers (77.16) and self-harmers (79.81). Overall, their responses indicated that that school counselors performed similarly to other mental health professionals, and hold accurate knowledge about the majority of the items contained on the knowledge measure.

When using the 70% criteria set by Beld (2007) to classify items as good, problematic, or poor (good = $\geq$ 70% accurate; problematic = $<$ 70% accurate $\geq$ 70% inaccurate; poor = $\leq$ 30% accurate), items responses indicated accurate beliefs about the

majority of the knowledge measure items; as 12 items (60%) were classified as good and no items were classified as poor. Several items indicated the presence of inaccurate beliefs, as eight items (40%) were classified as problematic. The items classified as problematic inquired about NSSI in regard to relationship to psychopathologies, functions, associated features and risk factors.

Over half of the items (62.5%) identified as problematic for school counselors were also identified as problematic or poor for school psychologists, with responses indicating that both school counselors and school psychologists may hold the inaccurate beliefs that self-injury is a manipulative act, is always preceded by sexual abuse, does not help individuals maintain a sense of identity, and does not provide an escape from depression. Items regarding sense of identity, manipulation, escape from depression, and sexual abuse only emerged as problematic due to a high amount of respondents selecting "unsure," indicating uncertainty or lack of clarity rather than the presence of false beliefs. Both groups evidenced a high amount of inaccuracy regarding the belief that self-injury is attention-seeking, as this item emerged as poor for psychologists, and only 32.9% of school counselors responded accurately.

While the majority of problematic items for school counselors were similar to that of school psychologists, school counselors also evidenced inaccurate beliefs in regard to several items about the relationship of NSSI to psychopathology. While the majority of participants provided a correct answer, and disagreed with the statements "Self-injury is a sign of madness/mental illness," "People who self-injure require psychiatric hospitalization," and "People who self-injure will eventually grow out of it," more than one-third (36-40%) incorrectly reported agreement or uncertainty.

Overall, respondents demonstrated an accurate understanding of the general characteristics of NSSI. Many items that were classified as problematic were done so due to high amounts of uncertainty rather than the presence of false beliefs. Half of the items identified as problematic were related to the functions of NSSI. Qualitatively, responses to items indicated adequate knowledge about most statements contained on the knowledge measure, and quantitatively, scores on the knowledge measure were commensurate with scores obtained in other studies for mental health professionals.

Research Question Two

The second research question intended to investigate the training needs of school counselors, and examined what experience they have in working with youth who self-injure, as well as perceived levels of knowledge, confidence and comfort in regard to providing support for youth who self-injure.

Experience. The majority of respondents report having 0 to 5 years of experience as a school counselor. This may skew the survey results in a few ways. First, the fact that many of the respondents have obtained their degree and entered the field rather recently may make it more likely that training on NSSI was included as part of their curriculum, making their awareness and general knowledge on the topic greater. This is important, because a great deal of research on NSSI is still in emergent stages. On the other hand, since these counselors have spent a relatively short amount of time practicing, they may have little direct experience actually working with individuals who self-injure, and consequently, may perceive their knowledge as less, or feel less comfortable/confident with the notion of providing support for individuals engaging in self-injurious behavior.

All respondents indicated being contacted by someone in the school about a student who was self-injuring, and 64.2% report receiving a direct referral for self-injury. In short, school counselors are working with youth who self-injure. The largest group of respondents report first becoming aware of self-injury through experience working with a student who engaged in the behavior. This is important to note, because it indicates that many school counselors are encountering this behavior before receiving adequate training.

The importance of adequate training on this topic cannot be stressed enough. In this sample of school counselors, 94% indicated that there has been no staff training on self-injury, and over 40% report that their most recent training was either more than a decade ago or never. While, overall, this sample demonstrated adequate knowledge of self-injury in many respects, there were many items in which they indicated uncertainty or false beliefs. The most problematic item, and perhaps the most alarming, stated that "Self-injury is attention seeking." Only 32% of respondents answered this item correctly. This is similar to what was found by Beld (2007), as almost 30% of school psychologists also answered this item incorrectly. Seven other items emerged as problematic, four of which were also found to be problematic by Beld. Both groups evidenced a number of inaccurate beliefs regarding NSSI, suggesting that the problem of inaccurate knowledge is not specific to one profession, but rather more of a systemic problem stemming from inadequate training. This conclusion is supported in the fact that 94.4% of respondents report that their schools have never held a training about NSSI. In order to remedy this lack of training, schools must first understand the significance of the problem.

Confidence and Comfort. While the majority (72.6%) of respondents indicated they felt confident in being able to recognize the signs of self-injury in a student, over 70% of respondents indicated they were not confident at all, or only somewhat confident in their ability to work with someone who self-injures. Additionally, while over 90% of respondents also reported being "comfortable" or "very comfortable" with the thought of self-injury, and that thinking or talking about the topic does not cause distress or discomfort, but more than 45% reported that they would be only somewhat confident or not confident at all in just conducting an initial interview of a student who engages in self-injury.

A large number of participants report being knowledgeable, comfortable and confident with their abilities to deal with self-injury indirectly (thinking about it, recognizing the signs of the behavior), although there is a lack of confidence in abilities in regard to providing direct support to the individual engaging in the behavior. School psychologists also indicated a high degree of confidence in regard to dealing with self-injury directly, though 84% indicated some degree of discomfort in regard to providing direct support to students who self-injure (Beld, 2007).

Training. When given the choice between six different resources that may increase confidence in working with youth who self-injure, over half of respondents indicated that more specific training on self-injury would be the most beneficial, and over 93% of respondents indicated interest in obtaining further training on the topic. Providing additional training and resources for school counselors working directly with students who self-injure was not only identified by the largest group of respondents, this is also identified by other researchers as being effective in increasing confidence and comfort in

supporting students (Clarke & Whittaker, 1998; Crawford et al., 1998; Huband & Tantum, 2000).

Training is necessary to dispel the presence of inaccurate knowledge, which can easily lead school counselors to respond inappropriately when working with someone who self-injures. Comprehensive understanding of the characteristics, functions and associated features of self-injury is necessary to ensure that decisions are being made based on correct information. School counselors must not only possess this comprehensive understanding in order to provide sensitive and efficacious support, but also be capable of thorough assessment and appropriate identification of functions, client needs, and the level of risk in regard to suicide (White Kress, 2003).

Research shows that professionals with a poor understanding of self-injury can actually do more harm than good in providing support to an individual who self-injures, in that inappropriate or insensitive responses to self-injurious behavior can actually reinforce negative emotions, perpetuate the cycle of harming, and makes seeking future treatment less likely (Clarke & Whittaker, 1998; Huband & Tantum, 2000). Additionally, research shows that increased training and education can significantly decrease the presence of inaccurate knowledge, as well as increase clients reported levels of satisfaction with their treatment (Crawford et al., 1998; Jeffrey & Warm, 2002).

In regard to resources accessible in the schools, the majority of participants report general training in crisis response and psychological issues, reading books or articles about general psychological issues, and having access to outside resources. While these are important resource to have, none of them involve specific training about NSSI, as is suggested (Jeffrey & Warm, 2002; Lieberman & Poland, 2007; Warm et al., 2002).

Research Question Three

The third research question was intended to investigate school response, professional response, protocol and policy, and resources. Participants in this study indicated that the primary role they serve in working with students who self-injure is to refer them to a professional in the community, contact parents, and in some cases provide individual counseling and develop academic supports. Over half of participants also indicated that they are solely responsible for working with self-injury cases that arise within their school. While schools are holding their school counselors responsible for working with students who self injure, they are not providing the training and resources necessary for efficacious support of these students. As previously mentioned, 64.4% report no staff training of any kind in regard NSSI. Less than 10% report receiving full-range training, as recommended by researchers (Lieberman & Poland, 2007; Walsh, 2006). Over half of participants did not know if they had a specific response for self-injury, and the other half indicated that the response plan was generic. Perhaps what is most alarming is that of these generic response plans, only 36% were created with the input of staff with mental health training. Beld (2007) and Butts (2008) report similar survey responses, and that the majority of respondents received no training at all, or were only trained about generic psychological issues.

Walsh (2006) proposes a comprehensive protocol for schools in regard to response to self-injury, and suggests that this begins with staff training on the full range of self-injurious behaviors. Staff should also be trained on how to differentiate NSSI from suicide, identify wounds that require immediate medical care, and to differentiate NSSI from body modification. Staff should also be trained to respond in a low-key tone

which portrays "respectful curiosity" (Walsh, 2006, p. 245). Lastly, Walsh states that staff should understand the complexity of the behavior, and that many environmental, social, and biological components play a role.

Lieberman and Poland (2007) provide additional insight about school response to self injury, and begin by recommending that schools adopt well-developed crisis plans that specifically address response to self-injury. They also suggest training for staff on how to recognize signs of self-injury, as well as implementing an evidenced-based prevention program that promotes effective communication and positive relationships while addressing physical and/or mental health risks commonly faced by youth today (e.g., substance abuse, bullying, depression, suicide, and, most importantly, help-seeking skills). Similar to Walsh (2006), Lieberman and Poland (2007) also recommend universal, full-range training on NSSI for all staff.

Limitations

One limitation of this study was the low response rate, which was 20%. The 33 respondents from Kentucky were used to determine response rate, as these were the individuals who received a personal email invitation to participate in the survey. The remaining 40 respondents accessed the survey through ASCA's SCENE forum. A possible explanation for this response rate could be the timing of the survey, as it was sent out at the end of May when many schools are approaching the end of the school year. Additionally, there may have been a lack of time to complete the survey, as often times the end of a school year may be one of the busiest times for school staff. Lastly, this low response rate could have been due to simple lack of interest in the topic. The

low response rate limits the amount one may be able to generalize the survey results to all school counselors.

Another limitation of the study was the years of experience reported in the sample demographics. The vast majority of respondents reported 0 to 5 years of experience in school counseling. This relatively short amount of time practicing as a counselor may make it less likely to have had experience working with NSSI, therefore possibly affecting perceived levels of confidence in comfort in providing treatment. Additionally, the years of experience likely do not reflect the typical years of experience held by all school counselors, once again making generalizability limited.

A third limitation of this study is that the survey demographic questions did not inquire about respondents' gender, therefore further limiting generalizability, in that there is no information regarding how accurately or inaccurately the sample gender distribution may reflect the gender distribution of the population. Additionally, no information could be obtained regarding differences in knowledge or experience as related to gender.

Practical Implications

One implication of this study is that school counselors generally have high levels of knowledge about NSSI. This specific knowledge about self-injury, combined with their history of mental health training makes school counselors a useful resource in the schools they serve.

Although school counselors demonstrated adequate knowledge in many areas, several inaccuracies and uncertainties still emerged in their response. School counselors may benefit from more specific or comprehensive NSSI training in regard to

functions, psychopathology, and associated features/risk factors. Additional training in these specific areas may decrease the amount of uncertainty reflected in participants' answers, and increase levels of confidence in regard to providing direct support to students who self-injure.

Respondents also indicated that the need for specific and comprehensive school response plans is very large. This is not only apparent in survey responses, but also expressed by participants in additional comments provided on an open-response item. In the majority of cases, school response components that need to be included in a plan are not present. Specific components that need to be a part of response plans include universal training, detailed crisis response plans, prevention programs, and specific training for mental health staff on comprehensive assessment and appropriate responses.

Further Research

Further research might focus on investigating school-wide prevention for NSSI, and may seek to find a universal prevention program effective in decreasing instances of NSSI, while not outwardly targeting NSSI as a behavior in order to guard against contagion. Researchers may also work towards a more universally accepted definition of NSSI in order to allow more concise information to be gathered regarding prevalence and co-occurring psychopathologies. Additionally, information gathered from the 20-item knowledge measure indicated inconsistencies and uncertainty in regard to the association of NSSI to psychopathologies, environmental risk factors, and functions of the behavior, suggesting that it may be beneficial to offer more thorough training about NSSI features to school staff.

A few participants' comments suggested further research in regard to how self-injurious behavior presents in males. The majority of comments provided by participants indicated that training was either very inadequate or nonexistent, and expressed a need for more training and resources in the future. Future research may seek to address this issue, in order to provide schools with additional information about the needs of their school counselors. Lastly, future researchers may consider resurveying school counselors in order to obtain a larger, more representative sample, in order to increase generalizability from the school counselor sample to the school counselor population.

In conclusion, while the small sample size makes generalizability of the results questionable, the study did inform researchers about the lack of training for school staff about NSSI, as well as specific areas of knowledge which could present as problematic for school counselors and their ability to provide efficacious support for students who self-injure.

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Appendix A

Approval Email

Re: Member Directory & Appropriate Usage
Kathleen Rakestraw [krakestraw@schoolcounselor.org]
You replied on 3/12/2010 1:48 PM.
Sent: Friday, March 12, 2010 9:36 AM
To: Amy Reed

Other students have used the directory for this purpose as well, so you're fine.

You might also want to post a link to it in the SCENE as well. We have a discussion forum called Survey Research Requests specifically for this purpose.

_____
Kathleen Rakestraw
krakestraw@schoolcounselor.org
Director of Communications
American School Counselor Association
(703) 864-8734
(703) 242-9351, fax

On Mar 12, 2010, at 10:29 AM, Amy Reed wrote:

Ms. Rakestraw,

I am hoping you can provide some insight on something for me. I am a graduate student and member of the ASCA, and would like to use the ASCA member directory to access a school counselor population for thesis research. I am unsure if this would be considered appropriate/ethical use of the directory in the eyes of the ASCA. The contact would include an electronic link to my survey of school counselor's knowledge, training and needs in regard to self-injury in the schools. If using the member directory is not plausible, would it be appropriate to post this survey link to the SCENE networking forum? Thank you for your time and consideration thus far!

Amy Reed
Western Kentucky University
School Psychologist Intern
SPEED S.E.J.A District #802
Crete-Monee District #201u
708-481-6100 ext. 3344

Appendix B

Human Subjects Review Board Approval

From: "Mooney, Paul" <paul.mooney@wku.edu>

Subject: Approval: HSRB 10-288
Date: Thu, 20 May 2010 14:36:44 -0500
To: "Reed, Amy, B" <amy.reed175@wku.edu>, "Jones, Elizabeth" <elizabeth.jones@wku.edu>

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 HS10-288, May 20, 2010

Amy Reed
c/o Dr. Elizabeth Jones
Psychology
WKU

Amy Reed:

Your research project, *School Counselors' Training Knowledge, and Perceptions of Non-Suicidal 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 Expedited Review Level until December 15, 2010.

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 Reed HS10-288

Appendix C

Survey Invitation

Dear ASCA member,

You are being invited to participate in a research survey of your knowledge of and experiences working with students who engage in self-injurious behavior. This research is being conducted through the Department of Psychology at Western Kentucky University. The purpose of this study is to gain information on the experiences school counselors have in working with students who self-injure. Even if you have not worked with students who self-injure, your participation in this survey will still be valuable to the researchers. Once you have completed the survey, you will have the option of emailing your contact information to the researchers in order to be included in a raffle to win a $50 Amazon.com gift certificate.

If you have any questions regarding the survey or the results, please contact Amy Reed at GraduateResearchWKU@gmail.com or Elizabeth Jones at elizabeth.jones@wku.edu, Department of Psychology, Western Kentucky University. You may also contact the Compliance Manager for WKU, Mr. Paul Mooney, (270) 745-4652, paul.mooney@wku.edu.

Thank you in advance for taking the time to complete this survey.

To participate, please go to:
www.surveymonkey.com/s/counselornssiknowledge

Appendix D

Survey Invitation Reminder

Dear ASCA member,

If you have already completed the survey on self-injury, thank you for taking the time to do so! If not, this notice is to remind you that you have been invited to go to www.surveymonkey.com/s/counselornssiknowledge to participate in a survey on self-injurious behavior. Your participation is greatly appreciated whether or not you have direct knowledge or experience in working with youth who self-injure. Once you have completed the survey, you will have the option of emailing your contact information to the researchers in order to be included in a raffle to win a $50 Amazon.com gift certificate.

If you have already completed the survey, thank you!

If you have any questions regarding the survey or results, please contact Amy Reed at GraduateResearchWKU@gmail.com or Elizabeth Jones at elizabeth.jones@wku.edu, Department of Psychology, Western Kentucky University. You may also contact the Compliance Manager for WKU, Mr. Paul Mooney, (270) 745-4652, paul.mooney@wku.edu.

Appendix E

Survey Invitation Final Reminder

Dear ASCA member,

This notice is to remind you that you have been invited to go to www.surveymonkey.com/s/counselorsnssiknowledge to participate in a survey on self-injurious

behavior. June 14th , 2010 will be your final opportunity to participate in this research survey. Your participation is greatly appreciated whether or not you have direct knowledge or experience in working with youth who self-injure. Once you have completed the survey, you will have the option of emailing your contact information to the researchers in order to be included in a raffle to win a $50 Amazon.com gift certificate.

If you have already completed the survey, thank you for taking the time to do so!

If you have any questions regarding the survey or results, please contact Amy Reed at GraduateResearchWKU@gmail.com or Elizabeth Jones at elizabeth.jones@wku.edu, Department of Psychology, Western Kentucky University. You may also contact the Compliance Manager for WKU, Mr. Paul Mooney, (270) 745-4652, paul.mooney@wku.edu.

Appendix F

Survey

Demographics

1) Age:_____

2) What is your race/ethnicity?
    A. African American
    B. Caucasian
    C. Asian
    D. Hispanic
    E. Native American
    F. Other:_____

3) How many years of experience have you had as a school counselor?
    A. 0-5
    B. 6-10
    C. 11-15
    D. 16-20
    E. 21-30
    F. 31 and above

4) What is the highest degree you have earned in the field of school counseling?
    A. M.A., M.S., or M.Ed
    B. Ed.S.
    C. Ed.D.
    D. Ph.D.
    E. Other:_____

5) What year did you receive your highest degree in school counseling?_____

6) In what city/state do you practice?_____

7) Do you currently practice in a public or private district/school?
    A. Public
    B. Private

8) How long have you been with your current school? _____

9) On estimate, how many students are in the school(s) in which you serve?
    A. <250
    B. 251-350
    C. 351-500
    D. 501-700
    E. 701-1000
    F. 1001-2000
    G. >2000

10) On estimate, how many students are in the district you service?
    A. Less than 5000
    B. 5,001-15,000
    C. 15,001-25,000

D. 25,001-35,000
E. 35,001-45,000
F. Over 45,000

11) Location of Schools:
   A. Metro (250,000+)
   B. Urban Large (100,000-249,999)
   C. Urban Middle (50,000-99,999)
   D. Town Large (25,000-49,999)
   E. Town Small (2,500-24,999)
   F. Rural (less than 2,500)

12) Indicate the level of school you are working in. If you serve more than one level indicate the level where you spend the majority of your time.
   A. Elementary
   B. Middle
   C. Secondary

Current Knowledge of Self-Injury (SI)

In this survey the term self-injury will be used. Self-mutilation, self-harm, deliberate self-harm, non-suicidal self-injury, deliberate self-mutilation, and cutters are other terms used to identify this behavior.

13) Based on your current knowledge of SI, please indicate to what extent you agree with the following statements by placing an "X" in the box under your response:

	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 feeling of staying in control.					
People who self-injure will eventually grow out of it.					
	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Self-injury can provide a distraction from thinking.					
Self-injury is usually a					

manipulative act.					
People who self-injure can obtain feelings of euphoria.					
Self-injury is a woman's problem.					
Self-injury can provide a release for anger.					
The best way to deal with people who self injure is to make them stop.					
Self-injury is an expression of emotional pain.					
People who self-injure have been sexually abused.					
Self-injury is a failed suicide attempt.					
Self-injury can provide the individual with a way to deal with problems.					
Self-injury is a coping strategy.					
Self-injury is attention seeking.					
Self-injury helps a person maintain a sense of identity.					
Self-injurers suffer from Munchausen's Disease (self-inflicted injuries performed to produce specific symptoms that will lead to hospital admissions).					
Self-injury provides escape from depression.					
People who self-injure need psychiatric hospitalization.					
Self-injury is a form of suicide.					
Self-injury is a precursor to suicide.					
Individuals who self-injure are suicidal.					
Self-injury is distinct from suicide.					

14) Please indicate to what extent you agree with the following statements by placing an "X" in the box under your response:

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Self-injury is a precursor to					

psychopathology (a serious emotional disturbance).					
Self-injury is distinct from psychopathology (a serious emotional disturbance).					
Self-injury can be a feature associated with psychopathology (a serious emotional disturbance).					
Students who self-injure are most often from middle to upper-middle class homes.					

15) Please indicate to what extent you agree with the following statements by placing an "X" in the box under your response:

	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, and blogs) specifically about self-injury are easily accessible.					
The media (internet, music, movies, TV, magazines) has become a mechanism for spreading information about self-injury.					
Self-injury can be contagious, spreading from person to person (word of mouth, modeling).					
Self-injury is a problem in my school (s).					

16) Please Indicate the extent to which you think the following are examples of self-injury:

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree

A student shows you a cut and says she tried to commit suicide the night before.					
A student tells you that she burns the inside of her thighs when she fails a test.					
A student comes into your office with multiple piercings.					
A student with severe psychosis blinds herself.					
When you ask a student about a series of scars on his arms, he tells you he did them during a ritual for a social group he belongs to.					
A student tells you that to relieve test anxiety she pulls out her hair or eyebrows.					
A student tells you he hurts himself to "relax".					
A student tells you he cuts himself so that his friends will think he is dangerous and cool.					
A student tells you that when he is upset he punches the wall until he breaks bones.					
A student tells you that her sports team branded her during an initiation.					
A student tells you that the previous weekend while intoxicated he broke his ankle when he jumped off a high wall.					
A student tells you she cuts herself to "feel alive".					
A student on the Autism spectrum repeatedly bangs his head on his desk.					
A students tells you the she picks at wounds she gets to keep them from healing.					

Non-Suicidal Self-Injury Defined

For the rest of this study, please use the following definition for self-injury:

Non-suicidal self-injury is the socially unaccepted, deliberate, self-inflicted harm of an individual's body to reduce psychological distress, without the intention to die as a consequence

This type of self-injurious behavior occurs without the presence of a psychotic state (such as schizophrenia) and does not have organic or developmental roots, such as seen with a developmental disability (e.g., autism spectrum disorder, mental retardation). Slang terms used to refer to individuals who self-injure include cutters, emo cutters, or common cutters.

17) What percentage of individuals in the general (non-clinical) population engages in self-injury?
    A. less than 1%
    B. 1-5%
    C. 6-10%
    D. 11-15%
    E. 16-20%
    F. Greater than 20%

18) At what age do most people begin to engage in self-injury?
    A. less than 5 years
    B. 5-8
    C. 9-12
    D. 13-15
    E. 16-22
    F. Greater than 22

19) What is the age of the youngest person you have worked with that self-injured? _____

20) How did you first become aware of self-injury?
    A. Journal/professional newsletter
    B. Lecture/training session
    C. Media (popular press, TV, internet)
    D. Experience working with students who self-injure
    E. Students or youth
    F. Acquaintances, colleagues and/or friends
    G. Had no knowledge of self-injury prior to this survey
    H. Other:_____

21) Which outlet has been your main information source on self-injury?
    A. Journal/professional newsletter
    B. Lecture/training session

C. Media (popular press, TV, internet)
D. Experience working with students who self-injure
E. Students or youth
F. Acquaintances, colleagues and/or friends
G. Had no knowledge of self-injury prior to this survey
H. Other:_____

22) On estimate, how many students directly reported self-injury to you during the last school year (2008-2009).
A. None
B. 1
C. 2-3
D. 4-6
E. 7-10
F. Greater than 10

23) How many times has someone come to you concerned about a youth who engages in self-injury?
A. 0
B. 1
C. 2-3
D. 4-6
E. 7-10
F. Greater than 10

24) What forms of self-injury have you seen or have been reported to you by students?

Circle all that apply:	ONLY RANK THE TOP THREE; place a 1 beside the most frequent form of self-injury you have seen; a 2 beside the second most common; and a 3 beside the third most common form of self-injury you have seen.
A. Cutting B. Scratching C. Burning D. Punching, hitting (self or objects with the body) E. Breaking bones F. Pulling out hair	A. _____Cutting B. _____Scratching C. _____Burning D. _____Punching, hitting (self or objects with the body) E. _____Breaking bones

G. Picking scabs to interfere with healing H. Banging body parts on objects I. Ingesting harmful materials J. Other:_____	F. _____Pulling out hair G. _____Picking scabs to interfere with healing H. _____Banging body parts on objects I. ____Ingesting harmful materials J. Other:_____

25) How knowledgeable are you about self-injury?
   A. Know nothing: It was not covered in a training program, I have not read scholarly work on it, and I have not read about it in the popular media (internet, music, movies, TV, magazines).
   B. Somewhat Knowledgeable: I am aware of it in the popular media and/or have talked with other professionals about self-injury.
   C. Knowledgeable: I have read scholarly work, attended a training session or have had experience working with someone who self-injures.
   D. Very Knowledgeable: I have read extensively about self-injury in the popular media and scholarly resources and/or attended multiple lectures/training sessions on the topic.

26) Would you be able to recognize the signs of self-injury in a student?
   A. Yes
   B. No
   C. Unsure

27) Do you feel you have the knowledge to know how to assist a youth who self-injures?
   A. No, I don't feel like I have any knowledge
   B. Somewhat, but I would need help
   C. Yes, I have some knowledge and would seek additional support in some instances
   D. Yes, I could do it all on my own

28) Given your current knowledge of self-injury, how confident would you be in working with someone who self-injures?
   A. Not confident at all
   B. Somewhat Confident

C. Confident
D. Very confident

29) Assuming adequate training and knowledge, how comfortable are you/ would you be working with someone who self-injures?
   A. Very comfortable, it would not bother me at all
   B. Comfortable
   C. Slightly uncomfortable
   D. I would not feel comfortable

30) Assuming you are knowledgeable about self-injury, how comfortable are you with the thought of self-injury?
   A. Very Comfortable: Talking or thinking about self-injury does not cause me any distress/discomfort
   B. Comfortable: Talking or thinking about self-injury does not cause intense distress/discomfort
   C. Somewhat Uncomfortable: Talking or thinking about the topic creates distress or discomfort, but I can cope with it
   D. Very Uncomfortable: Talking or thinking about the topic creates distress or discomfort that is difficult to cope with
   E. Extreme Discomfort: The topic creates such extreme distress or discomfort that I avoid it if possible

31) How comfortable would you be in doing an initial interview with a student who has been referred to you about his/her self-injury?
   A. Not confident at all
   B. Somewhat Confident
   C. Confident
   D. Very confident

32) What would assist you in feeling more confident in working with youth who reveal they self-injure?
   A. More training
   B. More experience dealing with someone who self-injures
   C. Supervised experience
   D. A set plan for dealing with youth who self-injure (such as school policy or procedure)
   E. A more specific plan for dealing with youth who self-injure
   F. Talking with other professionals who work with students who self-injure
   G. Nothing
   H. Other:_____

33) What training/resources do you have available? (circle all that apply)
   A. Training on self-injury specifically
   B. Crisis response training (not for self-injury specifically)

C. Training in general psychological issues
D. Have read books on self-injury
E. Have read article(s) in a professional journal on self-injury
F. Have read books on general psychological issues
G. Have a set crisis plan to follow
H. Have access to outside resources for information (local treatment groups, credible websites)
I. Professional peer support
J. None
K. Other:_____

34) If you have attended a professional training session on self-injury, when was the most recent training session you attended?
A. Within the last calendar year
B. 1-5 years ago
C. 6-10 years ago
D. 11-15 years ago
E. 16-20 years ago
F. Over 20 years ago
G. Have not attended professional training on self-injury

35) Would you like to receive more training on self-injury?
A. Not interested
B. Somewhat interested
C. Interested
D. Very interested

The following questions relate to how you or your school/district responds to self-injury.

36) On estimate, how frequently are youth referred to you for self-injury?
A. Daily
B. Weekly
C. Monthly
D. Very rarely
E. Never

37) What is your primary role in working with youth who self-injure?
A. Individual therapy/ counseling
B. Refer student to a professional in the community (ex: therapist, social worker, hospital)

C. Be able to provide a student with information (ex: books or pamphlets on self-injury, website addresses for support groups)
D. Develop academic and/or counseling supports within the school
E. Contact parents
F. No role
G. Other:_____

38) Are professionals other than school counselors in your district primarily responsible for dealing with self-injury?
A. Yes
B. No

39) If so, which professional(s) are responsible for responsible for responding to youth who self-injure?
A. Another school counselor
B. School social worker
C. School psychologist
D. School nurse
E. School therapist
F. I don't know
G. Other:_____

40) What type of plan does your district have for dealing with students who self-injure?
A. Specific plan (addresses self-injury specifically, separate from other response plans)
B. Inclusive plan (addresses self-injury specifically, but is part of a larger response plan)
C. Generic plan (Have a general emergency/crisis response plan to address issues like self-injury, but response to self-injury not specified)
D. No plan utilized
E. I don't know
F. Other:_____

41) If you use a specific plan or crisis response, do you use your own or one written by the school/district?
A. Own
B. School/district
C. We have no specific plan

42) If you used a plan designed by the school, who designed it?
A. Individual (school psychologist, school counselor, school nurse, social worker, outside researcher)

B. School committee, interdisciplinary with mental health involvement
C. School committee, interdisciplinary without mental health involvement
D. I don't know
E. No available plan
F. Other:_____

43) Which of the following options/actions are included in your school response to self-injury? (select all that apply)
A. Assess/ Talk to student
B. Call parents
C. Refer student to school administrator
D. Refer student to school nurse
E. Refer student to school mental health staff
F. Encourage student/parent to seek to mental health support outside school
G. Refer student to police
H. Send student to hospital/ medical care center
I. Ask student/ parent for permission to develop academic and/ or counseling supports within the school itself
J. Document incident
K. Do not know what steps are included in the plan
L. No available plan

44) If your district had a staff training on self-injury, which of these activities were included? (please select all that apply)
A. The staff was trained on the full range of self-injury, including direct and indirect self-injury
B. The staff was trained on how to differentiate self-injury from suicide
C. The staff was trained on how to ascertain which self-injury wounds are in need of medical attention (e.g. wounds that need suturing, infected wounds)
D. The staff was trained on how to differentiate between self-injury and body modification (e.g., tattooing, body piercing)
E. The staff was trained on how to respond to self-injury in a low key dispassionate tone
F. The staff was trained on how the school needs to respond to the student's treatment (e.g., not to expect rapid extinction of the behavior)
G. The staff was trained on how to reduce contagion
H. Our district has not had a staff training on self-injury

45) If your district's training included how to reduce contagion, which of these activities were included? (please select all that apply)
A. How to reduce communication about self-injury among peers
B. How to reduce public exhibition of wounds
C. How to deal with groups, such as group therapy vs. individual therapy

D. Our district has not had a staff training on self-injury

46) As an educator, is there anything you want us, as researchers in this area to know about your experiences with self-injurious behavior?

47) How did you learn about this survey?
   A. I was sent an email.
   B. I accessed it though ASCA's SCENE forums

/

Thank you for participating in this study!

If you wish to participate in a raffle drawing for a $50 gift card to Amazon.com, please supply your name and address to graduateresearchwku@gmail.com. Your personal information will be kept separate from your survey responses.

Appendix G

Informed Consent

Project Title: School Counselors' Training, Knowledge, and Perceptions of Non-Suicidal Self-Injury

Investigators: Amy Reed, B.A. and Elizabeth Jones,
Ph.D., Department of Psychology, 270-745-4414

You are being asked to participate in a project conducted through Western Kentucky University investigating school counselors' knowledge of adolescents who self-injure. Please read the following information carefully. It describes the purpose of the study, the procedure to be used, risks and benefits of your participation and what will happen to the information that is collected from you. If you agree to participate in this project, the University requires that you give your signed agreement to participate in this project by clicking on the "I Agree" button below.

If you have any questions about the purpose of the project, the procedures to be used, and the potential benefits or possible risks of participation please contact the investigators through the email addresses indicated below. You may ask him/her any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.

If you then decide to participate in the project, please click the "I Agree" at the bottom of this text.

1. Nature and Purpose of the Project: The purpose of this survey is to investigate school counselor's perceptions and levels of knowledge, training, existing school prevention and protocol, resources and training opportunities available in regard to self-injury.

2. Explanation of Procedures: Upon your consent, you will be asked to complete a survey that can be accessed by clicking the "I Agree" button below. You will be asked questions regarding your demographic information, your current knowledge of self-injury, and you and/or your schools' response to self-injury.

3. Discomfort and Risks: There are no known risks associated with participation. However, you need to be advised that the topic of self-injury is one that many find disturbing. You may feel free to discontinue if such occurs. Further, if you engage in self-injurious behavior, participating in this survey could have unwanted consequences. Please visit www.selfinjury.com , call 1-800-DONTCUT, or contact the researcher(s) if this is the case.

4. Benefits: Upon completion of the survey, you will receive the chance to be entered into a raffle drawing for one $50 gift certificate from www.Amazon.com. The results of this survey will provide better information regarding knowledge and perceptions of self-injury. Counselors, psychologists, professors, and parents will benefit in that this research will provide information to help better train these individuals to deal with the increasing problem among adolescents.

5. Confidentiality: All responses to this survey will be kept in a database that is blind to your name and any email or Internet information.

6. Refusal/Withdrawal: Refusal to participate in this study will have no effect on any future services you may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty. If you personally engage in self-injurious behavior, you will suffer no repercussions for not participating.

7. Questions: If you have any questions regarding the survey or results, please contact Amy Reed at GraduateResearchWKU@gmail.com or Elizabeth Jones at elizabeth.jones@wku.edu, Department of Psychology, Western Kentucky University. You may also contact the Compliance Manager for WKU, Mr. Paul Mooney, (270) 745-4652, paul.mooney@wku.edu.

Thank you in advance for your participation and support by taking the time to fill out the following information.

Please read the following statements carefully and click the "I Understand" and "I Agree" buttons that follow to acknowledge that you have read and understood the following considerations and agreements.

1. Because of subject matter, I realize the discussion may be uncomfortable or disturbing, and that I may withdraw without penalty at any time if such occurs.

◉ I understand

2. I acknowledge that responding to items concerning self-injurious behavior may cause discomfort and/or trigger thoughts of self-injury.

☐ I understand.

3. You understand also 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.

☐ I agree

☐ I decline

4. You understand that your continued cooperation with this research implies your consent.

☐ I understand

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT
THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY
THE WESTERN KENTUCKY UNIVERSITY HUMAN SUBJECTS REVIEW BOARD
Paul Mooney, Compliance Coordinator
TELEPHONE: (270) 745-4652

HSRB APPLICATION HS10-288
APPROVED: May 20, 2010 to December 15, 2010

EXEMPT EXPEDITED FULL BOARD

DATE APPROVED: May 20, 2010