
School Counsellors' Understanding of Non-Suicidal Self-Injury: Experiences and International Variability La compréhension de l'automutilation non-suicidaire chez les conseillers scolaires: Les expériences et la variabilité internationale

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ABSTRACT

Non-suicidal self-injury (NSSI) is a concern among professionals working with youth. The present study examined school counsellors' experiences, training and school preparedness, perceived knowledge, beliefs, and intervention approaches related to NSSI. Participants were 470 school counsellors (417 female, 53 male) from across North America (156 Canada, 314 United States). Although NSSI is largely within counsellors' scope of practice, as evidenced by the 92% who reported working with a student who engaged in NSSI at some point during their career, counsellors reported only moderate levels of NSSI knowledge, a lack of formal training, and an absence of school policies concerning NSSI management. American counsellors endorsed more media-based representations about NSSI than their Canadian counterparts. Discussion focuses on the need for training among school counsellors and the improvement of service delivery across North America for youth who engage in NSSI.

RÉSUMÉ

L'automutilation non-suicidaire (AMNS) est préoccupante pour les professionnels travaillant auprès des jeunes. Cette étude visait à examiner les expériences, la formation et la préparation scolaire, le niveau perçu de connaissance, les croyances, et les approches à l'intervention liée à l'AMNS. Les participants composaient 470 conseillers scolaires (417 femmes, 53 hommes) de toute l'Amérique du Nord (156 du Canada, 314 des États-Unis). Bien que l'AMNS fait largement partie du champ d'expérience des conseillers (92 % d'entre eux ont indiqué avoir déjà travaillé au cours de leur carrière avec un étudiant qui démontrait des comportements d'AMNS), les conseillers ont indiqué une connaissance seulement modérée de l'AMNS, un manque de formation, et une absence de politiques scolaires au sujet de la gestion de l'AMNS. Les conseillers américains appuyaient davantage les représentations médiatiques à propos de l'AMNS comparativement aux conseillers canadiens. La discussion porte sur le besoin de former les conseillers scolaires et l'amélioration de la prestation des services à travers l'Amérique du Nord pour les jeunes qui démontrent des comportements d'AMNS.

Non-suicidal self-injury (NSSI) is defined as the deliberate, self-inflicted destruction of body tissue without conscious suicidal intent and for purposes not socially sanctioned (Nixon & Heath, 2009). Cutting, scratching, and burning are reported as the most common forms of self-injury. Recent studies exploring the occurrence of NSSI in schools indicate that 14% to 20% of adolescents will report engaging in NSSI on at least one occasion (Laye-Gindhu & Schonert-Reichl, 2005; Muehlenkamp & Gutierrez, 2007; Nixon, Cloutier, & Aggarwal, 2002; Ross & Heath, 2002). Higher rates have been reported in university and college samples, with prevalence rates ranging from 12% to 38% (Gratz, Conrad, & Roemer, 2002; Heath, Toste, Nedecheva, & Charlebois, 2008; Whitlock, Eckenrode, & Silverman, 2006). The majority of youth report that their self-injury began during early adolescence between the ages of 13 and 15 years (see Rodham & Hawton, 2009).

The most commonly endorsed function of NSSI concerns emotion regulation, although other endorsed functions include self-punishment, anti-dissociation, and anti-suicide (see Klonsky & Muehlenkamp, 2007, for a review). As such, treatment modalities that focus on emotion regulation difficulties, emotional acceptance, and distress tolerance (i.e., mindfulness and dialectic-behaviour therapy) have been shown to be effective treatment approaches for NSSI (Gratz, 2006; Gratz & Chapman, 2009; Muehlenkamp, 2006; Nixon, Aulakh, Townsend, & Atherton, 2009). With these facts taken together, it is clear that adolescence is a critical age for responding to NSSI, highlighting the need for prevention and early intervention during this developmental period.

An absence of baseline and longitudinal data makes it impossible to state that NSSI is becoming more prevalent among youth; however, preliminary research reports suggest that mental health professionals may be encountering NSSI more often than before. For example, Whitlock, Eells, Cummings, and Purington (2009) surveyed mental health professionals from both college and university counselling centres and found that the majority perceived an increase in NSSI incidences over the span of five years, as well as an increase in help-seeking behaviours specific to individuals who engage in self-injury. This apparent increase in both NSSI prevalence rates and help-seeking behaviour can potentially pose a challenge for school professionals, who are on the front line of identification, assessment, and management of NSSI in the school environment (Toste & Heath, 2010).

The school setting can often be a primary environment where students experience a sense of safety, security, and acceptance. This type of environment can serve as a strong resiliency factor during childhood and adolescence (National Institute of Child Health and Human Development – Early Child Care Research Network, 2002, 2004; Nickolite & Doll, 2008). Schools provide youth with access to a variety of mental health resources and professionals.

One group of professionals that play a crucial role in the delivery of mental health services to youth-in-need is school counsellors. A school counsellor has a broad role with various responsibilities, including working with students who experience emotional difficulties, providing training and resources to other school

professionals, and acting as a community liaison through referral to outside mental health services (Harris & Jeffery, 2010; Roberts-Dobie & Donatelle, 2007). Although school counsellors are trained to identify internalizing and externalizing problems among youth (Reeves, Wheeler, & Bowl, 2004), including conduct disorders, depression, and anxiety, it remains unknown whether they are equally prepared with respect to NSSI.

A second critical role that school counsellors may play in their schools involves the implementation of policies regarding NSSI. Typically, once a behaviour or issue has been identified as problematic within the school environment, institutions create formal policies to address concerns (Best, 2006; Walsh, 2006). Notably, these policies should detail the process by which professionals working in schools should respond when encountering cases of NSSI (Lieberman, Toste, & Heath, 2009; Toste & Heath, 2010).

Current attempts to assess the extent of NSSI service delivery are hampered by the scant attention that the behaviour has received in the literature, despite the need for increased training, education, and prevention concerning NSSI in educational settings (White, Trepal-Wollenzier, & Nolan, 2002). Thus, despite observations of NSSI within school- and community-based settings, less attention has been devoted to examining the experiences of practitioners, specifically school counsellors, who are the key professionals working with adolescents who engage in NSSI.

SCHOOL PROFESSIONALS' PERCEPTIONS AND EXPERIENCES OF NSSI

Despite the limited research in this area, a handful of studies examining various facets of school professionals' experiences with NSSI have been conducted. This is an important focus for researchers, stemming from the recurring expression of training needs by other professionals working with clients who engage in NSSI. For example, teachers report feeling overwhelmed and ill-prepared when faced with NSSI within the school environment (Heath, Toste, & Bettam, 2006; Heath, Toste, Sornberger, & Wagner, 2011).

Similarly, Best (2006) interviewed a variety of school professionals in Great Britain, including teachers, nurses, care workers, and guidance counsellors. This study specifically asked these professionals about their experiences, perceptions, and responses to deliberate self-harm in educational settings. A broader term than NSSI, deliberate self-harm does not specify whether suicidal intent is present or not, and includes a wider range of self-harming behaviours such as self-poisoning and substance abuse (Hawton, Haw, Houston, & Townsend, 2002; Nixon & Heath, 2009). It was found that teachers' awareness of deliberate self-harm ranged from low to virtually nonexistent, and they generally reported a sense of discomfort and anxiety concerning the actual behaviour. Counsellors reported receiving training in related areas such as bereavement and loss, but not deliberate self-harm. Furthermore, a lack of consistency was found across educational settings concerning existing policies regarding deliberate self-harm (Best, 2006).

To examine counsellors' training curriculum concerning NSSI, Reeves et al. (2004) surveyed individuals who taught a popular British-accredited counsellor training program. The majority of surveyed respondents indicated that the training, skills, and curriculum provided to trainees (i.e., potential professional counsellors) were not adequate in terms of successfully working with clients at risk for engaging in self-harm (Reeves et al., 2004). Additionally, over 65% of respondents did not feel that they were well informed about current government directives regarding NSSI. Therefore, although this study did not directly assess school counsellors' knowledge and experience with NSSI, the findings suggest that, from the onset of their career, professional counsellors receive limited training and information concerning self-injury in the school environment.

Harris and Jeffery (2010) recently examined Canadian guidance counsellors' and educational psychologists' perceptions of working with students who engaged in high-risk behaviours, including "self-mutilation" (alternate terminology for NSSI that often focuses on cutting behaviours). Guidance counsellors reported moderate levels of preparedness and effectiveness with regard to self-mutilation prevention (Harris & Jeffery, 2010). Interestingly, respondents perceived their role as school leaders with respect to self-mutilation, yet indicated wanting less responsibility in dealing with the assessment and intervention processes concerning self-mutilation. Moreover, those who reported having applied experience with self-mutilation prevention indicated higher levels of overall preparedness, as well as effectiveness. These results serve to highlight the important relationships between experience, preparedness, and effective prevention and intervention related to high-risk behaviours.

SCHOOL COUNSELLORS' KNOWLEDGE AND ATTITUDES

There is one study to date that has specifically examined the knowledge and attitudes of school counsellors regarding NSSI alongside their experiences working with self-injurers. Roberts-Dobie and Donatelle (2007) surveyed 433 American counsellors about their experiences, knowledge, and needs regarding effective responses to NSSI. The majority of respondents (81%) reported working with adolescents who engage in NSSI at some point in their career, and 51% reported having done so within the last academic year. Although the majority of school counsellors (75%) felt that they were the most appropriate people within the school to provide consultation, only 6% of participants reported being extremely knowledgeable (measured by a Likert-type scale) with regards to the root causes, symptoms, treatment, and appropriate referrals when dealing with NSSI. The majority of respondents (92%) indicated an interest in learning more about NSSI. Furthermore, respondents identified many treatment barriers, such as a lack of training and need for additional support from other educational professionals (e.g., teachers and school psychologists). Respondents also expressed a clear need for a unified protocol concerning self-injury, and indicated that school policies were significantly lacking compared to other health issues such as suicide attempts, alcohol abuse, and detection of physical or sexual abuse.

Although comprehensive, Roberts-Dobie and Donatelle's (2007) survey data were collected in 2003, and there has been an abundance of research related to the occurrence of NSSI since that time. In addition, the authors did not examine treatment modalities employed by school counsellors regarding NSSI, nor did they expand the survey to include school counsellors from outside the United States. Therefore, it is of interest to examine the current state of NSSI knowledge, experiences, attitudes, and treatment approaches among Canadian counsellors. Doing so will provide understanding of how NSSI is being managed within Canadian schools and provide a stepping stone to developing effective and appropriate response tactics. Additionally, in order to address the presence of NSSI within schools, it would be beneficial to examine how school counsellors' experiences, knowledge, and beliefs regarding the behaviour and overall service delivery have changed from previous years.

In sum, there is a need to examine both Canadian and American school counsellors' present knowledge and experiences related to self-injury in schools. Research in this area is considerably lacking, despite high rates of occurrence, making NSSI a concern across North America. This information will allow for the further development and successful implementation of effective school response policies concerning NSSI and may illuminate possible differences between school counsellors working in Canadian and American school settings.

RESEARCH OBJECTIVES

The present study has two central objectives. The first is to provide a recent, comprehensive report of school counsellors' understanding and experiences of NSSI in the schools. Specifically, this includes descriptions of (a) how frequently school counsellors encounter NSSI, (b) training and school preparedness for managing NSSI in the schools, (c) school counsellors' perceptions of their own knowledge of NSSI, (d) school counsellors' beliefs about NSSI, and (e) school counsellors' courses of action and approaches to intervention.

The second objective is to provide a preliminary view of the international variability in school counsellors' experiences with NSSI by comparing the responses of Canadian and American counsellors. Specifically, comparisons were made between Canadian and American counsellors on experiences, training and school preparedness, perceived knowledge, beliefs, and approaches to intervention. Examining differences between these two countries will provide insight into how school counsellors across North America effectively manage the occurrence of NSSI in schools. An examination of these differences may elucidate which processes and experiences are effective for school counsellors and which areas need attention.

METHOD

Participants

Participants in this study included 470 school counsellors (417 female, 53 male) from across North America (156 Canada, 314 United States). Counsellors

ranged in age from 23 to 67 years ($M = 40.74$, $SD = 10.55$) and indicated a range of 0.5 to 38 years of professional counselling experience ($M = 6.80$, $SD = 6.43$). No significant differences in age or years of experience were observed between Canadian and American participants. Canadian counsellors (83.3% female) had an average of 7 years of experience working as a school counsellor ($SD = 6.52$), and American school counsellors (91.4% female) had an average of 6.67 years of experience ($SD = 6.38$). In the academic year of 2005–2006, when the data were collected, Canadian and American school counsellors reported working with a similar number of students who engaged in NSSI ($M = 3.11$, $SD = 4.87$; $M = 3.00$, $SD = 3.85$, respectively).

Procedure

School counselling associations for each province and state across North America were contacted via e-mail with an invitation for their members to participate in an online research study. Each association was asked to distribute the electronic flyer, which detailed the project and invited counsellors to complete an online survey via their membership's electronic mailing list. The flyer provided participants with a direct link to the website hosting the survey (i.e., ZapSurvey).

In addition to collecting information regarding school counsellors' experiences with NSSI in the school setting and their perceptions of this behaviour, a second objective of this project was to enhance training on this topic. Upon survey completion, counsellors were given the opportunity to leave their contact information to participate in a free online professional training workshop on NSSI in the schools and the role of school counsellors in identification, assessment, and referral. All 470 participants indicated that they would be interested in completing an online professional development workshop. Registration information was shared with participants following completion of the survey; however, data are not available regarding the number of participants who followed through with completion of the workshop.

Measure

Participants completed the School Counsellor Self-Injury Survey online, a 45-item measure that is broken down into two main sections: background information on NSSI, and experiences working with students who self-injure. The measure contains a series of statements that were developed based on a thorough review of the literature and assesses (a) experience with students who engage in NSSI, (b) professional training to deal with NSSI and school preparedness, (c) perceptions of knowledge, (d) beliefs about NSSI, and (e) past responses and intervention approaches used with students who engage in NSSI.

The 23 items related to beliefs (see Table 1 and 2) about NSSI used a 5-point Likert scale, with participants indicating the extent to which they agreed with each statement (i.e., *strongly disagree* to *strongly agree*). One 3-part question (concerning perceptions of root causes, symptoms, and treatment of self-injury) employed a Likert scale with responses ranging from 1 (*not at all knowledgeable*)

Table 1
School Counsellors' Beliefs About Non-Suicidal Self-Injury

Statement	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Those who self-injure often report a history of physical abuse	1.9	26.3	28.9	40.3	2.6
Substance abuse is common in people who self-injure	1.1	30.3	30.9	36.7	1.1
Individuals who self-injure are often suicidal	6.4	59.7	18	14.8	1.1
Self-injury is a sign of mental illness	6.0	35.6	27.2	28.4	2.8
Self-injury is caused by a chemical imbalance	7.3	44.0	40.9	7.3	0.4
Self-injury is a coping mechanism for stress	0.2	0.4	2.2	48.8	48.4
Self-injury is an attention-seeking behaviour	4.3	27.3	30.1	34.8	3.4
Individuals report feeling calm and relaxed after self-injuring	—	5.2	9.9	64.5	20.4
Self-injury is a means of self stimulation	1.1	12.5	19.1	61.3	6.0
A person feels physical pain during self-injury	3.1	33.8	19.6	38.8	4.80
Individuals who self-injure are most likely to be girls	0.2	5.8	12.3	65.9	15.7
Individuals who self-injure often report a history of sexual abuse	0.4	19.1	40.9	35.9	3.7
A person who self-injures is likely to injure others	31.9	61.2	5.6	0.9	0.4
Individuals who self-injure feel that they cannot stop	—	6.5	12.3	67.5	13.8
Self-injury is a way to feel in control	0.6	1.1	3.6	57.1	37.6
Self-injury is a way to decrease negative emotions	0.4	12.2	12.9	63.1	11.4
Individuals who self-injure often also have symptoms of an eating disorder	1.9	23.2	41.4	32.6	0.9
Self-injury occurs largely amongst white, upper-middle-class individuals	2.6	28.2	36.6	31.0	1.5
Individuals who self-injure often report a history of emotional abuse	0.6	8.2	28.1	58.8	4.3
Depression is common in people who self-injure	0.2	1.7	8.6	78.3	11.2
Borderline Personality Disorder is common in adolescents who self-injure	1.7	17.8	47.1	30.4	3.0
Most adolescents who self-injure report their behaviour to an adult	16.5	59.7	14.8	8.8	0.2
Most adolescents self-injure once or twice and then stop	15.2	62.5	14.8	7.3	0.2

Note: All values are percentages (%).

Table 2

Comparison of Canadian and American School Counsellors' Beliefs About Non-Suicidal Self-Injury

Statement	Canadian	American	<i>t</i>	<i>d</i>
	<i>M</i> (SD)	<i>M</i> (SD)		
Those who self-injure often report a history of physical abuse	3.05 (.95)	3.19 (.88)	1.55	0.15
Substance abuse is common in people who self-injure	2.98 (.88)	3.10 (.85)	1.35	0.13
Individuals who self-injure are often suicidal	2.42 (.79)	2.45 (.88)	.326	0.03
Self-injury is a sign of mental illness	2.72 (.98)	2.93 (.98)	2.21*	0.21
Self-injury is caused by a chemical imbalance	2.43 (.70)	2.52 (.77)	1.22	0.12
Self-injury is a coping mechanism for stress	4.35 (.65)	4.49 (.54)	2.42*	0.23
Self-injury is an attention-seeking behaviour	3.01 (.94)	3.08 (.97)	.71	0.07
Individuals report feeling calm and relaxed after self-injuring	3.90 (.78)	4.00 (.67)	1.88	0.13
Self-injury is a means of self-stimulation	3.51 (.82)	3.60 (.82)	1.24	0.10
A person feels physical pain during self-injury	3.30 (.91)	2.94 (1.0)	-4.36*	0.37
Individuals who self-injure are most likely to be girls	3.94 (.76)	3.89 (.70)	-.62	0.06
Individuals who self-injure often report a history of sexual abuse	3.12 (.83)	3.28 (.79)	2.03*	0.19
A person who self-injures is likely to injure others	1.69 (.62)	1.80 (.62)	1.79	0.17
Individuals who self-injure feel that they cannot stop	3.82 (.78)	3.90 (.67)	1.23	0.11
Self-injury is a way to feel in control	4.20 (.67)	4.34 (.63)	2.26*	0.21
Self-injury is a way to decrease negative emotions	3.62 (.88)	3.77 (.80)	1.76	0.17
Individuals who self-injure often also have symptoms of an eating disorder	3.09 (.86)	3.06 (.79)	-.33	0.03
Self-injury occurs largely amongst white, upper-middle-class individuals	2.87 (.87)	3.07 (.86)	2.38*	0.23
Individuals who self-injure often report a history of emotional abuse	3.47 (.82)	3.63 (.67)	2.13*	0.21
Depression is common in people who self-injure	3.93 (.53)	4.00 (.53)	1.41	0.13
Borderline Personality Disorder is common in adolescents who self-injure	3.03 (.79)	3.20 (.80)	2.15*	0.20
Most adolescents who self-injure report their behaviour to an adult	2.16 (.84)	2.16 (.79)	-.05	0.00
Most adolescents self-injure once or twice and then stop	2.25 (.77)	2.09 (.75)	-2.19*	0.21

Note: **p* < .05.

to 7 (*extremely knowledgeable*). The remaining 21 items in the survey used either yes/no or checklist response formats concerning background information on self-injury and experiences working with students who self-injure. Responses were not forced choice, although the majority of participants answered all items. The current survey was adapted with permission from Roberts-Dobie and Donatelle (2007), and no psychometric properties are currently available.

RESULTS

Experiences with Non-Suicidal Self-Injury

OCCURRENCE OF NSSI IN THE SCHOOLS

Of the surveyed counsellors, 92% ($n = 431$) reported working at some point in their career with a student who engaged in NSSI. The counsellors who indicated having previous experience ($n = 431$) reported working with approximately three students who engage in NSSI in the past academic year. Additionally, these counsellors reported working with an average of nine students who engaged in NSSI over the course of their career ($SD = 14.91$). In order to understand school procedures for responding to NSSI, all counsellors ($N = 470$) were asked which member of the school personnel would be most likely to be consulted if a student was identified as a self-injurer. The majority of counsellors (68%) indicated that, as the school counsellor, they would most likely be consulted. Additional responses included another school counsellor (9%), school social worker (5%), and school nurse (4%). Interestingly, only 46% of school counsellors felt that they were the most appropriate person to provide consultation, followed by an outside therapist (23%) or school psychologist (7%). The remainder of counsellors indicated another consultation with a school counsellor, school social worker, behaviour technician, or educational aide, and outside referral to a psychologist or psychiatrist as being appropriate courses of action (see Table 3).

Table 3
Reports of School Professional Felt to Be Most Appropriate to Provide Consultation Regarding Self-Injury

Professional	Frequency	Percent (%)
Me, the school counsellor	214	46
Outside therapist/psychotherapist	110	23
School psychologist	32	7
Other	31	7
Psychiatrist/local children's hospital	23	5
Another school counsellor	22	5
School social worker	19	4
Psychologist (other type)	15	3
School nurse	3	0.6
Behaviour technician/educational aide	1	0.0

TRAINING AND SCHOOL PREPAREDNESS

School counsellors reported various sources of information for learning about NSSI, falling into four categories: educational (e.g., coursework, textbook); professional (e.g., journal, conferences, colleagues, in-service training); media (e.g., Internet, television, newspapers, magazines); and personal (e.g., knowing an individual who self-injures). Respondents could select all sources of information that they had accessed. Of all participants, 38% indicated educational sources of information, 26% of those participants reported obtaining information from university coursework, and 25% reported obtaining it from textbooks. Professional training sources were chosen by 93% of all of the participants. Of this 93%, 71% reported contact with professional colleagues, 52% reported obtaining information from a professional journal, 50% reported attending a session on NSSI at a professional conference, and 35% reported receiving in-service training and education. Media sources were chosen by 70% of all participants; 57% of these participants reported obtaining information from the Internet while 43% reported obtaining information from other mass media outlets, such as television, newspapers, and magazines. Finally, 57% of all participants mentioned personal sources of information; 56% of school counsellors reported knowing someone who self-injures, and 2% reported engaging in self-injury themselves (presently or previously).

To assess overall preparedness for managing NSSI within the school setting, counsellors were asked if their school district had an identified protocol for responding to cases of self-injury. The majority of participants (63%) indicated that they did not have a policy to deal with NSSI, and 20% reported that they were unsure if a policy existed.

PERCEPTIONS OF KNOWLEDGE

Participants were asked to rate their own knowledge concerning root causes, symptoms, and treatment of NSSI on a 7-point scale. A composite score of the three items was used to define *not very knowledgeable* (score of 1 or 2), *moderately knowledgeable* (score of 3 to 5), and *extremely knowledgeable* (score of 6 or 7). With regard to knowledge concerning root causes of self-injury, 12% of school counsellors reported themselves as not very knowledgeable, 78% as moderately knowledgeable, and 11% as extremely knowledgeable ($M = 4.02$, $SD = 1.2$). When asked about symptoms of NSSI, 13% of school counsellors reported themselves as not very knowledgeable, 76% as moderately knowledgeable, and 12% as extremely knowledgeable ($M = 4.08$, $SD = 1.27$). When considering psychological treatments for NSSI, 29% reported themselves as not very knowledgeable, 66% as moderately knowledgeable, and 5% as extremely knowledgeable ($M = 3.32$, $SD = 1.32$).

BELIEFS ABOUT SELF-INJURY

Participants were asked to respond to a series of statements concerning NSSI beliefs (e.g., etiology, functions, stereotypes). A complete list of all statements and associated frequencies is reported in Table 1. Participants responded on a 5-point scale, ranging from *strongly agree* to *strongly disagree*; a composite score of

the responses was used to identify responses as agree (*agree* and *strongly agree*) or disagree (*disagree* and *strongly disagree*). A general profile regarding beliefs about NSSI emerged from this analysis. Only a minority of counsellors agreed that self-injury was a sign of mental illness (31%), and a majority did not agree that self-injuring individuals were suicidal (66%). Three-fourths of the counsellors (76%) did not agree that adolescents who self-injure report their behaviour to an adult.

In terms of causes of the behaviour, 51% disagreed that self-injury was caused by a chemical imbalance, but many of the counsellors agreed that self-injurers had a history of emotional abuse (63%), physical abuse (43%), and sexual abuse (40%). In regards to comorbid disorders, school counsellors agreed that self-injury was associated with depression (90%), substance abuse (38%), borderline personality disorder (34%), and eating disorders (33%). Functions of NSSI chosen by school counsellors included a coping mechanism for stress (97%), a way to feel in control (95%), a way to decrease negative emotions (75%), a means of self-stimulation (68%), and an attention-seeking behaviour (38%). Many agreed that individuals felt calm and relaxed following episodes of engaging in NSSI (85%).

In terms of stereotypes associated with the behaviour, 93% of counsellors did not agree that a person who self-injures is likely to injure others, 78% agreed that it was a repetitive behaviour, while 81% indicated that individuals who self-injure cannot stop. Counsellors were divided as to whether individuals felt pain when they self-injured (37% disagreed, 44% agreed) and believed that self-injury occurred most often among girls (82%) from a white, upper-middle-class background (33%).

INTERVENTION APPROACHES

School counsellors were asked to report what actions they have taken in the past, and would take in the future, when working with a student who engaged in NSSI. The majority of participants reported that they had provided individual counselling to students in the past (80%) and/or contacted the student's parent/guardian (75%). Additionally, 7% reported providing group counselling. Participants reported that their actions often included referrals to the school nurse (21%), school social worker (15%), principal (12%), school psychologist (12%), and/or referrals outside of the school setting to a psychiatrist and/or clinical psychologist (66%), a physician (33%), and/or social work/child protective services (25%).

School counsellors were asked to indicate the specific intervention approach or approaches (respondents could check all that applied) used when working with students who engage in NSSI. More than half of participants reported empathetic listening (61%), followed by individual therapy (60%). As these two modalities were chosen the most, it was of interest to examine how many respondents chose either one or both modalities. Of the 470 respondents, 40% reported using both approaches, 20% reported using individual therapy, and 18% reported using empathetic listening. Additionally, respondents reported that they used problem-solving skills building (54%), relaxation techniques (44%), effective communication (40%), and/or cognitive behavioural therapy (39%). Other chosen modalities

included client-centred therapy, mindfulness techniques, social skills training, family intervention, group therapy, and/or dialectical behavioural therapy. As multiple responses could be chosen, it was interesting to examine how many methods respondents typically reported. On average, respondents chose three approaches ($SD = 2.28$). See Figure 1 for distribution of responses.

In order to tap school counsellors' general approval of these actions, participants were asked what actions they would take if they worked with a student who engaged in NSSI in the future. Twenty-six percent of school counsellors indicated they would take a different course of action than they had when working with a self-injurer in the past. Moreover, 39% of respondents felt that almost all students who self-injure should be referred for a psychiatric evaluation. Nevertheless, there was general consensus (84%) that school counsellors should be the professionals responsible for conducting interventions with students who self-injure.

Comparison of Canadian and American School Counsellors' Responses

All survey responses were compared between Canadian and American school counsellors regarding their experiences with NSSI. When asked who would serve as a consultant for a case of NSSI at their school, 58% of Canadian respondents indicated that they would most likely serve as the consultant, compared to 72% of American school counsellors.

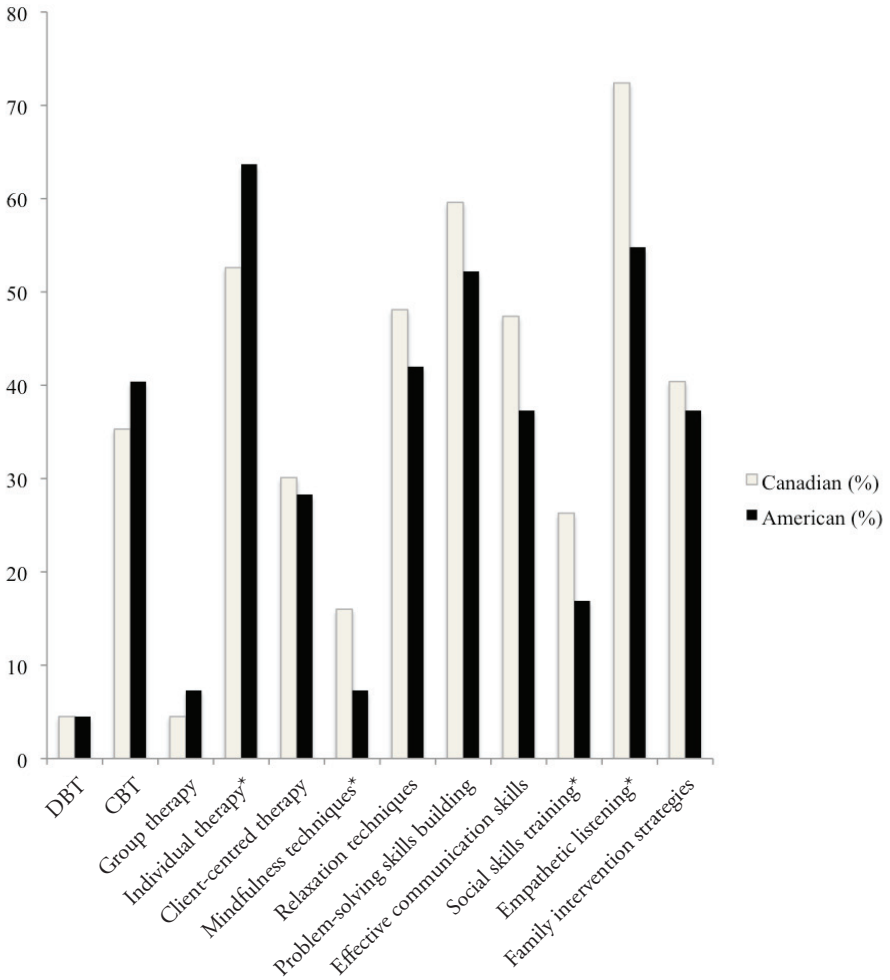
Independent sample t -tests were conducted to examine differences in perceptions of knowledge between Canadian and American school counsellors. No significant differences were found between Canadian and American school counsellors' reported knowledge of root causes of self-injury, $t(468) = -.028$, $p = ns$, $d = .01$ (Canadian: $M = 4.02$, $SD = 1.22$; American: $M = 4.00$, $SD = 1.19$); knowledge of symptoms, $t(468) = -.312$, $p = ns$, $d = .02$ (Canadian: $M = 4.10$, $SD = 1.25$; American: $M = 4.07$, $SD = 1.27$); or knowledge regarding psychological treatments for NSSI, $t(468) = -.71$, $p = ns$, $d = .06$ (Canadian: $M = 3.38$, $SD = 1.38$; American: $M = 3.29$, $SD = 1.29$).

Canadian and American school counsellors reported how knowledgeable they believed the teachers and students in their schools were about NSSI. There were no significant differences between Canadian and American counsellors' perception of teacher knowledge about NSSI, $t(346) = 2.10$, $p = ns$, $d = .12$ (Canadian: $M = 2.06$, $SD = 0.85$; American: $M = 2.17$, $SD = 0.96$), or student knowledge, $t(356) = 1.91$, $p = ns$, $d = .22$ (Canadian: $M = 2.82$, $SD = 1.24$; American: $M = 3.07$, $SD = 1.04$).

Independent t -tests were conducted to examine differences in the 23 beliefs about NSSI of Canadian and American school counsellors. The groups differed significantly on nine items, with American counsellors endorsing stronger beliefs (i.e., agreeing/disagreeing to a greater degree) on seven of the nine items. Means, standard deviations, and group comparisons for all statements are reported in Table 2.

Several significant differences were revealed in treatment modalities reported by school counsellors across North America (see Figure 1). American school counsel-

Figure 1
Comparison of Treatment Approaches Reported by Canadian and American School Counsellors



Note. CBT = cognitive behavioural therapy. DBT = dialectical behavioural therapy

* $p < .05$

lors reported using individual therapy ($\chi^2(1) = 5.38, p = .002$) more frequently than their Canadian counterparts. Canadian school counsellors, however, reported using mindfulness ($\chi^2(1) = 8.60, p = .003$), social skills training ($\chi^2(1) = 5.76, p = .016$), and empathetic listening ($\chi^2(1) = 13.61, p = .000$) more often than their American counterparts.

DISCUSSION

The results of the current study provide a detailed report of school counsellors' understanding and experiences of NSSI in the schools. Additionally, the results offer insight concerning the international variability among school counsellors' experiences with NSSI by comparing the responses of Canadian and American counsellors. The present findings also offer some indications regarding the progress made over recent years with respect to how NSSI is managed within schools.

School Counsellors' Understanding and Experiences

The findings of the present study indicate that counsellors do not perceive that they have received adequate training in the area of NSSI, despite empirical evidence suggesting that NSSI is very much within the school counsellors' scope of practice. The majority of counsellors (92%) reported working with a self-injuring student at some point in their career.

Furthermore, it appears that NSSI is being encountered more frequently within the school environment. Counsellors who reported having previous experience working with youth who engage in NSSI reported working with approximately nine self-injuring students over the course of an average seven-year career, translating to approximately one student per year. However, the number seems to be increasing: of those who had worked with a student who self-injures, counsellors reported working with three self-injurers within the last academic year alone. It remains unclear if such an increase is a result of an overall augmentation in help-seeking behaviour among youth, or if it can perhaps be attributed to an increase in overall NSSI prevalence rates. Taken together, these findings suggest that self-injury is within the scope of practice for school counsellors in North America, and it is becoming a behaviour that school counsellors are required to deal with among youth more often than before.

In terms of preparedness, the majority of school counsellors (68%) identified themselves as the most likely school contact in the event that a student were to be identified as a self-injurer; however, slightly fewer than half (46%) of respondents felt that they were the most appropriate contact. Harris and Jeffery (2010) described similar findings, with school counsellors requesting minimal responsibility in respect to NSSI assessment and intervention despite identifying themselves as team leaders on this topic. Although notable, this finding must be considered with the knowledge that NSSI assessment and intervention requires considerably more expertise and skill than does serving as the initial school contact. The findings of the current study implicitly suggest a degree of unpreparedness, as school

counsellors were unable to see themselves as the most appropriate on-site mental health professional to provide consultation on a self-injuring case. Such findings underscore the need for professional development and training with respect to NSSI, as school counsellors have the opportunity to play a critical position as the front-line professional responsible for identification, assessment, and management of NSSI in the school environment (Toste & Heath, 2010).

School policies and response protocols are essential to effectively manage NSSI in schools (Lieberman et al., 2009; Walsh, 2006). Despite this, the present findings reveal that the majority of school counsellors (63%) indicate that their respective school districts lack protocols for responding to cases of NSSI, and one fifth of current respondents were unaware if their school even has a policy in place. These results are largely consistent with Roberts-Dobie and Donatelle (2007), who found that 67% of surveyed school counsellors reported that their schools lacked NSSI policies. Therefore, based on the perceptions of this sample, it appears that very little progress has been made in developing effective school policies regarding NSSI over the past several years. This is true despite a continued increase in both NSSI occurrence within the schools and NSSI awareness among mental health professionals. This lack of progress is problematic, as school policies provide crucial guidelines and procedures, and serve as a key informational resource for professionals (Lieberman et al., 2009; Toste & Heath, 2010).

The majority of counsellors rated their own knowledge of self-injury as moderate with regard to the root causes, symptoms, and treatment of self-injury. Although their moderate levels of knowledge may be a result of hesitancy to incur certain responsibilities that accompany advanced levels of knowledge, it is possible that moderate levels of knowledge may result from a lack of formal training, which was also evidenced. These findings are consistent with Roberts-Dobie and Donatelle (2007), who reported that the majority of counsellors rated their competency in working with students with NSSI as moderate overall. Taken together, these findings suggest a need for formal training and education with respect to NSSI. As NSSI is a behaviour that is within the scope of North American school counsellors' practice, it is of concern that little progress has been made in the area of school counsellors' professional growth related to NSSI in this sizeable sample.

Of particular interest was the evaluation of sources of information for school counsellors' knowledge. Reflecting the lack of formal education in the area, educational sources of information (e.g., coursework, textbook) were not prominent; only about one quarter of respondents indicated they had accessed these sources. Although the vast majority of participants endorsed professional training sources, only half reported attending a professional conference and only one third reported receiving any in-service training or formal NSSI education. Although Reeves and colleagues (2004) found that school counsellors are sufficiently trained to identify and often treat a variety of externalizing and internalizing disorders in adolescents, such as depression and anxiety, it appears that similar training has not occurred with respect to NSSI. Inadequate training leaves school counsellors underprepared both to address the needs of youth who engage in NSSI, which may reduce their

ability to serve as an appropriate school contact, or to provide training to other professionals who may encounter NSSI in the school environment.

Unexpectedly, when asked what sources were used to access information about self-injury, more than half of the school counsellors cited “knowing someone who self-injures” as their source of information. It is unclear from the responses, however, whether counsellors were referring to students or personal connections. Future research should be conducted to clarify the extent to which mental health practitioners are drawing on personal experiences versus therapeutic encounters and expertise. School counsellors frequently cited mass media (including the Internet) as an informational source. Although reliance on the Internet for information was not unexpected (Whitlock, Lader, & Conterio, 2007), these results highlight the need to direct counsellors to credible and reliable Internet sources, as mass media information concerning NSSI can often be inaccurate and promote misconceptions (Beettam, Sornberger, & Heath, 2009; Purington & Whitlock, 2010; Whitlock et al., 2007).

School counsellors appear to have a generally accurate depiction of self-injury, accurately identifying many functions, traits, and associated comorbid disorders. However, the majority of counsellors did not believe self-injuring individuals were suicidal. Although it is correct that these are distinct behaviours, this question did not assess whether counsellors understood that individuals with a history of NSSI are at an increased risk for suicide-related behaviours. It is important that school counsellors not only understand the difference between these two behaviours, but that they also recognize self-injury as a potential warning sign of distress and follow up with a suicide risk assessment when necessary (Muehlenkamp & Gutierrez, 2004; Whitlock & Knox, 2007). Additionally, the majority of counsellors did not believe that adolescents who self-injure typically report their behaviour to an adult, which appears to be the case, as counsellors reported only working with an average of three self-injuring students in the last academic year, despite prevalence rates which suggest that 14% to 20% of youth engage in NSSI at least once (Laye-Gindu & Schonert-Reichl, 2005; Muehlenkamp & Gutierrez, 2007; Nixon et al., 2002; Ross & Heath, 2002).

The current study provides a preliminary view of typical courses of action and approaches to intervention taken by school counsellors when faced with NSSI in the school environment. A general consensus was shown: the majority of respondents (84%) indicated that school counsellors should be conducting NSSI interventions. Typical courses of action for working with a self-injurer included contacting the students' parents, providing individual counselling, and/or referring the student to another school professional (e.g., school nurse, principal, school social worker, school psychologist) or outside professional (e.g., child protective services, psychiatrist, psychologist, physician). Interestingly, the majority of respondents suggested a “full psychiatric evaluation.” This is of concern, as only a minority of youth who engage in NSSI behaviours do so repetitively as a symptom of more serious psychiatric issues (Heath, Toste, & Zinck, 2008; Ross & Heath, 2002; Whitlock et al., 2006). As the frequency and chronic nature of

the behaviour can be highly variable, it is suggested that not all youth will require a full psychiatric evaluation. In accordance with Heath and Nixon (2009), it is suggested that the school counsellor perform an initial assessment and triage, which includes suicide risk assessment, evaluation of physical injury, and appraisal of co-occurring mental health issues.

It also appears that school counsellors had reservations with regard to how effectively they had intervened with a self-injuring student in the past, as a quarter of respondents indicated they would change previously used NSSI intervention strategies. It is important to note that we cannot assume this change in course of action is due to lack of confidence, as it could very possibly illustrate professional growth and change among counsellors' intervention approaches. Qualitative examination of school counsellors' practices and analyses of their actions would serve to enhance our understanding of how complex therapeutic or intervention decisions are made.

The current study provides a view of school counsellors' previous approaches to NSSI treatment and intervention. Specifically, although empathetic listening (61%) and individual therapy (60%) were the most frequently reported modalities, problem-solving skills building, relaxation techniques, effective communication, and cognitive behavioural therapy were also frequently reported. Other less frequently reported modalities included client-centred therapy, mindfulness techniques, social skills training, family intervention, group therapy, and dialectical behavioural therapy. Respondents indicated using an average of three treatment approaches concerning NSSI treatment and interventions, which may be attributed to the lack of formal training received or moderate degree of knowledge regarding NSSI. It is also possible that information regarding evidenced-based treatments for NSSI has not yet been made accessible to counsellors across North America, as this is a new area of research and many treatment approaches currently have limited empirical support.

International Variability in School Counsellors' Responses

Counsellors from both Canada and the United States reported working with a similar number of students who engage in NSSI, although American counsellors were more likely than Canadian counsellors (72.3% versus 58.3%, respectively) to report having any student identified as engaging in NSSI referred to them for a consultation. As such, it is clear that self-injury is a behaviour that school counsellors are encountering regularly across North America; yet in the United States, a school counsellor is more likely to be perceived by other school personnel as the appropriate person to consult with students who engage in NSSI.

Canadian and American counsellors did not differ with regards to their perceived knowledge concerning causes, symptoms, and knowledge of NSSI, with both groups reporting only moderate knowledge in all three areas. This result suggests that increasing general NSSI knowledge among school counsellors across North America is needed, which can be achieved through augmenting professional development, education, and training efforts.

Canadian and American school counsellors shared similar NSSI beliefs, but some significant differences were noted. Canadian and American counsellors reported similar beliefs regarding the etiology, functions, and commonly co-occurring disorders associated with NSSI. However, American counsellors were more likely to endorse common misconceptions and beliefs that were largely congruent with how self-injury is typically depicted in the media. Misconceptions of NSSI typically include viewing the behaviour as a consequence of sexual abuse, a failed suicide attempt, performed for attention, or suggestive of a diagnosis of Borderline Personality Disorder (BPD; see Klonsky & Glenn, 2009).

For example, American counsellors viewed NSSI as a sign of a mental illness, and as a behaviour occurring most often among white, upper-middle-class individuals with a history of sexual and/or emotional abuse. Furthermore, American counsellors endorsed items that described NSSI as a repetitive, pain-free behaviour often associated with characteristics of BPD in adolescents. These representations concerning NSSI may be largely due to the fact that school counsellors are choosing to access informal sources of information (e.g., Internet, television) that may not depict the full range of self-injury observed among youth. The presence of self-injury within the media has increased dramatically within recent years, appearing on television, movies, and the Internet (D'Onofrio, 2007). Media information concerning NSSI can often be inaccurate and promote common misconceptions (Beettam et al., 2009; Whitlock et al., 2007). It is crucial that these common misconceptions be challenged, as school counsellors are at the front line of recognizing and providing intervention for NSSI within the school environment. Misconceptions among school professionals can be detrimental to the quality of support and treatment provided to youth who engage in this behaviour (Toste & Heath, 2010). For a full review of common misconceptions concerning NSSI, see Klonsky and Muehlenkamp's (2007) guide for mental health practitioners.

In terms of treatment modalities, American school counsellors utilized individual therapy significantly more often than Canadian counsellors, whereas Canadian counsellors utilized mindfulness, social skills training, and empathetic listening more often. Although mindfulness has been shown to be an effective treatment approach for NSSI (Gratz, 2006; Gratz & Chapman, 2009; Muehlenkamp, 2006), only 16% of Canadian counsellors and 7% of American counsellors endorsed this successful treatment modality. This suggests that, despite its effectiveness, mindfulness is used minimally as a treatment approach by school counsellors. Moreover, empathetic listening was endorsed most, with approximately 55% of Canadian and 72% of American school counsellors utilizing this approach with self-injuring students. Although empathetic listening represents a cornerstone of counsellor training and is considered essential for building rapport, it is important that counsellors develop a strong understanding of how to communicate around issues of NSSI when utilizing such a modality. It is essential that the professional does not unconsciously encourage the youth to "re-live" incidents of self-injury, which could serve to trigger further episodes and reinforce the behaviour (Walsh,

2006). In sum, professional development that focuses on current effective school-based approaches to treatment for NSSI is warranted.

The current study is not without limitations. It should be noted that participation recruitment to complete the online survey was conducted through advertisement in conjunction with a free online professional training workshop, which may potentially have attracted school counsellors who were previously familiar with NSSI and had a desire to obtain further training. Moreover, the forced-choice format of the survey may not have been the optimal choice given the complexity of surveyed content (i.e., counsellors' activities). Due to the online nature of data collection and the distribution of the survey link via electronic mailing lists of the membership counselling associations, the authors were unable to determine a response rate. As such, the sample may not be representative of school counsellors across all geographic regions of North America. Additionally, the phrasing of the suicidality question may have been potentially misleading as the question did not address the nature of the link between NSSI and suicidality. Future studies may benefit from rewording the question, or by including an additional question that appropriately assesses the nature of the link between the two behaviours.

CONCLUSIONS

The current study provided a detailed view of school counsellors' current understanding of, and experiences with, NSSI within the schools, in addition to examining international variability between Canadian and American school counsellors. Furthermore, these results allow us to consider how school counsellors' experiences, knowledge, and beliefs regarding the behaviour and overall service delivery concerning NSSI has changed in recent years. These findings provide a snapshot of how NSSI is being addressed within the schools. School counsellors reported limited to moderate knowledge regarding root symptoms, causes, and treatment of NSSI, which is disconcerting as the majority of school counsellors identified themselves as the most likely contact when a student is identified as a self-injurer. Findings clearly demonstrate that there is a lack of formal training among school counsellors in our sample, which is worrisome when paired with use of informal informational resources such as mass media (e.g., television, Internet).

Canadian and American school counsellors were quite similar in their overall experiences with NSSI, although some interesting differences emerged. School counsellors differed with respect to their beliefs concerning NSSI, as American school counsellors endorsed media-based representations of self-injury to a greater degree. However, both groups reported moderate knowledge where expertise was expected. Moreover, training and general school preparedness were lacking, with school policies being largely nonexistent across North America. Furthermore, effective treatment strategies (such as mindfulness-based techniques) were minimally endorsed. These results highlight the need for formal training and further education of school counsellors who serve at the front line of addressing this behaviour in the schools.

Overall, these results suggest that school counsellors regularly encounter NSSI within their practice, and that the majority of cases have occurred within the last year of practice, highlighting an increase of NSSI prevalence within the school environment. As such, future research should seek to qualitatively examine school counsellors' experiences in order to capture the complexity and fully understand the nature and scope of service delivery activities related to NSSI within the schools. Although the present study sought to examine differences among North American counsellors, future quantitative studies should seek to examine the diversity at an international scale across broader samples, which would serve to provide a global depiction concerning school counsellors' NSSI knowledge, training, and overall experiences. Lastly, research is also needed to explore factors that might enhance service access by students, and possible alternative intervention and prevention modalities (e.g., online resources). Clearly these avenues of investigation are essential, as the study of self-injury in the schools is nascent; such information would greatly inform professional development and serve to improve service delivery.

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