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Treating Nonsuicidal Self-Injury: Experience of Graduate Mental Health Students

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Pacific University
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Abstract
Nonsuicidal self-injury (NSSI) is common and rising in clinical and nonclinical populations, particularly among adolescents. Little is known about the training or experiences of graduate mental health students in diagnosing and treating self-injuring clients. In March 2010, students in accredited clinical psychology, counseling psychology, and social work programs across the United States were invited to participate in an online survey. A total of 500 respondents rated and described their training with respect to NSSI as well as their experiences with and perceptions of both clients who engage in self-injurious behaviors and the behaviors themselves. Among other findings, results indicated that 78.1% of students doing clinical practice were seeing clients who engaged in self-injury, but only 21.6% had received formal training on NSSI. Similarly, few students were familiar with self-injury assessment tools. Only 20% believed they knew enough to treat NSSI effectively. The findings suggest that graduate mental health programs should strengthen training and supervision on nonsuicidal self-injury.

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TREATING NONSUICIDAL SELF-INJURY:
EXPERIENCE OF GRADUATE MENTAL HEALTH STUDENTS

A THESIS
SUBMITTED TO THE FACULTY
OF
SCHOOL OF PROFESSIONAL PSYCHOLOGY
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HILLSBORO, OREGON

BY
MARGARETHA J. L. SCHUERMAN

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APPROVED:
Genevieve L. Y. Arnaut, Psy.D, Ph.D.
Abstract

Nonsuicidal self-injury (NSSI) is common and rising in clinical and nonclinical populations, particularly among adolescents. Little is known about the training or experiences of graduate mental health students in diagnosing and treating self-injuring clients. In March 2010, students in accredited clinical psychology, counseling psychology, and social work programs across the United States were invited to participate in an online survey. A total of 500 respondents rated and described their training with respect to NSSI as well as their experiences with and perceptions of both clients who engage in self-injurious behaviors and the behaviors themselves. Among other findings, results indicated that 78.1% of students doing clinical practice were seeing clients who engaged in self-injury, but only 21.6% had received formal training on NSSI. Similarly, few students were familiar with self-injury assessment tools. Only 20% believed they knew enough to treat NSSI effectively. The findings suggest that graduate mental health programs should strengthen training and supervision on nonsuicidal self-injury.

Keywords: nonsuicidal self-injury, graduate training, students, clinical psychology, counseling psychology, social work
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Introduction

Nonsuicidal self-injury – the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned – has occurred across times, societies, and cultures (Favazza, 2009; International Society for the Study of Self-Injury [ISSS], 2010). Yet the behavior has only become the focus of more widespread scientific investigation in the last 10 to 15 years (Favazza, 2009; Nock, 2010). In this relatively brief time period, mental health professionals have gained valuable knowledge and insight into a behavior that often appears baffling and unnatural to both mental health professionals and laypeople (Favazza, 1998; Klonsky & Muehlenkamp, 2007).

The increased clinical and research interest in nonsuicidal self-injury (NSSI) has led to the understanding that this behavior occurs in clinical and nonclinical populations across age groups, but with higher prevalence rates reported among the younger age segments (Briere & Gil, 1998; Darche, 1990; DiClimente, Ponton, & Hartley, 1991; Hilt, Cha, & Nolen-Hoeksema, 2008; Klonsky, Oltmanns, & Turkheimer, 2003; Laye-Gindhu & Schonert-Reichl, 2005; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Ross & Heath, 2002; Whitlock, Eckenrode, & Silverman, 2006). We have also learned that individuals engage in NSSI for a broad range of reasons, with affect regulation being the most commonly reported (Briere & Gil, 1998; Hoffman & Kress, 2008; Klonsky, 2007a; Klonsky & Muehlenkamp, 2007). Various theoretical models to explain NSSI have been and continue to be investigated, including the functional model (Nock & Cha, 2009), the interpersonal model (Prinstein, Guerry, Browne, & Rancourt, 2009), and the biological model (Sher & Stanley, 2009).
Several researchers have shown that nonsuicidal self-injury is correlated with suicidal ideation and behaviors, as well as with high-risk health behaviors (Guertin, Lloyd-Richardson, Spirito, Donaldson, & Boergers, 2001; Laye-Gindhu & Schonert-Reichl, 2005). Unfortunately, the increased understanding of NSSI has not yet culminated in treatments with demonstrated effectiveness (Klonsky & Muehlenkamp, 2007; Nock, 2010). A possible reason is that proposed treatments have failed to fully address the complexity and multifarious functions of NSSI (Walsh, 2010). However, several promising clinical trials are being carried out in which the treatment intervention is based on a functional analysis of a client’s self-injuring behaviors (Andover, Schatten, & Morris, 2010).

Because NSSI is a prevalent, complex, and often secretive behavior, mental health professionals at all levels should be adequately trained in assessment and treatment of this behavior. White, McCormick, and Kelly (2003) pointed out that mental health professionals should also be trained in recognizing and managing possible negative countertransference reactions to the behavior. Otherwise, therapists’ negative reactions to NSSI and clients’ anticipation of these negative reactions can hinder effective diagnosis and treatment (Hoffman & Kress, 2008; Klonsky & Weinberg, 2009). Both factors can negatively impact an effective therapeutic relationship and in turn treatment outcome.

Little is known about therapists’ experience with treating self-injuring clients, although a recent study was conducted with college and university mental health providers (Whitlock, Eells, Cummings, & Purington, 2009). Even less is known about graduate mental health students’ knowledge of and experience with identifying and treating NSSI. The purpose of this study was to explore graduate clinical psychology,
counseling psychology, and social work students’ preparation for and experience with treating NSSI. To aid the flow of the text, I use the terms nonsuicidal self-injury (or its abbreviation, NSSI) and self-injury interchangeably.
Literature Review

In recent years, NSSI has increasingly attracted the attention of mental health professionals and the popular media (Nock, 2010; Zila & Kiselica, 2001). Even though this increase in attention could suggest that NSSI is a recent phenomenon, in reality self-injury has occurred across time, societies, and cultures (Favazza, 2009; Nock, 2010). Research has demonstrated that nonsuicidal self-injury is prevalent in both clinical and nonclinical populations, particularly among adolescents (Briere & Gil, 1998; Klonsky et al., 2003; Lloyd-Richardson et al., 2007).

Much remains to be learned about effective treatments for nonsuicidal self-injury (Nock, 2010). The lack of vital information to date is partially the result of the complexity and heterogeneity of nonsuicidal self-injury in terms of its presentation, features, and functions (Klonsky & Muehlenkamp, 2007). Other related factors are inadequate dissemination of research findings (Klonsky & Muehlenkamp, 2007) and the lack of a commonly accepted definition of nonsuicidal self-injury (Claes & Vandereycken, 2007; Rodham & Hawton, 2009). The purpose of this literature review is to provide an overview of our current understanding of the characteristics, functions, and treatment approaches to nonsuicidal self-injury and to highlight the need for adequate training of current and future mental health professionals. I have limited this review to articles in which the authors explored nonsuicidal self-injury separate from suicidal ideation and behaviors and articles that go beyond addressing nonsuicidal self-injury within the diagnostic framework of borderline personality disorder (America Psychiatric Association [APA], 2000). Furthermore, I have excluded articles that addressed stereotypical
nonsuicidal self-injury, which typically occurs among individuals with developmental or neuropsychiatric disorders, or major nonsuicidal self-injury (e.g., self-castration), which occurs primarily among individuals with psychotic or substance use disorders (Nock & Favazza, 2009).

**Definition**

Mental health researchers and clinicians have used a myriad of terms and definitions to describe self-injury. A quick scan of the self-injury literature will confront the reader with terms such as parasuicide (Levy, Yeomans, & Diamond, 2007), self-injurious behavior (White et al., 2003), self-harm (Warm, Murray, & Fox, 2002), deliberate self-harm (Gratz, 2001), self-inflicted violence (Brown & Bryan, 2007), and self-mutilation (Briere & Gil, 1998). The vague and often inconsistent delineation of the behaviors described by each of those terms has hampered the systematic study and understanding of nonsuicidal self-injury (Nock, 2010; Rodham & Hawton, 2009).

The distinctions among nonsuicidal self-injury, other self-harming behaviors, and harmless behaviors are often not clear-cut (Klonsky, 2007). Good and clear definitions of nonsuicidal self-injury are therefore essential. Suyemoto and Kountz (2000) proposed that a definition of nonsuicidal self-injury should reflect six issues: directness and social acceptability of the bodily harm, frequency and degree of physical damage cause by the behavior, and intent and psychological state of the self-injuring individual while engaging in the behavior. The directness of nonsuicidal self-injury sets it apart from behaviors that may indirectly cause bodily harm, such as drinking alcohol or unbalanced food intake (Nock, 2010). Similarly, social acceptability delineates beautification and creative expression (e.g., ear piercing) from nonsuicidal self-injury (Claes & Vandereyken, 2007;
Nock & Favazza, 2009). Intent helps to distinguish nonsuicidal self-injury from suicidal behaviors (Whitlock et al., 2006) and from socially sanctioned creative expression (Nock, 2009). For example, body piercings carried out with the intent to increase physical attractiveness would not be categorized as NSSI, whereas body piercings performed to release overwhelming emotions would be characterized as NSSI (Klonsky, 2007b). The final three elements – psychological state, frequency, and degree of damage – point to the distinction between NSSI occurring among normally developing, nonpsychotic individuals and similar but involuntary behaviors occurring in individuals with developmental or neuropsychiatric disorders or during an altered mental state such as psychosis or intoxication (Nock & Favazza, 2009).

The above six elements have been reflected in the proposed definition of NSSI for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2010), as follows: “intentional self-inflicted damage to the surface of his or her body, of a sort likely to induce bleeding or bruising or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), for purposes not socially sanctioned (e.g., body piercing, tattooing, etc.), but performed with the expectation that the injury will lead to only minor or moderate physical harm” (para. 1). For the purpose of this thesis, I defined NSSI as non-socially sanctioned but mutilating behaviors performed with the intention of inflicting harm to one’s body without the obvious intention of committing suicide. This definition was used by Whitlock et al. (2009) in their survey of college mental health providers, which constituted the starting point of this thesis.
**Epidemiology**

**Prevalence rates.** An accurate estimation of NSSI prevalence rates and trends in clinical and non-clinical populations is wrought with difficulties. One important factor has been the limited inclusion of self-injury in the *DSM-IV-TR* (APA, 2000) as one of the diagnostic criteria for borderline personality disorder, as opposed to a separate mental health disorder. This formulation has impacted the incorporation of self-injury in large-scale mental health epidemiological studies such as the National Comorbidity Survey – Replication (Kessler & Merikangas, 2004; Nock, 2010). In the absence of large-scale epidemiological data, current prevalence estimates are mainly based on small-scale studies, which have used varying self-injury definitions and inclusion criteria, assessment methods, study samples, and recruitment methods. As emphasized by Nock (2010), individuals have been classified in some studies as engaging in self-injury even after a single mild instance of self-injury.

Notwithstanding the above, NSSI seems to be widespread and increasing in clinical and nonclinical populations. Briere and Gil (1998) assessed self-injury (defined as “intentionally hurting yourself [e.g., by scratching, cutting, or burning] even though you weren’t trying to commit suicide” over the last six months; p.611) in a stratified random sample in the United States with 1,442 adults. Approximately 4% of participants reported a history of self-injury. Similar results were obtained in a study of 1,936 Air Force recruits (Klonsky et al., 2003), in which 4.2% of male participants (*n* = 1,236) and 3.6% of female participants (*n* = 750) reported a history of self-injury. In the Klonsky et al. study, participants were classified as having a history of self-injury based on endorsement
of either or both of two items: “I have hurt myself on purpose several times” (p. 1503) or “When I get very tense, hurting myself physically somehow calms me down” (p. 1503).

Assuming that the NSSI prevalence rate among adults in the United States is about 4% as indicated by these studies, prevalence rates for younger nonclinical populations are considerably higher than those for adults in the community. Several studies have pointed to adolescent and young adult NSSI prevalence rates in the range of 14% to 17%. For example, Ross and Heath (2002) conducted screening and semi-interviews with 440 students (210 boys and 221 girls) in seventh to eleventh grade in the United States to assess the presence of self-injury, which was defined as “whether they had ever hurt themselves on purpose” (p. 71). Approximately 14% of students reported a history of self-injury. Laye-Gindhu and Schonert-Reichl (2005) found similar rates in a study with 424 adolescents (188 boys and 236 girls) attending a public high school in Canada. A total of 15% of participants indicated engaging in self-injury, which the researchers defined as “deliberate and voluntary physical self-injury that is not life-threatening and is without any conscious suicidal intent” (p. 447). Whitlock et al. (2006) conducted a study among 3,069 undergraduate and graduate students from two northeastern U.S. universities. Participants were presented a list of 16 self-injurious behaviors and asked “Have you ever done any of the following with the intent of hurting yourself?” (p. 1941). Overall, 17% of participants reported a life-time self-injury history.

In contrast, two more recent studies have pointed to higher prevalence rates among adolescents. In a study by Lloyd-Richardson et al. (2007) among 663 high school adolescents (302 boys and 361 girls) in the United States, 46.5% of participants reported engaging in self-injury during the past year. In this study, the authors measured the
presence of self-injury with the Functional Assessment of Self-Mutilation (FASM), in which participants are asked “whether they purposefully engaged in each of 11 different NSSI behaviors . . . within the past year” (p. 65). Hilt, Cha, et al. (2008) similarly assessed self-injury using the FASM among 94 girls aged 10-14. Of the participants, 56% reported a life-time history of self-injury and 36% self-injurious practices during the last year.

Based on a limited number of studies, self-injury prevalence rates appear to be higher among clinical populations than in nonclinical populations. Briere and Gil (1998) found a 21% 6-month self-injury prevalence rate among 390 clinical adults (246 mental health outpatients, 144 psychiatric inpatients; 43 men, 203 women; mean age 36 years, $SD = 10$). NSSI was assessed in this study through one item on the Trauma Response Scale (“intentionally hurting yourself [e.g., by scratching, cutting or burning] even though you weren’t trying to commit suicide . . . over the last six months”, p. 611). DiClemente et al. (1991) conducted a study on cutting behavior (“self-caused physical injury by cutting with sharp implements”, p. 736) among 76 psychiatrically hospitalized male and female adolescents (40 girls and 36 boys). Over 60% of participants endorsed a life-time history of cutting behavior. A similarly high prevalence rate of 40% was found by Darche (1990) in a study with 48 adolescent female inpatients (aged 13-17) with a history of NSSI.

**Forms of self-injury.** A wide range of self-injurious behaviors has been documented in the literature. The most frequently reported NSSI method is “cutting or carving oneself with a sharp implement such as a razor” (Nock, 2010, p. 346). Other often-used methods include banging, hitting, burning, scratching, and inserting objects
under the skin (Klonsky, 2007b; Klonsky & Muehlenkamp, 2007; Lloyd-Richardson et al., 2007; Nock, 2010; Ross & Heath, 2002).

Differences in preferred method have been observed among clinical and nonclinical populations. In a large-scale study among 2,875 male and female graduate and undergraduate students, the three most commonly reported NSSI methods were severe scratching or pinching of the skin (51.6% of respondents) followed by banging and punching objects (37.6%) and cutting (33.7%; Whitlock et al., 2006). In contrast, in Briere and Gil’s (1998) study of a predominantly clinical sample of adults (89 women and 4 men), the most widely reported self-injuring method was cutting (71% of respondents), biting (60%), and scratching (58%). However, it is important to keep in mind that most individuals who engage in repeated self-injury use multiple methods (Klonsky & Muehlenkamp, 2007; Nock, 2010).

**Gender differences in NSSI.** Views on gender differences in self-injury have shifted in recent years. Traditional wisdom has suggested that girls and women were more likely to engage in self-injury than were boys and men (Klonsky & Muehlenkamp, 2007). However, Andover, Primack, Gibb, and Pepper (2010) pointed out that many historical studies have been focused primarily on self-injury among girls and women. Several recent studies in which males have been included have shown comparable self-injury prevalence rates across genders regardless of age group. In the earlier quoted study, Briere and Gil (1998) observed that adult self-injury prevalence rates did not differ among men and women both in the community and clinical samples. Andover, Primack, et al. (2010) examined NSSI characteristics among self-injuring undergraduate students matched for general psychological distress with non-self-injuring undergraduate students and did not
find significant gender differences in NSSI prevalence rates. Similar findings have been reported for high school adolescents (Lloyd-Richardson et al., 2007) and for sixth- to eighth-grade students (Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008).

Notwithstanding the above results, gender differences have been observed in preferred self-injury method and functions of NSSI. Claes, Vandereycken, and Vertommen (2007) conducted a study of 399 inpatient psychiatric patients in Belgium (265 women and 134 men) of whom 41.4% reported at least one instance and type of NSSI (defined as “deliberate self-injury during the past year [scratching, bruising, cutting, burning, and biting]”; p. 614). Female participants were significantly more likely than male participants to engage in scratching, bruising, cutting, and nail-biting. Andover, Primack, et al. (2010) also found gender differences in NSSI method in their study of 103 nonclinical undergraduates in the United States (47 men and 74 women), in which NSSI was assessed through the Self-Mutilative Behaviors Interview. In this study, female undergraduates reported a significant preference for cutting and scratching behaviors, whereas male undergraduates expressed a significant preference for burning behaviors.

Significant differences between male and female participants were also documented in the above-mentioned study by Claes et al. (2007) regarding functions of NSSI. Female participants were significantly more likely than male participants to engage in NSSI “to avoid negative feelings…, to avoid painful memories…, to get into a twilight or numb state…, to punish myself…, to make myself unattractive…, and to avoid or suppress suicidal thoughts” (p. 627). Male participants were more likely to engage in NSSI for positive interpersonal functions (i.e., getting attention) and less likely to conceal self-injury lesions than were female participants.
**Functions of NSSI.** Much remains to be understood about reasons why individuals intentionally engage in self-injury. Numerous reasons have been identified through empirical research (e.g., Briere & Gil, 1998; Laye-Gindhu & Schonert-Reichl, 2005), with the most frequently reported motivations being affect regulation and self-punishment (Klonsky, 2007a). Another important finding has been that individuals usually engage in NSSI for multiple reasons and in response to various psychological limitations (Prinstein et al., 2009). Hoffman and Kress (2008) pointed out that the function of NSSI often changes over time for an individual. However, it is important to keep in mind that most of our current understanding about the functions of NSSI is based on self-report (Nock, 2010) and that respondents may be unaware of or unwilling to share the motivations for their self-injury.

Recently, mental health professions have focused on more overarching models to explain why people engage in NSSI (Nock, 2009); these approaches include the functional model, the interpersonal model (Prinstein et al., 2009), and biological models (Sher & Stanley, 2009) of NSSI. A detailed review of these models goes beyond the scope of this literature review. Therefore, I will discuss only the functional model, which has received the most empirical support. Authors of the Four Function model (FFM) of self-injury have focused on psychological factors (Nock, 2009). In this approach, NSSI is classified based on the type of reinforcement (i.e., positive or negative reinforcement) and the locus of the intended change (i.e., intrapersonal or interpersonal, Nock & Cha, 2009). For example, self-injurious behaviors intended to reduce feelings of worthlessness would be classified as an automatic (i.e., intrapersonal) negative reinforcer. In contrast, self-injurious behaviors performed to secure attention from others would function as a social
(i.e., interpersonal) positive reinforcer. Several studies have provided empirical support for the FFM (Lloyd-Richardson et al., 2007; Nock & Prinstein, 2004, 2005).

**Comorbidities.** NSSI has long been considered to be either a hallmark of borderline personality disorder or a covert suicide attempt (Favazza, 1998; Klonsky & Muehlenkamp (2007). However, even though empirical research has confirmed that self-injury is a frequently occurring characteristic of borderline personality disorder (Klonsky, 2007), self-injury can also occur in the absence of other mental health disorders. At the same time, the correlation between self-injury and other diagnoses has been well-established in clinical and nonclinical populations, including eating disorders (Favazza & Conterio, 1989; Claes, Vandereycken, & Vertommen, 2001; Styer, Gebhardt, & Juzwin, 2010) and mood and anxiety disorders (Andover, Pepper, Ryabchenko, Orrico, & Gibb, 2005; Klonsky et al., 2003; Nock & Prinstein 2005; Ross & Heath, 2002).

The presence of mental health disorders among community adolescents in Finland who engage in self-injury was recently explored by Hintikka et al. (2009). A sample of 44 adolescents who engaged in self-injury (41 girls and 4 boys, mean age 15.2 years, $SD = 1.5$) were matched based on gender and age with controls who had never engaged in the behavior. Girls who self-injured were significantly more likely to meet criteria for other mental health disorders than were girls who had never engaged in the behavior; the most common comorbid disorders were major depressive disorders, anxiety disorders, and eating disorders. No mental disorder prevalence differences were observed between boys who engaged in self-injury and boys who did not have a history of self-injury.

The relationship between NSSI and suicidal behaviors is complex. Self-injurious and suicidal behaviors often occur at the same time, even though these behaviors differ in
frequency, intent, lethality of method, preferred method, and other characteristics (Walsh, 2006, 2010). A considerable share of individuals with a history of NSSI have attempted suicide, with prevalence rates estimated at 50% for nonclinical populations and 70% for clinical populations (Muehlenkamp & Gutierrez, 2007; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006).

**Other characteristics of NSSI.** Two other characteristics of NSSI that have received attention in the professional literature are its possibly addictive and contagious natures. In the earlier mentioned Briere and Gil (1998) study, 93 participants with a history of self-injury were asked to what degree they had control over the behavior. According to the researchers, only 28% of participants stated that they were always in control, whereas 34% indicated that they felt in control less than half of the time. At the same time, 84% of participants voiced that they were sometimes able to refrain from self-injury.

Nixon, Cloutier, and Aggarwal (2002) reported similar findings regarding the potentially addictive nature of NSSI in a study with 42 psychiatrically hospitalized adolescents (6 boys and 36 girls; mean age 15.7 years; $SD = 1.5$ years) who had a history of NSSI. Of the participants, 97.6% endorsed three or more addictive items, such as “the behavior occurs more often and/or severity . . . has increased,” “SI continues despite recognizing it as harmful,” “Tension level reoccurs if discontinue SU,” “SI causes problems socially,” and “The behavior is time-consuming” (p. 1338).

As mentioned earlier, the rate of NSSI seems to be rising in clinical and nonclinical populations. Yet the reasons for this increase are unknown. Several authors have hypothesized that the increase in NSSI may be linked to social learning
The few studies that have been carried out in this area seem to support a social learning component to NSSI. For example, Deliberto and Nock (2008) conducted a study with 64 adolescents (ages 12-19 years) who had a history of self-injury. The authors reported that adolescents who engaged in self-injury obtained the idea to self-injure primarily from peers (38%) as opposed to from other sources. Muehlenkamp et al. (2008) conducted a cross-sectional study among 1,965 undergraduate students (65.7% women, mean age = 19.34 years; $SD = 1.41$ years) to explore a possible correlation between rates of NSSI and prior exposure to NSSI and suicidal behaviors. The authors concluded that students who had been exposed to NSSI behaviors in others were significantly more likely to have engaged in NSSI themselves.

In a recent study, Prinstein et al. (2010) with 377 community adolescents (Grades 6-8; 50% girls) and 140 psychiatric inpatient adolescents (Grades 7-9; 72% girls) similarly explored the role of peer influence on the NSSI behaviors. For adolescents in the community sample, the authors concluded that a history of NSSI behaviors in best friends was a significant predictor for NSSI behaviors in female sixth-graders. For adolescents in the clinical sample, the authors reported that NSSI behaviors among a groups of friends was a predictor of NSSI in female participants and that adolescents who engaged in self-injury appeared to befriend others who engaged in similar behaviors.

**Treatment**

Opinions in the professional mental health field differ regarding the existence of effective therapies to reduce self-injury. On the one hand, Nock (2010) stated that “there currently are no evidenced-based interventions or prevention programs for self-injury” (p.
On the other hand, Klonsky and Muehlenkamp (2007) reported that “there are a number of treatments that appear to be effective in remedying self-injury. Cognitive-behavioral interventions have received most attention in clinical trials addressing NSSI, including conventional Cognitive-Behavioral Therapy (CBT), Problem-Solving Therapy (PST), and Dialectical Behavior Therapy (DBT, Muehlenkamp, 2006). Other interventions that are being explored are psychodynamic therapy and pharmacotherapy (Klonsky & Muehlenkamp, 2007; Nock, 2010).

Several studies have been published exploring the effectiveness of CBT in reducing NSSI. Tyrer et al. (2003) carried out a randomized trial of brief Manual Assisted Cognitive-Behavior Therapy (MACT) in the United Kingdom. A total of 480 patients with a history of NSSI were randomly assigned to MACT (n = 239) or Treatment As Usual (TAU; n = 241). The researchers concluded that MACT was effective in reducing the number of self-harm episodes but that there was no difference between the MACT and TAU groups at 6 or 12 months post-treatment.

Slee, Garnefski, van der Leeden, Arensman, and Spinhoven (2008) conducted a study in the Netherlands with 90 participants who had recently engaged in deliberate self-poisoning or self-injury (85 women and 5 men; ages 15-35 years). Participants were randomly assigned to TAU only or TAU plus a brief manual-based intervention, which combined elements of CBT, DBT, and PST. The researchers concluded that participants treated with CBT plus TAU had significantly fewer self-harm episodes at 9 months post-intervention compared to participants treated with TAU. However, the internal and external validity of this study was affected by the inclusion of clients who had engaged in deliberate self-poisoning by overdose and by non-standardized TAU.
DBT-type interventions have similarly been applied to reduce NSSI. However, most interventions were carried out with individuals diagnosed with borderline personality disorder (Klonsky & Muehlenkamp, 2007). For example, Linehan, Comtois, Murray, et al. (2006) conducted a study with 100 women (ages 18-45 years) who met DSM-IV-TR (APA, 2000) criteria for borderline personality disorder and who had a history of suicide or NSSI. Participants were randomly assigned to a one-year DBT intervention or to Community Treatment By Experts (CTBE). The researchers concluded that DBT was effective in reducing instances of NSSI but that there was no significant difference between DBT and CTBE.

Psychodynamic interventions have also been used to treat clients diagnosed with borderline personality disorder, as these individuals often engage in NSSI (Klonsky & Muehlenkamp, 2007). For example, Levy, Clarkin, Foelsch, and Kernberg (2007, as cited in Levy et al., 2007) treated 26 women diagnosed with borderline personality disorder with Transference-Focused Psychotherapy (TFP) and compared them with 17 women in a TAU group. Participants treated with TFP showed significant reductions in suicidal behaviors and increases in global functioning. However, data on reductions in NSSI behaviors in this study were unavailable.

**Assessment**

As established in previous sections, NSSI regularly occurs in clinical and nonclinical populations, especially among younger individuals. Even though evidence-based treatments for NSSI do not yet exist, assessment of the behavior is important for several reasons. For example, Nock (2010) pointed out that individuals should be routinely assessed for self-injury because such behaviors can be accompanied by a wide
range of Axis I and Axis II disorders. Slee et al. (2008) identified several other important reasons to assess NSSI behaviors: NSSI can become more severe over time, there is a risk of accidental suicide and permanent physical lesions, the behaviors are associated with suicidal behaviors, and individuals who engage in self-injury frequently experience high levels of emotional distress. Finally, Walsh (2007) stressed the importance of assessing the functions of self-injury as a prerequisite for the development and application of effective treatments.

Several psychometrically sound measures have been developed to assess NSSI (Nock, 2010), and they focus predominantly on three domains: history, context, and functions of NSSI (Klonsky & Weinberg, 2009). However, it is important to keep in mind that these measures have been developed primarily for research purposes rather than for clinical interventions (Walsh, 2007) and have typically been tested on only a few populations (Klonsky & Weinberg, 2009). Similarly, most measures are not adequate to monitor treatment progress (Nock, 2010). Currently available tools specifically developed to assess NSSI can be grouped into three categories: omnibus measures, functional measures, and behavioral measures. In the next few paragraphs, I summarize the most well-established NSSI measures, based on Klonsky and Weinberg’s (2009) account.

Omnibus NSSI measures generally assess a broad range of NSSI, such as “topography, frequency, lethality, intent/functions, history of NSSI, and history of suicidality” (Klonsky & Weinberg, 2009, p. 189). Within this group the most well-established measures in terms of psychometric properties are the 31-item Suicide Attempt Self-Injury Interview (SASII; Linehan, Comtois, Brown, Heard, & Wagner, 2006) and
the 169-item Self-Injurious Thoughts and Behaviours Interview (SITBI; Nock, Holmberg, Photos & Michel, 2007).

Functional measures, on the other hand, specifically focus on the functions or motivations of self-injury. Again, two measures stand out in this group: the Functional Assessment of Self-Mutilation (FASM; Lloyd, Kelley, & Hope, 1997) and the Inventory of Statements About Self-Injury (ISAS; Glenn & Klonsky, 2007). The FASM, a 22-item measure, has a specific focus on possible reasons for self-injury and matches the FFM described earlier in the section. The ISAS, a slightly longer 36-item measure, similarly is used to assess motivations for NSSI and it has two factors that measure “interpersonal functions” and “intrapersonal functions” (Klonsky & Glenn, 2008, p. 217). Finally, among the behavioral measures, which more narrowly assess characteristics of the behavior itself, the Deliberate Self-Harm Inventory (DSHI; Gratz, 2001) was specifically developed for college populations and has the best psychometric properties.

The stance of a therapist in assessing NSSI is as important as the selection of an appropriate assessment tool. Several authors have pointed out the importance of therapists containing their responses to self-injuring clients, such as disgust, shock, and blame (Bierdrager & Schuerman, in press; Favazza, 1998; Klonsky & Weinberg, 2009; Walsh, 2007; White et al., 2003). In addition, a strong therapeutic relationship is essential because clients who engage in self-injury often are aware of the potentially negative reactions of others (Klonsky & Weinberg, 2009). Finally, therapists should avoid unintentionally reinforcing NSSI behaviors by being overly supportive (Walsh, 2007). Some authors have therefore recommended that a therapist exhibit a “low-key,
dispassionate demeanor” (Walsh, 2007, p. 106) or “respectful curiosity” (Kettlewell, 1999, as cited in Klonsky & Weinberg, 2009, p. 184) when assessing and treating NSSI.

**Mental Health Professionals’ Experiences in Treating NSSI**

As seen from the information presented earlier, NSSI is a highly complex behavior that is more prevalent than many other mental health disorders (Nock, 2010). Therefore, mental health professionals at all levels and across settings are likely to encounter clients who engage in NSSI (Klonsky, 2007b) and need to be able to undertake (risk-) assessment and provide treatment, including psychoeducation. An added challenge is that individuals who engage in NSSI sometimes will not routinely disclose the behavior out of fear of negative reactions (Hoffman & Kress, 2008; Klonsky & Weinberg, 2009). These fears are not unfounded. As Favazza (1998) stated, “The typical clinician . . . treating a client who self-mutilates is often left feeling a combination of helpless, horrified, guilty, furious, betrayed, disgusted, and sad” (p. 259). Similarly, White et al. (2003) pointed out that managing negative countertransference was “one of the most critical considerations” (p. 222) in therapy with clients who engage in NSSI. White et al. also referred to the ethical obligation of mental health professionals to monitor personal responses and to practice within the boundaries of their competence.

The competence of mental health professional in working with individuals who engage in NSSI is largely determined by their academic and clinical training, continuing education, experience, and supervision (Hoffman & Kress, 2008; White et al., 2003). Hoffman and Kress therefore stressed the need for graduate-level training programs to disseminate knowledge on causes and functions of self-injury and treatment. Yet little is known about mental health professionals’ experiences with and training for working with
clients who engage in self-injury, although a recent study was conducted with college and university mental health providers (Whitlock et al., 2009). Even less is known about graduate mental health students’ knowledge of and experience with identifying and treating NSSI. The purpose of this study was therefore to explore graduate clinical psychology, counseling psychology, and social work students’ preparation for and experience with treatment of NSSI.
Method

I submitted a research proposal to Pacific University’s Internal Review Board (IRB) for approval on November 25, 2010. On November 30, 2010, Pacific University’s IRB declared the research proposal eligible for IRB exemption (Appendix A). In this section, I describe the data collection method, targeted participants, and survey content.

Participant Recruitment and Procedure

I collected data through an online survey using Survey Monkey (Appendix B). The survey targeted students in U.S. doctoral clinical and counseling psychology programs accredited by the American Psychological Association, as well as students obtaining a Master’s degree in social work programs accredited by the Council on Social Work Education (CSWE). Directories of accredited programs posted at the websites of these organizations (www.apa.org; www.cswe.org) were used to create a list of 224 doctoral-level clinical psychology programs, 67 doctoral-level counseling psychology programs, and 197 Master of Social Work (MSW) programs. This list did not include programs that were located outside the United States (i.e., Canada) or in which Spanish was the language of instruction.

Contact information for the Director of Clinical Training or a similar representative was obtained from each program through e-mail or from the program’s website. If no relevant information could be obtained, the head of the program was included in the final mailing list. Representatives of 11 MSW programs indicated that their program did not offer a clinical track, and these programs were not included in the final mailing list, leaving 187 MSW programs.
Between March 4, 2010, and March 17, 2010, I sent e-mails to the identified representative of these programs with the request to forward a survey invitation to their students. The standard e-mail and invitation letter are included as Appendix C. Contact persons at four MSW and five clinical psychology programs declined participation in the research. Reasons stated included university policies against forwarding survey participation requests or involving students in research, concerns that survey participation could overburden students or result in lower response rates to universities’ internal surveys, and lack of familiarity with electronic survey invitations. Representatives from two clinical psychology programs, one counseling psychology program, and three MSW programs pointed out the need for approval from their respective institutions’ IRB. I responded to these programs by indicating that I could send a copy of Pacific University’s IRB approval but would not submit a request for additional IRB approval from their program. Representatives of all six programs reiterated that they would not participate without additional IRB approval.

Upon starting the online survey, participants were presented with an informed consent form and asked to indicate agreement to a statement of consent by clicking “Next.” Participants were welcome to discontinue the survey at any point and could skip all but four questions. The four required questions related to the participant’s current degree program, his or her clinical training year, the number of self-injuring clients the participant had treated, and his or her choice regarding participation in a gift certificate drawing. The purpose of the required questions was to verify whether a participant belonged to the survey’s target group and to present participants with questions that were most relevant to their experience. The required question regarding participation in the
drawing was needed in order to redirect participants to a second survey where they could enter a contact e-mail address, thereby keeping their e-mail addresses separate from the study data.

**Survey**

The survey was modeled after the *Survey of Practices in Detecting and Treating Self-injury in College Populations* used by Whitlock et al. (2009, Appendix D). These authors gave approval to use and adapt their survey (J. Whitlock, personal communication, October 9, 2009). Similar to Whitlock et al.’s definition, I defined self-injury as non-socially sanctioned but mutilating behaviors performed with the intention of inflicting harm to one’s body without the obvious intention of committing suicide. In addition, examples of self-injury were provided in the survey (e.g., skin cutting, scratching, or pulling hair) as well as examples of behaviors not considered self-injury (e.g., piecing and tattooing).

The Whitlock et al. (2009) survey contained 52 questions, of which 14 were not incorporated in this study. Seven of those questions pertained to participants’ experience with the survey, such as *Do you recommend additional questions?* and *If you had difficulty answering certain questions, which questions gave you difficulty and why?*. An additional seven questions seemed less relevant to the experience of graduate mental health students than to Whitlock et al.’s sample of college mental health providers; for example, *Do you have a private practice?*. The remaining 38 questions were incorporated in the current survey, often with slight modifications to suit the specific circumstances of graduate mental health students. I added four demographic questions and two questions related to participants’ current clinical placement. Furthermore, survey questions on
NSSI-related training were expanded to cover different forms of training as well as supervision. Several additional questions were included on routine NSSI screening at a student’s current clinical placement and familiarity with self-injury assessment instruments.

I anticipated that respondents would have varying levels of both general clinical experience and specific experience treating clients who engage in self-injury. To maximize the relevance of survey items to all respondents, three subsets of questions were created. All participants responded to a standard set of 26 questions. Participants who endorsed clinical experience were given 14 additional questions, regardless whether this clinical experience included NSSI clients. A final set of 13 questions was presented only to graduate mental health students who endorsed treatment experience with self-injurious clients. Answer formats varied throughout the survey and included multiple-choice, Likert-scale, and open-ended response options.

The 26 standard questions (see Table 1) related to individual and academic demographics, training on therapeutic interventions, NSSI-related training, perceived knowledge of NSSI, comfort level with treating self-injurious clients, NSSI incidence trends among the general population, and perceptions of self-injurious behaviors and self-injurious clients.

Individual demographics were assessed through four items asking about age category, gender, ethnicity, and student status (i.e., U.S. citizen or international student). A further six items each related to academic demographics and prior training received on clinical interventions, including NSSI-specific training. Participants who endorsed training on self-injury within their degree program were invited to describe the training
Table 1

*Standard Survey Items*

<table>
<thead>
<tr>
<th>Question category and category items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual demographics</strong></td>
</tr>
<tr>
<td>What is your age category?</td>
</tr>
<tr>
<td>What is your gender?</td>
</tr>
<tr>
<td>How would you describe your ethnicity?</td>
</tr>
<tr>
<td>Are you an international student?</td>
</tr>
<tr>
<td><strong>Academic demographics</strong></td>
</tr>
<tr>
<td>In what region of the United States is the college or university at which you are studying?</td>
</tr>
<tr>
<td>How would you describe the university or institute at which you are studying?</td>
</tr>
<tr>
<td>What degree program are you enrolled in?</td>
</tr>
<tr>
<td>What is the highest degree you have obtained?</td>
</tr>
<tr>
<td>In which year of the program are you currently enrolled?</td>
</tr>
<tr>
<td>What year of clinical training are you in?</td>
</tr>
<tr>
<td><strong>Training on clinical interventions, including NSSI-specific training</strong></td>
</tr>
<tr>
<td>In what therapeutic technique(s) have you received formal training</td>
</tr>
<tr>
<td>In your degree program, have you received formal classroom training on self-injurious behavior?</td>
</tr>
<tr>
<td>In your degree program, have you attended specialized training (e.g., colloquia) on self-injury?</td>
</tr>
<tr>
<td>Have you attended any other professional training on self-injury?</td>
</tr>
<tr>
<td>What types of additional training/information would be helpful for you in assessing and treating self-injurious clients?</td>
</tr>
<tr>
<td><strong>Perceived knowledge of NSSI</strong></td>
</tr>
<tr>
<td>How well-informed about self-injurious behaviors do you consider yourself?</td>
</tr>
<tr>
<td>How familiar are you with the literature on non-suicidal self-injury?</td>
</tr>
<tr>
<td>With which self-injury assessment instruments are you familiar?</td>
</tr>
<tr>
<td><strong>NSSI-incidence trends among the general population</strong></td>
</tr>
<tr>
<td>Have you noticed an increase among the general population in self-injurious behaviors in the past several years?</td>
</tr>
<tr>
<td><strong>Comfort level with treating self-injurious clients</strong></td>
</tr>
<tr>
<td>Generally speaking, how comfortable are you or do you expect yourself to be with treating clients who practice self-injurious behaviors?</td>
</tr>
<tr>
<td><strong>Perceptions of self-injurious behaviors and self-injurious clients</strong></td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
</tr>
<tr>
<td>Self-injurious behavior does not have to be addressed directly because it is a symptom of other disorders</td>
</tr>
<tr>
<td>Self-injurious behavior only needs to be addressed when it hinder treatment progress</td>
</tr>
<tr>
<td>Self-injurious behavior is important because it provides a clue to underlying issues</td>
</tr>
<tr>
<td>Self-injurious behavior is highly destructive and should therefore be eliminated</td>
</tr>
<tr>
<td>Eliminating self-injurious behavior should be a goal of therapy</td>
</tr>
<tr>
<td>Asking self-injurious clients to sign and adhere to ‘no harm’ contracts is an important element of treatment</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td>Clients should be asked about self-injurious behavior even if there is little evidence of it</td>
</tr>
<tr>
<td>Clients should be asked about self-injurious behavior only if there is clear evidence of it</td>
</tr>
<tr>
<td><strong>Functions and general characteristics of NSSI and self-injurious clients</strong></td>
</tr>
<tr>
<td>Clients with self-injurious behavior, are likely to have Borderline Personality Disorder</td>
</tr>
<tr>
<td>Self-injury is a manipulative behavior</td>
</tr>
<tr>
<td>Self-injury is a functional coping mechanism</td>
</tr>
<tr>
<td>Self-injury is an addictive behavior</td>
</tr>
<tr>
<td>Self-injurious behavior can be contagious</td>
</tr>
<tr>
<td>Self-injurious behavior usually develops in isolation</td>
</tr>
</tbody>
</table>
received. Two items measured respondents’ perceived knowledge of NSSI, including familiarity with relevant literature and assessment instruments. Several standard questions were designed to explore respondents’ perceptions of NSSI incidence trends in the general population and comfort level with treating self-injurious clients. Perceptions of NSSI clients and behaviors were explored in four questions in which respondents were asked to indicate agreement with each of 16 statements. The exact wording of these statements varied slightly for respondents who did and who did not endorse treatment experience with NSSI clients. Six statements related to the need to address self-injurious behaviors in a clinical setting. The remaining 10 statements pertained to assessment, functions, and general characteristics of NSSI. Before exiting the survey, all respondents were invited to share additional views on self-injurious behavior in clients and were given the opportunity to participate in a drawing for one of six gift certificates.

Participants who endorsed clinical experience were presented with 14 additional questions (see Table 2). These questions covered characteristics of respondents’ clientele, NSSI treatment and screening protocols at the current clinical placement site, prevalence of self-injurious clients in the current case load, and clinical training and supervision experiences regarding NSSI. Several items verified treatment and screening protocols for
Table 2

**Survey Items for Respondents who Endorsed Clinical Experience**

<table>
<thead>
<tr>
<th>Question category and category items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current clientele</strong></td>
</tr>
<tr>
<td>Which description best fits your current clinical placement?</td>
</tr>
<tr>
<td>What age groups do you work with in your current clinical placement/internship?</td>
</tr>
<tr>
<td><strong>NSSI treatment and screening protocols at current clinical placement site</strong></td>
</tr>
<tr>
<td>Do the waiting or treatment rooms of the institutions at which you are doing your clinical placement/internship contain literature for clients on self-injurious behavior?</td>
</tr>
<tr>
<td>Does the institute at which you are doing your clinical placement/internship possess a set of recommendations for managing self-injurious clients or behaviors?</td>
</tr>
<tr>
<td>Does the institute at which you are doing your current clinical placement/internship incorporate routine screening for self-injurious behavior in the client’s intake?</td>
</tr>
<tr>
<td>Do the waiting room or treatment rooms of the institution at which you are doing your clinical placement/internship contain literature for clients on mental health disorders other than self-injury, such as depression, anxiety, or eating disorders?</td>
</tr>
<tr>
<td>Does the institute at which you are doing your clinical placement/internship possess a protocol or set of recommendations for managing mental health disorders other than self-injury, such as depression, anxiety, or eating disorders?</td>
</tr>
<tr>
<td>All of the clinicians here see clients who self-injure at some point or another</td>
</tr>
<tr>
<td>Very few of the clinicians I work with see self-injurious clients</td>
</tr>
<tr>
<td>Most self-injurious clients in the institute are referred to me</td>
</tr>
<tr>
<td>Most self-injurious clients in the institute are referred to a particular person or particular person in our institute, but I am not that person</td>
</tr>
<tr>
<td><strong>Prevalence of self-injurious clients in current case load</strong></td>
</tr>
<tr>
<td>How many clients have you treated whom you know to have engaged in self-injurious behavior, as defined in this survey, in all of your training placements?</td>
</tr>
<tr>
<td>Approximately what percentage of your current clients engage in self-injurious behaviors?</td>
</tr>
<tr>
<td>How would you characterize the incidence of self-injurious behaviors in the clients you have seen to date?</td>
</tr>
<tr>
<td><strong>NSSI clinical training and supervision</strong></td>
</tr>
<tr>
<td>At your current or previous training site(s), have you received training on self-injury?</td>
</tr>
<tr>
<td>Has your current or have any of your past supervisor(s) raised the topic of self-injurious behavior</td>
</tr>
<tr>
<td>Has your current or have any of your past supervisor(s) provided training on self-injurious behavior?</td>
</tr>
<tr>
<td>Does your current or did your past supervisor(s) appear comfortable discussing self-injurious behaviors?</td>
</tr>
</tbody>
</table>

included; for example, *Does the institute at which you are doing your clinical placement/internship possess a protocol or set of recommendations for managing mental health disorders other than self-injury, such as depression, anxiety, or eating disorders?*

A final set of 13 questions was presented only to graduate mental health students who endorsed treatment experience with self-injurious clients (see Table 3). These items comprised details on treatment and documentation of self-injurious behaviors,
competence, NSSI comorbidities, and characteristics of self-injury and self-injuring clients. One of the items invited respondents to confirm agreement with each of five statements related to NSSI treatment competence; for example, *Most of my peers know enough about self-injurious behavior to treat it effectively*, and *Most of my supervisors know enough about self-injurious behavior to provide effective supervision*. In the item related to the functions of self-injurious behavior, respondents were presented with a list of 21 possible reasons for self-injurious behavior and asked to endorse up to 7 reasons most commonly given by their clients.
Table 3

Survey Items for Respondents Who Endorsed NSSI Treatment Experience

<table>
<thead>
<tr>
<th>Question category and category items</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NSSI treatment</strong></td>
<td></td>
</tr>
<tr>
<td>How many clients have you treated who you know to have engaged in self-injurious behavior, as defined in this survey, in the last year?</td>
<td></td>
</tr>
<tr>
<td>Approximately how long ago did you first encounter a client who practices self-injurious behaviors?</td>
<td></td>
</tr>
<tr>
<td>How often is self-injury the primary reason your self-injurious clients seek help?</td>
<td></td>
</tr>
<tr>
<td>If stopping self-injurious behavior is a therapeutic goal, what technique(s) do you find work(s) best in achieving the goal?</td>
<td></td>
</tr>
<tr>
<td>Have you changed your approach to treating self-injurious behavior over time?</td>
<td></td>
</tr>
<tr>
<td>If stopping self-injury is a therapeutic goal, how effective is therapy in helping a client stop self-injuring?</td>
<td></td>
</tr>
<tr>
<td><strong>NSSI competence</strong></td>
<td></td>
</tr>
<tr>
<td>Most of my peers know enough about self-injurious behavior to treat it effectively</td>
<td></td>
</tr>
<tr>
<td>Most of my supervisors know enough about self-injurious behavior to provide effective supervision</td>
<td></td>
</tr>
<tr>
<td>Self-injury is a subject clinicians-in-training generally need to know more about</td>
<td></td>
</tr>
<tr>
<td>I know enough about self-injurious behavior to treat it effectively</td>
<td></td>
</tr>
<tr>
<td>I am aware of resources for referring a self-injurious client I cannot successfully treat</td>
<td></td>
</tr>
<tr>
<td><strong>NSSI documentation</strong></td>
<td></td>
</tr>
<tr>
<td>How often do you note self-injurious practices in a client’s chart?</td>
<td></td>
</tr>
<tr>
<td><strong>NSSI comorbidities</strong></td>
<td></td>
</tr>
<tr>
<td>In your professional experience, how often do self-injurious behaviors present with:</td>
<td></td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td></td>
</tr>
<tr>
<td>Eating disorders</td>
<td></td>
</tr>
<tr>
<td>Depressive disorders</td>
<td></td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td></td>
</tr>
<tr>
<td>History of sexual abuse</td>
<td></td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td></td>
</tr>
<tr>
<td>History of childhood trauma other than sexual abuse</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td><strong>Characteristics of self-injury and self-injuring clients</strong></td>
<td></td>
</tr>
<tr>
<td>In general, what is the gender breakdown of self-injuring clients you have seen in your clinical work?</td>
<td></td>
</tr>
<tr>
<td>Generally speaking, how difficult to treat do you find clients who practice self-injurious behaviors, even if treatment focus is not specific to self-injurious behavior</td>
<td></td>
</tr>
<tr>
<td>Based on your clinical experience, how addictive do you perceive self-injurious behavior to be</td>
<td></td>
</tr>
<tr>
<td>In your professional experience, what are the seven reasons clients most commonly give for their self-injurious behavior?</td>
<td></td>
</tr>
</tbody>
</table>
Results

Between 5 March 2010 and 27 April 2010, a total of 500 graduate mental health students participated in the survey on graduate mental health students’ experiences with treating NSSI. Of these respondents, 325 chose to participate in a drawing for one of six gift certificates and entered their contact details in a separate survey. The two data sets were exported from Survey Monkey into Excel 2007 on 5 May 2010. I inspected the main survey response set for missing data and outliers and deleted 29 response sets, leaving 471. Of the deleted response sets, 16 were deleted because participants did not provide data beyond individual demographics. A further 13 data sets were excluded because respondents did not belong to the survey target population. The 471 main survey responses were exported into SPSS Statistics 17.0 for statistical analysis.

No responses were deleted from the second survey, which contained contact details of 325 participants in the gift certificate drawing. Winners of the drawing were identified using a random integer generator program (www.random.org). The thus-identified respondents (i.e., participant numbers 296, 36, 157, 177, 322, and 255) were contacted by e-mail on 29 May 2010 and notified of their status. The six winning respondents were asked to contact me by 15 June 2010 to confirm their e-mail addresses and interest in receiving a gift certificate. All winning respondents contacted me by the identified date, except for participant number 157. On 16 June 2010, I identified one alternative winner of the drawing with the earlier mentioned random integer program. I

1 Participants to the survey were able to skip all but four questions. Furthermore, participants were frequently invited to respond only if they agreed with survey items. As a result, I was occasionally limited to calculating the absolute number and not the proportion of respondents who endorsed a survey item.
notified this respondent (i.e., participant number 208) of his or her status on 16 June 2010. The respondent confirmed his or her e-mail address and interest in receiving a gift certificate on 17 June. I e-mailed the gift certificates to the six winning respondents between 31 May and 19 June 2010.

**Characteristics of Study Respondents**

**Respondents’ demographic characteristics.** Of the 471 respondents, most were female (89.2%) and between 20 and 30 years of age (70.7%). Respondents were predominantly of European American ethnicity (79.1%), with percentages for other ethnicities ranging from 5.1% (Asian American) to 0.4% (Pacific Islander). Only 3.0% of respondents endorsed international student status. Further details of respondent demographic characteristics are given in Table 4.

Table 4

**Demographic Characteristics of Survey Respondents**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-25</td>
<td>172</td>
<td>36.5</td>
</tr>
<tr>
<td>26-30</td>
<td>161</td>
<td>34.2</td>
</tr>
<tr>
<td>31-40</td>
<td>83</td>
<td>17.6</td>
</tr>
<tr>
<td>41-50</td>
<td>31</td>
<td>6.6</td>
</tr>
<tr>
<td>Over 50</td>
<td>24</td>
<td>5.1</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>49</td>
<td>10.4</td>
</tr>
<tr>
<td>Female</td>
<td>420</td>
<td>89.2</td>
</tr>
<tr>
<td>Transgendered</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>European American</td>
<td>370</td>
<td>79.1</td>
</tr>
<tr>
<td>Asian American</td>
<td>24</td>
<td>5.1</td>
</tr>
<tr>
<td>African American</td>
<td>17</td>
<td>3.6</td>
</tr>
<tr>
<td>Bi-ethnic</td>
<td>17</td>
<td>3.6</td>
</tr>
<tr>
<td>Latino American</td>
<td>13</td>
<td>2.8</td>
</tr>
<tr>
<td>Middle Eastern American</td>
<td>12</td>
<td>2.6</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>2.8</td>
</tr>
<tr>
<td>International student</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>457</td>
<td>97.0</td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>3.0</td>
</tr>
</tbody>
</table>
**Respondents’ academic characteristics.** Approximately the same percentage of respondents were from the Midwest (25.7%), Southeast (24%), Northeastern United States (18.1%) or the West coast (25.1%). The rest (8.8%) were from Alaska, Hawaii, or other areas. Most respondents endorsed attending a graduate mental health program at a state university (76.1%) or a private university (19.8%). MSW students constituted just over 60% of survey respondents, and doctoral students in clinical and counseling constituted the remaining 40%. More than three-quarters of participating doctoral students attended a clinical psychology program (77.8%). The majority of students endorsed being in the first or second academic training year (65.2%), which may reflect the large number of MSW participants in the study. Over half of the respondents (52.3%) stated they were in their first or second clinical training year, and 22.5% indicated that they had not yet started clinical training. The remaining 25.3% of respondents confirmed having more than two years of clinical experience. Approximately three-quarters of respondents endorsed their previous highest degree to be in a psychology or social work related field. Further details on respondents’ academic characteristics are presented in Table 5.

**Respondents’ clinical experience.** As mentioned earlier, 471 valid survey response sets were analyzed. Almost 80% of these respondents endorsed clinical experience ($n = 365$). Among the respondents with clinical experience, 71.2% ($n = 260$) endorsed treatment experience with self-injurious clients (Figure 1).
Table 5

*Academic Characteristics of Survey Respondents*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School region</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwest</td>
<td>121</td>
<td>25.7</td>
</tr>
<tr>
<td>West coast</td>
<td>118</td>
<td>25.1</td>
</tr>
<tr>
<td>Southeast</td>
<td>102</td>
<td>21.7</td>
</tr>
<tr>
<td>Northeast</td>
<td>85</td>
<td>18.1</td>
</tr>
<tr>
<td>Southwest</td>
<td>24</td>
<td>5.1</td>
</tr>
<tr>
<td>Alaska/ Hawaii</td>
<td>17</td>
<td>3.6</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>University type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State university</td>
<td>357</td>
<td>76.1</td>
</tr>
<tr>
<td>Private university</td>
<td>93</td>
<td>19.8</td>
</tr>
<tr>
<td>Free-standing School of Professional Psychology</td>
<td>14</td>
<td>3.0</td>
</tr>
<tr>
<td>Online institute</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Degree program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSW</td>
<td>288</td>
<td>61.1</td>
</tr>
<tr>
<td>Ph.D. Clinical Psychology</td>
<td>72</td>
<td>15.3</td>
</tr>
<tr>
<td>Psy.D. Clinical Psychology</td>
<td>68</td>
<td>14.4</td>
</tr>
<tr>
<td>Ph.D. Counseling Psychology</td>
<td>40</td>
<td>8.5</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Program year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second</td>
<td>159</td>
<td>33.8</td>
</tr>
<tr>
<td>First</td>
<td>148</td>
<td>31.4</td>
</tr>
<tr>
<td>Third</td>
<td>58</td>
<td>12.3</td>
</tr>
<tr>
<td>Fourth</td>
<td>37</td>
<td>7.9</td>
</tr>
<tr>
<td>Fifth</td>
<td>35</td>
<td>7.4</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>6.6</td>
</tr>
<tr>
<td><strong>Clinical training year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second</td>
<td>128</td>
<td>27.2</td>
</tr>
<tr>
<td>First</td>
<td>118</td>
<td>25.1</td>
</tr>
<tr>
<td>Not yet</td>
<td>106</td>
<td>22.5</td>
</tr>
<tr>
<td>Fourth</td>
<td>34</td>
<td>7.2</td>
</tr>
<tr>
<td>Third</td>
<td>29</td>
<td>6.2</td>
</tr>
<tr>
<td>Predoctoral internship</td>
<td>17</td>
<td>3.6</td>
</tr>
<tr>
<td>Other</td>
<td>39</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>Highest previous degree in any field</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.A./ B.S. Psychology</td>
<td>159</td>
<td>33.8</td>
</tr>
<tr>
<td>M.A. / M.S. Clinical Psychology</td>
<td>67</td>
<td>14.2</td>
</tr>
<tr>
<td>B. S.W.</td>
<td>47</td>
<td>10.0</td>
</tr>
<tr>
<td>M.A. /M. S. Counseling Psychology</td>
<td>28</td>
<td>5.9</td>
</tr>
<tr>
<td>B.A. / B.S. Sociology</td>
<td>26</td>
<td>5.5</td>
</tr>
<tr>
<td>B.A./ B.S. with psychology minor</td>
<td>25</td>
<td>5.3</td>
</tr>
<tr>
<td>Ph.D. in a psychology-related field</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Other</td>
<td>118</td>
<td>25.1</td>
</tr>
</tbody>
</table>
Training on Clinical Interventions, Including NSSI-Specific Training

Training on clinical interventions. Survey participants confirmed formal training in a broad range of general clinical interventions. The three therapeutic techniques most frequently endorsed were cognitive behavior therapy ($n = 324, 68.8\%$), family therapy ($n = 176, 37.3\%$), and psychodynamic therapy ($n = 160, 34.0\%$); the least common were existential therapy ($n = 40, 8.5\%$) and Gestalt therapy ($n = 51, 10.8\%$). Further details are given in Figure 2.

NSSI-specific training. Only 21.6\% of respondents indicated they had received formal classroom training on self-injurious behavior. The percentage of respondents who acknowledged other forms
of NSSI training ranged from 7.7% for specialized training (e.g., colloquia) to 16.7% for other professional training (Table 6).

A two-way contingency table analysis was conducted to evaluate whether NSSI training was related to participants’ degree program (i.e., MSW, Clinical Psychology, or Counseling Psychology). NSSI formal classroom training was found to be significantly related to respondents’ degree program (Pearson $\chi^2 [2, n = 429] = 8.45, p < 0.05$). The effect size based on the phi coefficient was small ($\phi = 0.14$). Of the students in MSW programs, 18.6% endorsed formal classroom training on NSSI, compared to 30.0% of students in doctoral-level clinical psychology students, and 13.5% of doctoral-level counseling psychology students. Specialized training on NSSI was also found to be significantly related to respondents’ degree program (Pearson $\chi^2 [2, n = 428] = 10.44, p < 0.05$). The effect size based on the phi coefficient was small ($\phi = 0.16$). Of the MSW respondents, 4.6% endorsed having received specialized classroom training on NSSI.
Table 6

*Participants’ Attendance at NSSI Training*

<table>
<thead>
<tr>
<th>Type of NSSI training</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal classroom training</td>
<td>21.6</td>
</tr>
<tr>
<td>Specialized training</td>
<td>7.7</td>
</tr>
<tr>
<td>Other professional training</td>
<td>16.7</td>
</tr>
</tbody>
</table>

compared to 13.8% of doctoral-level clinical psychology respondents, and 8.1% of the
doctoral-level counseling psychology respondents. No significant relationship was found
between participants’ degree program and other professional training on NSSI (Pearson $\chi^2$
[2, $n = 428$] = 3.80, $p = 0.15$, $\varphi = 0.094$).

**Knowledge about NSSI.** Most respondents considered themselves *a little*
*informed* or *somewhat informed* about self-injurious behaviors. Only 5.1% of respondents
endorsed being *not at all informed*, and 14.2% endorsed being *very well informed*.
Similarly, 74.0% of participants expressed being *slightly familiar* or *moderately familiar*
with the NSSI literature. However, striking differences in familiarity with the NSSI
literature were observed between students who endorsed clinical experience and those
who did not (Table 7).

**Familiarity with NSSI assessment instruments.** Familiarity with self-injury
assessment instruments was generally low. Out of 471 participants, the number of
respondents who endorsed familiarity with the four best established self-injury
assessment tools (FASM, ISAS, SASII, SITBI; Klonsky & Weinberg, 2009)
Table 7

Participants’ Self-Reported Familiarity with Literature on NSSI

<table>
<thead>
<tr>
<th>Familiarity with literature on NSSI</th>
<th>No clinical experience (n = 100)</th>
<th>Clinical experience (n = 330)</th>
<th>Total (n = 430)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not familiar</td>
<td>42.0</td>
<td>4.2</td>
<td>13.0</td>
</tr>
<tr>
<td>Slightly familiar</td>
<td>42.0</td>
<td>38.5</td>
<td>39.3</td>
</tr>
<tr>
<td>Moderately familiar</td>
<td>14.0</td>
<td>40.9</td>
<td>34.7</td>
</tr>
<tr>
<td>Not familiar</td>
<td>2.0</td>
<td>16.4</td>
<td>13.0</td>
</tr>
</tbody>
</table>

ranged from 11 (ISAS) to 36 (SASII). A large number of participants (n = 273) denied familiarity with any self-injury assessment instrument (Figure 3).

Training preferences. In response to the question *What types of additional training/information would be helpful for you in assessing and treating self-injurious clients?*, participants endorsed a wide variety of training modalities (Figure 4). The three modalities anticipated to be most helpful were clinical training (n = 329), specialized training (n = 318), and classroom training (n = 291). Respondents expressed least interest in Grand Rounds (n = 70) and role plays (n = 146).

General Perceptions of NSSI Behaviors and Clients

Prevalence trends. In response to the item on perceived NSSI prevalence trends in the general population, similar proportions of respondents indicated noticing an increase (38.4%) or being unsure (36.6%). The remainder (25.0%) expressed not having noticed an increase.
Figure 3. Familiarity with Self-Injury Assessment Instruments.
Deliberate Self-Harm Inventory (DSHI; Gratz, 2001); Firestone Assessment of Self-Destructive Thoughts (FAST; Firestone & Firestone, 1996); Functional Assessment of Self-Mutilation (FASM; Lloyd, Kelley, & Hope, 1997); Inventory of Statements about Self-Injury (ISAS; Glenn & Klonsky, 2007); Self-Harm Behavior Questionnaire (SHBQ; Guiterrez, Osman, Barrois, & Kopper, 2001); Self-Harm Inventory (SHI; Sanstone, Widermand, & Sanstone, 1998); Self-Injurious Thoughts and Behaviors Interview (SITBI; Nock, Holmberg, Photos, & Michel, 2007); Self-Injury Motivation Scale (SIMS; Osuch, Noll, & Putnam, 1999); Suicide Attempt Self-Injury Interview (SASII; Linehan, Comtois, Brown, et al., 2006); Suicide Behaviors Questionnaire (SBQ; Linehan, 1981).

Figure 4. NSSI Training Preferences.
Comfort levels with treating self-injuring clients. Regarding comfort level with treating NSSI clients, differences were observed among respondents who did and did not endorse clinical experience. Of the respondents who endorsed clinical experience, 40.6% indicated feeling less comfortable treating clients who engaged in NSSI than treating other clients, compared with 23.2% of respondents who did not have clinical experience (Table 8).

Table 8

Respondents’ (Anticipated) Comfort Levels with Treating NSSI Clients

<table>
<thead>
<tr>
<th>(Anticipated) comfort level with clients who practice self-injurious behaviors</th>
<th>Percentage of respondents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No clinical experience ($n = 100$)</td>
<td>Clinical experience ($n = 330$)</td>
</tr>
<tr>
<td>Less comfortable than with other clients</td>
<td>23.2</td>
<td>40.6</td>
</tr>
<tr>
<td>As comfortable as with other clients</td>
<td>58.6</td>
<td>54.7</td>
</tr>
<tr>
<td>More comfortable than with other clients</td>
<td>3.0</td>
<td>0.0</td>
</tr>
<tr>
<td>I am not sure</td>
<td>15.0</td>
<td>15.0</td>
</tr>
</tbody>
</table>

A two-way contingency table analysis was conducted to evaluate whether (anticipated) comfort levels with treating clients who engage in NSSI was related to having clinical experience. Clinical experience was found to be significantly related to (anticipated) comfort levels ($\chi^2 [3, n = 430] = 18.31, p < 0.05$). Of the respondents who endorsed clinical experience, 39.3% stated being less comfortable with treating clients who engage in NSSI compared to 23.0% of respondents who did not have
clinical experience. The effect size based on the phi coefficient was small to medium ($\phi = 0.21$).

**Assessment and treatment of NSSI.** All respondents were invited to endorse agreement with each of 16 statements related to treatment, assessment, functions, and characteristics of self-injury and clients engaging in this behavior. Regarding assessment and treatment, 266 respondents indicated that *Clients should be asked about NSSI even if there is little evidence of it.* This may be linked to a similarly large numbers of respondents who endorsed that *NSSI is highly destructive and should therefore be eliminated* ($n = 264$) and that *NSSI is important because it provides a clue to underlying issues* ($n = 191$). Respondents who expressed that the *Eliminating NSSI should be a goal of therapy* ($n = 223$) far outnumbered respondents who voiced that *NSSI only needs to be addressed when it hinders treatment progress* ($n = 18$). No-harm contracts were considered an important element of treatment by 88 respondents. Further details are presented in Table 9.

**Functions and characteristics of self-injury and self-injuring clients.**

Regarding functions and general characteristics of self-injury and clients engaging in this behavior, respondents predominantly regarded self-injury to be a functional coping mechanism ($n = 311$) that most often occurred in private ($n = 242$) and had addictive properties ($n = 210$). A sizeable number of respondents considered self-injury to be a manipulative behavior ($n = 119$). Strikingly few respondents ($n = 31$) endorsed a statement that clients with self-injurious behavior were likely to have borderline personality disorder. Regarding peer influence, slightly more respondents indicated that self-injurious behavior could be contagious ($n = 133$) compared with those
Table 9

Perceptions Regarding Assessment and Treatment of NSSI Behaviors and Clients

<table>
<thead>
<tr>
<th>Statement</th>
<th>No. of respondents who endorsed the statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients should be asked about NSSI even if there is little evidence of it</td>
<td>266</td>
</tr>
<tr>
<td>NSSI is highly destructive and should therefore be eliminated</td>
<td>264</td>
</tr>
<tr>
<td>Eliminating NSSI should be a goal of therapy</td>
<td>223</td>
</tr>
<tr>
<td>NSSI is important because it provides a clue to underlying issues</td>
<td>191</td>
</tr>
<tr>
<td>Asking NSSI clients to sign and adhere to no harm contracts is an important element of treatment</td>
<td>88</td>
</tr>
<tr>
<td>Clients should be asked about NSSI only if there is clear evidence of it</td>
<td>73</td>
</tr>
<tr>
<td>NSSI does not have to be addressed directly because it is a symptoms of other disorders</td>
<td>23</td>
</tr>
<tr>
<td>NSSI only needs to be addressed when it hinders treatment progress</td>
<td>22</td>
</tr>
</tbody>
</table>

who stated that the behavior usually developed in isolation ($n = 101$). The occurrence of self-injury in groups of two or more was endorsed by 86 respondents.

**Clinical Experience, including Clinical Experience with Self-Injuring Clients**

**Clinical placements and client age groups.** To set the context for survey responses regarding nonsuicidal behaviors and clients, participants with clinical experience were asked to describe their current clinical placements and client age groups. Respondents indicated working at a diverse range of clinical placements (see Table 10). The three most commonly endorsed clinical placement description were *other* ($n = 78$), *community mental health* ($n = 35$), and *university counseling center/ student mental health* ($n = 35$). The least common clinical placements were *forensic/ criminal justice (prison/ jail, $n = 7$), VA medical center ($n = 9$), and inpatient psychiatric hospital* ($n = 14$).
Table 10

*Respondents’ Current Clinical Sites, By Type*

<table>
<thead>
<tr>
<th>Description of current clinical placement</th>
<th>No. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>78</td>
</tr>
<tr>
<td>Community mental health</td>
<td>67</td>
</tr>
<tr>
<td>University counseling center/ Student mental health</td>
<td>35</td>
</tr>
<tr>
<td>Department school clinic</td>
<td>33</td>
</tr>
<tr>
<td>Outpatient psychiatric clinic/ hospital</td>
<td>24</td>
</tr>
<tr>
<td>School</td>
<td>24</td>
</tr>
<tr>
<td>Medical clinic (hospital)</td>
<td>23</td>
</tr>
<tr>
<td>Child clinic</td>
<td>18</td>
</tr>
<tr>
<td>Inpatient psychiatric hospital</td>
<td>14</td>
</tr>
<tr>
<td>VA medical center</td>
<td>9</td>
</tr>
<tr>
<td>Forensic/ Criminal Justice (prison/ jail)</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>332</td>
</tr>
</tbody>
</table>

In terms of client age groups, most participants with clinical experience endorsed working with adults between ages 18 and 65 (n = 250). In addition, a sizeable number of respondents indicated working with clients in each of the following age groups: 13 to 17 (n = 145), 6 to 12 (n = 115), 0 to 5 (n = 66), and over 65 years (n = 89).

**Cumulative treatment experience with self-injuring clients.** Close to 80% of respondents who endorsed clinical experience had treated at least one self-injuring client. The largest proportion of respondents (34.8%) had treated two to five self-injuring clients in total (Table 11). A two-way contingency table analysis was conducted to evaluate whether respondents’ graduate mental health degree program was related to treatment experience with clients who engage in NSSI. Degree program was found to be significantly related to treatment experience with clients who engage in NSSI.
Table 11

*Respondents' Cumulative Treatment Experience with Self-Injuring Clients*

<table>
<thead>
<tr>
<th>Total number of NSSI clients treated</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>73</td>
<td>21.9</td>
</tr>
<tr>
<td>1-5</td>
<td>45</td>
<td>13.5</td>
</tr>
<tr>
<td>2-5</td>
<td>116</td>
<td>34.8</td>
</tr>
<tr>
<td>6-10</td>
<td>50</td>
<td>15.0</td>
</tr>
<tr>
<td>11-20</td>
<td>22</td>
<td>6.6</td>
</tr>
<tr>
<td>&gt;20</td>
<td>27</td>
<td>8.1</td>
</tr>
<tr>
<td>Total</td>
<td>333</td>
<td>100.0</td>
</tr>
</tbody>
</table>

(Pearson $\chi^2 [2, 331] = 7.05, p < 0.05$). Of the MSW respondents, 72.8% endorsed treatment experience with clients who engage in NSSI, compared to 85.3% of doctoral-level clinical psychology respondents, and 83.9% of the doctoral-level counseling psychology respondents. The effect size based on the phi value ($\phi = 0.15$) was small.

Among the respondents who endorsed treatment experience with clients who engage in NSSI, 82.7% indicated treating at least 1 self-injuring client during the last year. Over 40% endorsed seeing 2 to 5 self-injuring clients during the preceding year. However, 73.1% of respondents stated that self-injury was never or infrequently the primary reason for self-injurious clients seeking help. Just over a quarter of respondents voiced that self-injury was the primary treatment reason *some of the time* (23.9%) or *most of the time* (2.6%).

**NSSI prevalence rates among current clients.** Participants with clinical experience confirmed a broad range of NSSI prevalence rates among their current clients. Of the 317 respondents to this question, most (60.6%) endorsed NSSI prevalence rates between 0 and 10%. Prevalence rates of 10-30% were confirmed by 49 respondents.
(15.5%), and rates of 60% by 30 respondents (9.5%). Forty-five respondents (14.5%) indicated not being sure of NSSI prevalence rates among their current clients (see Figure 5).

![NSSI Prevalence Rate among Respondents’ Current Clients](image)

**Figure 5.** NSSI Prevalence Rate among Respondents’ Current Clients.

**Characteristics of Self-Injury and Self-Injuring Clients**

**General characteristics.** Regarding gender breakdown of self-injuring clients, most respondents endorsed that their clients engaging in NSSI were all or largely female. Considerable fewer respondents indicated their clients who engaged in NSSI had been equally split by gender (20.4%) or were all or almost all male (8.7%). Just over half of the respondents (52.3%) considered clients who practiced self-injurious behaviors to be as difficult to treat as other clients. At the same time, a considerable proportion of respondents (35.5%) considered self-injuring clients more difficult to treat than other clients, even if the treatment focus was not specific to self-injurious behavior. Close to 10% of respondents stated that they were not sure about whether they found it more difficult to treat clients who self-injured. Approximately 90% of respondents endorsed the
addictive component of self-injurious behavior and stated that they perceived NSSI to be very addictive (34.7%) or somewhat addictive (56.1%). Only 9.3% of respondents did not consider NSSI to be an addictive behavior.

Comorbidities. Several authors have documented that NSSI often presents with other mental health disorders, suicidal ideation, or a history of childhood trauma, including sexual abuse (e.g., Andover et al., 2005; Hintikka et al., 2009; Klonsky et al., 2003). Participants who had endorsed treatment experience with self-injuring clients were therefore asked about the frequency with which selected mental health disorders, symptoms, or a trauma history occurred together with NSSI. Between 53.4% and 63.0% of respondents indicated that NSSI sometimes presented with anxiety disorders, depressive disorders, eating disorders, suicidal ideation, or a history of childhood (sexual) trauma. The percentage of respondents who stated that each of those conditions occurred nearly always ranged from 11.3% (anxiety disorders) to 21.3% (depressive disorders). In comparison to the earlier mentioned disorders, relatively more respondents endorsed borderline personality disorder (BPD) as nearly always co-occurring (29.8%) than respondents who classified this disorder as sometimes co-occurring (42.0%, see Figure 6).

Functions of NSSI

As mentioned in the literature review, individuals engage in NSSI for a broad range of reasons. Survey respondents with clinical experience with client who engage in NSSI were therefore asked to indicate up to seven reasons that clients most commonly give for their self-injurious behavior. The seven reasons most frequently endorsed by respondents were reducing emotional pain by creating physical pain (n = 208), releasing unbearable tension (n = 188), distracting from unpleasant memories/thoughts (n = 148),
Figure 6. Frequency of Self-Injurious Behaviors Occurring with Selected Other Conditions/Disorders.

Stopping feeling numb/out of touch (n = 148), communicating emotional distress (n = 142), coping with feelings of anxiety and depression (n = 139), and gaining a sense of being in control (n = 134). The seven reasons least frequently endorsed were stopping suicidal ideation/attempt (n = 18), shocking people (n = 18), changing body image/appearance (n = 14), taking revenge on significant others (n = 12), following group norms (n = 10), seeking excitement (n = 7), and other (n = 7). Further details are presented in Figure 7.

Clinical Policies, Practices, and Supervision

NSSI screening and treatment protocols. All respondents with clinical experience were asked whether NSSI screening and treatment protocols were in place at their current clinical placements. More than half of the respondents indicated that screening for self-injurious behavior was routinely incorporated in a client’s intake.
However, just over a quarter of respondents endorsed that recommendations were in place for managing self-injurious clients or behaviors. This number was considerably smaller than the number of respondents who stated that treatment recommendations were in place for other mental health disorders (52.0%), such as depression, anxiety, or eating disorders. A similar pattern was observed for available client literature on NSSI and other mental health disorders.
health disorders. A surprisingly large number of respondents indicated being unsure whether screening protocols, treatment recommendations, or relevant literature were available (Figure 8).

![Figure 8. Protocols and Literature on NSSI and Other MHD at Respondents’ Current Clinical Placements](chart)

Note. MHD = mental health disorders

**Documentation of NSSI.** Participants who endorsed treatment experience with clients who engage in NSSI were asked how often they noted self-injurious practices in a client’s chart. Approximately 75% of respondents stated they documented NSSI always (59.3%) or almost always (15.8%). Close to 10% of respondents indicated they never (2.1%) or almost never (7.9%) noted self-injury in clinical charts (Table 12).

**NSSI clinical training and supervision.** The majority of respondents with clinical experience (71.4%) endorsed receiving training on self-injury at their current or previous training site(s). A similarly encouraging number of supervisors appeared to be
Table 12

**Documentation of NSSI Behaviors**

<table>
<thead>
<tr>
<th>Frequency of noting NSSI practices in a client’s chart</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>5</td>
<td>2.07</td>
</tr>
<tr>
<td>Almost never</td>
<td>19</td>
<td>7.88</td>
</tr>
<tr>
<td>Sometimes</td>
<td>36</td>
<td>14.94</td>
</tr>
<tr>
<td>Almost always</td>
<td>38</td>
<td>15.77</td>
</tr>
<tr>
<td>Always</td>
<td>143</td>
<td>59.34</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>241</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

comfortable with discussing NSSI (77.3%), even though a slightly smaller percentage of current or past supervisors (63.4%) had actually raised the topic of NSSI in supervision. Close to 35% of respondents endorsed receiving NSSI training by a current or past supervisor. It should be noted that the above percentages refer to respondents’ cumulative training and supervision experience) as opposed to experiences at the current clinical placement only.

**Assignment of self-injuring clients.** Regarding assignment of clients who engage in NSSI, 153 out of 335 respondents with clinical experience (45.7%) indicated that *all the therapists here see clients who self-injure at some point or another*. At the same time, a sizeable portion of respondents (31.6%) expressed that *very few of the clinicians I work with see self-injurious clients*. Few respondents endorsed that clients who engage in NSSI were referred to a particular person or particular persons at the clinical placement site (*n* = 21; 6.2%) or to him or herself (*n* = 4; 1.1%). Fifty-one respondents (15.2%) stated that they were unsure about the assignment at their clinical placement of clients who engage in NSSI.
Treatment of Self-Injury and Self-Injuring Clients

NSSI treatment effectiveness. Respondents who endorsed treatment experience with clients who engage in NSSI ($n=243$) were asked which therapeutic technique(s) worked best if stopping self-injurious behavior was a treatment goal. The largest number of respondents indicated finding cognitive behavior therapy (CBT) most effective ($n = 181$, 74.4%), followed by Dialectic Behavior Therapy (DBT, $n = 88$, 36.2%). Therapies that incorporated interpersonal and family relationship were endorsed by 50 (20.5%) and 42 (17.2%) respondents respectively. Hypnosis ($n = 3$, 1.2%) and multisystemic therapy ($n = 28$, 11.5%) were endorsed by the fewest respondents (Figure 9). However, it should be noted that these responses will at least partially reflect the degree to which respondents had received training in each of these therapeutic interventions. As mentioned earlier (see page 42), considerably more respondents endorsed prior training in CBT ($n = 324$) compared to – for example – multisystemic therapy ($n = 77$).

![Figure 9. Treatment Approaches Considered Most Effective to Stop NSSI.](image-url)
Over half the respondents indicated that therapy was somewhat effective in helping a client to stop self-injury. Only one-fifth of respondents (19.9%) endorsed therapy being very effective to achieve discontinuation of NSSI, whereas 3.7% of respondents expressed they considered therapy not at all effective in this respect. Approximately 20% of respondents to this question stated they were not sure. The limited effectiveness of therapy in helping clients cease self-injurious behaviors was also reflected in perceived NSSI incidence trends among respondents’ cumulative caseload. Only 15.1% of respondents stated that the incidence of self-injury had *decreased substantially*, whereas 24.3% endorsed that NSSI incidence had decreased a little. Over 30% of respondents expressed that the incidence of self-injury had not changed (22.5%) or increased (8.9%). Most respondents (71.4%) affirmed they had not changed their approach to treating self-injurious behavior over time.

**NSSI Treatment competency.** Respondents who had endorsed treatment experience with self-injuring clients were invited to voice agreement with each of five statements related to their own NSSI treatment competence and the NSSI treatment competence of peers, and supervisors. A large number of participants \((n = 213)\) expressed that clinicians-in-training generally needed to know more about self-injury. Fewer respondents \((n = 99)\) stated that their supervisors knew enough about self-injurious behavior to provide effective supervision. The need for additional knowledge on self-injury was reflected in the items related to NSSI treatment competence. Only 50 respondents indicated that they knew enough about self-injurious behavior to treat if effectively. A slightly larger number of respondents \((n = 87)\) declared being aware of resources for referring a self-injurious client they could not successfully treat. A mere 27
participants endorsed that most of their peers knew enough about self-injurious behavior to treat it effectively.
Discussion

The purpose of this study was to explore graduate mental health students’ preparation for and experience with treating individuals who engage in NSSI. The results suggest that most graduate mental health students who have had clinical training experience (78.1%) have encountered clients with a history of NSSI during their clinical training practice. It seems reasonable to assume that the actual number of clients with a history of NSSI exceeded participants’ estimates, for several reasons. First, routine intake screening for NSSI was conducted at just over half of respondents’ current clinical placements. Second, most clients who engaged in NSSI sought mental health help for reasons other than self-injury. Third, clients may have been reluctant to disclose a history of self-injury out of concern over therapists’ negative reactions (Hoffman & Kress, 2008; Klonsky & Weinberg, 2009).

Study participants reported a broad range of NSSI prevalence rates (from 0% to 80-100%) among their current clients. Furthermore, participants endorsed lower NSSI prevalence rates than were found in Whitlock et al.’s (2009) study. For example, 43.5% of participants in this study estimated NSSI prevalence rates among current clients to be between 0% and 5%, compared to 24.1% in the Whitlock et al. study. The prevalence rates reported by participants in the current study probably partially reflects the diversity of clinical practicum sites and client age groups. For example, psychiatric inpatient adolescents would likely report higher prevalence NSSI rates than would outpatient clients in older age groups (Rodham & Hawton, 2009). Another contributing factor could have been that some students were more aware of NSSI than were other students because of prior training and experience, and these students therefore may have been more likely
to ask clients whether they ever had engaged in self-injury than were students who did not have prior training or experience.

A surprisingly large number of respondents indicated that women constituted the majority of clients with a history of NSSI behaviors (71%). This finding counters current reports that female and male prevalence rates are similar (Andover et al., 2010; Hilt, Nock, et al., 2008; Lloyd-Richardson et al., 2007). Reasons for this discrepancy are unclear but may relate to the characteristics of clinical practicum sites. However, a similarly large share of women/girls who engaged in self-injury was reported in the Whitlock et al. (2009) study.

Respondents’ observation that clients who have a history of NSSI often present with other mental health disorders or with suicidal ideation is consistent with contemporary NSSI literature (Andover et al., 2003; Claes et al., 2001; Favazza & Conterio, 1989; Hintikka et al., 2009; Klonsky et al., 2003; Muehlenkamp & Gutierrez, 2007; Nock & Prinstein, 2005; Nock et al., 2006; Ross & Heath, 2002; Styer et al., 2010). Similarly, participants’ observations regarding NSSI functions and characteristics matched contemporary research findings (Briere & Gil, 1998; Klonsky, 2007; Laye-Gindhu & Schonert-Reichl, 2005; Nock, 2010). Of the seven most frequently reported motivations for clients’ self-injurious behavior in this survey, five could be classified as affect regulation (i.e., reducing emotional pain by creating physical pain, releasing unbearable tension, distracting from unpleasant memories/thoughts, stopping feeling numb/out of touch, and coping with feelings of anxiety and depression; Nock, 2010). Furthermore, endorsement of intrapersonal reasons for NSSI far outweighed endorsement of interpersonal reasons. Participants also endorsed the potentially addictive and
contagious characteristics of NSSI, which have also been cited in the literature as an aspect of NSSI (Briere & Gil, 1998; Deliberto & Nock, 2008; Muehlenkamp et al., 2008; Nixon et al., 2002; Prinstein et al., 2010). A relatively large number of respondents ($n = 88$) perceived self-injury as manipulative behavior. This result is not in line with other research findings that have suggested that the interpersonal function of self-injury is much less important than the intrapersonal function (Nock, 2007). The reasons for respondents’ perceptions of NSSI as manipulative behavior are unclear. A possible explanation is that respondents included participants who were in the early stages of academic training and who therefore may have had limited familiarity with contemporary research findings.

Respondents confirmed the importance of routine NSSI assessment ($n = 266; 56.4\%$) and of addressing NSSI in therapy ($n = 233, 49.5\%$; Nock, 2010; Skee et al., 2008). At the same time, most participants ($n = 266, 56.4\%$) lacked familiarity with NSSI assessment tools. Reasons for this may relate to limited routine NSSI screening and treatment protocols at clinical sites, the heavy research focus of most NSSI assessment tools (Walsh, 2007), participants’ limited familiarity with NSSI literature, and the possibly lower emphasis on assessment training in counseling psychology and MSW programs than in clinical psychology programs.

Participants voiced a preference for the use of CBT and – to a lesser degree – DBT and Interpersonal Group Therapy for treating NSSI behaviors. Participants in the Whitlock et al. (2009) study expressed a similar preference for CBT and DBT. These preferences may reflect the focus on these interventions in contemporary research. However, it seems equally likely that they also partially reflect the large number of participants who received training in CBT. Respondents’ perceptions of the limited
effectiveness of current NSSI interventions is in line with contemporary research finding (Klonsky & Muehlenkamp, 2007; Nock, 2010) and with findings in the Whitlock et al. study. The limited effectiveness of NSSI treatment was further confirmed in the relatively small proportion of participants (15.1%) who confirmed that NSSI behaviors had decreased substantially among their clients.

As seen in the information presented above, most respondents had encountered clients with history of self-injury and recognized the importance of NSSI assessment and treatment. However, relatively few students (21.6%) had received academic preparation for working with these clients, such as classroom training. A possible reason for this lack of training could be that classroom materials are tailored to cover generally accepted mental health disorders, such as those included in the DSM-IV-TR (APA, 2000). As mentioned earlier, NSSI is covered in the DSM-IV-TR (APA, 2000) only as one of the diagnostic criteria for Borderline Personality Disorder. The absence of large-scale epidemiological data on NSSI prevalence rates in the general population may similarly have contributed to inadequate academic training on NSSI (Kessler & Merinkangas, 2004; Nock, 2010). Furthermore, inconsistent routine screening for and documentation of NSSI at clinical sites – as reported by study participants – may hamper general awareness of NSSI prevalence rates among clients.

In contrast to the above lack of didactic training, many participants reported that they had received clinical training (71.4%) and supervision (63.4%) on NSSI treatment. However, it should be noted that respondents’ answers reflected their cumulative training and supervision experiences as opposed to experiences at their current clinical placement only. Therefore, the percentage of practicum sites that provided clinical training or
supervision on NSSI is likely to be lower than the percentages indicated above. Also,
fewer than half of the students who endorsed receiving supervision for treatment of NSSI
believed their supervisors knew enough about self-injurious behaviors to provide
effective supervision.

Taking into account the finding that most students received limited NSSI training,
it is not surprising that the majority of respondents regarded themselves to be only a little
(39.7%), or somewhat (41.1%) informed about NSSI. Similarly, most participants stated
they were only slightly (39.3%) to moderately (34.7%) familiar with the NSSI literature
and did not consider themselves knowledgeable enough to treat NSSI effectively. In
comparison, 61.2% of respondents in the Whitlock et al. (2009) study indicated they were
somewhat informed about NSSI, and 28.8% considered themselves to be very well
informed. Similarly, only 28.3% of respondents in the Whitlock et al. study voiced
knowing enough about NSSI to treat it effectively.

More than half the respondents (55.6%) in the current study stated they felt or
expected themselves to feel as comfortable treating clients who engage in self-injury as
they did treating other clients. Interestingly, participants with clinical experience were
less comfortable treating clients who self-injured than were participants who had not yet
started clinical practice. Reasons for this are not known but may relate to inadequate
NSSI training and the negative reactions some clinicians experience in working with this
group of clients (Favazza, 1989). Similarly, respondents who had not yet started clinical
practice may have underestimated their personal reactions to clients who engage in self-
injury or may have overestimated their ability to promote effective change in these
behaviors. Only 35% of respondents who had treated clients who self-injured regarded
them as more difficult to treat than other clients. This proportion is smaller than the 54% of respondents who reported them to be more difficult to treat in the Whitlock et al. study (2009). This result could reflect the possibility that the current generation of graduate mental health students has been exposed to NSSI behaviors in nonclinical settings (e.g., among peers at school and in social settings).

**Implications**

The above findings suggest that graduate mental health programs should consider strengthening academic instruction, clinical training, and supervision on NSSI. A special focus on assessment and treatment of NSSI appears warranted. The training should also address an effective therapeutic relationship, including management of negative countertransference reactions (Favazza, 1998; Hoffman & Kress, 2008; Klonsky & Weinberg, 2009; Walsh, 2007; White, McCormick, & Kelly, 2003). For example, White, Trepal-Wollenzier, and Nolan (2002) suggested that visualization and body awareness techniques can aid clinicians in identifying personal feelings toward clients who engage in self-injury.

Very little is known about the best way to provide training on NSSI to graduate mental health students and practicing mental health clinicians. However, one study on NSSI training has been carried out with nurses. McAllister, Moyle, Billet, and Zimmer-Gembeck (2009) conducted a qualitative study with 36 emergency nurses in Australia (72% women, mean age = 34.6 years). Participants were given a 3-hr training, which included general information on NSSI and effective treatment techniques, as well as solution-focused nursing. Following the training, participants reported feeling better prepared to understand and respond effectively to patients who presented with NSSI.
Results of this study suggest that academic and clinical training can help prepare students to more effectively work with clients who engage in self-injury.

Hoffman and Kress (2008) proposed several ways to support graduate mental health students’ in working with individuals who self-injure. First, assessment and treatment of NSSI should be included in the program curriculum. Second, supervisors should review session tapes to assess students’ reactions to clients who disclose a history of NSSI and the impact of these reactions on the session. Furthermore, supervisors should help supervisees to distinguish NSSI from suicidal behaviors and to develop a plan to address in-session episodes of NSSI. Finally, the use of popular media (e.g., movies and the internet) could enhance students’ understanding of the functions of NSSI. Participants in the current study regarded clinical training ($n = 329$), specialized training ($n = 318$), classroom training ($n = 291$), and reading materials ($n = 256$) as most helpful in assessing and treating clients who engage in self-injury. Grand rounds ($n = 70$) and role plays ($n = 146$) were least favored. Training directors should consider these preferences in their curriculum development.

**Directions for Further Research**

This study provides a snapshot of the experiences of graduate mental health students in working with clients who self-injure. The replication of this study with other categories of graduate mental health students is recommended, such as with students seeking a Master’s degree in Counseling Psychology or a degree in Psychiatry. Similarly, the replication of this study outside the United States would facilitate international comparisons of the experiences of graduate mental health students in working with clients who engage in NSSI. Another important area of future research is the training format that
would best prepare and support students in working with clients who self-injure. Related to this, an investigation into teaching staffs’ perceptions of NSSI could shed light on barriers to revising curricula of graduate mental health programs. Furthermore, research is recommended among individuals with a history of NSSI but who have stopped this behavior; these individuals could provide an insider’s perspective on effective treatments and on the stigmatization of individuals who engage in this behavior.

**Strengths and Limitations of the Current Study**

This study has several strengths. First, no data have been published to date on the experiences of graduate mental health students with treating NSSI. Therefore, results of this study help us understand those experiences and the academic and clinical support that would be most relevant to graduate mental health students in treating clients who self-injure. Second, I used the survey developed by Whitlock et al. (2009) for their study among college mental health providers, which has aided in comparing experiences with and perception of graduate mental students with providers who have completed their studies and have more clinical experience. Third, the study targeted all accredited clinical psychology, counseling psychology, and MSW programs in the United States and thereby avoided selection bias. Fourth, the survey used a clearly stated definition of NSSI, which matches the definition adopted by the ISSS. A final strength is the sample size of the study (500 respondents).

This study also has several limitations. Although the sample size was relatively large, survey results may not be generalizable to graduate mental health students at large for several reasons. First, the response rate was low considering that there are over 35,000 students in accredited clinical psychology, counseling psychology, and MSW programs in
the United States (Council on Social Work Education [CSWE], 2010; APA, 2010). Second, data were collected through an anonymous online survey. Students who decided to participate may have differed in several important ways from the overall population of graduate mental health students. For example, students who responded may have had more clinical experience with clients who self-injure than do graduate mental health students at large. Similarly, graduate mental health programs whose administrators declined participation in the survey may have differed in some respects from those programs whose administrators allowed participation; however, only 15 programs declined participation. Furthermore, only doctoral-level clinical psychology, counseling psychology, and MSW students were invited to participate in this survey. Therefore, findings of this study cannot be generalized to, for example, students seeking a Master’s degree in Counseling Psychology.

Another limitation was the fact that all data were collected through self-report. Therefore, recall and response bias may have systematically affected the results. Because I am a student in a doctoral clinical psychology program, I am less familiar with MSW training. Therefore, MSW students may have experienced some survey items as irrelevant or ill-fitting to their academic or clinical experience. However, because the survey was based on one included in an earlier study (Whitlock et al., 2009), this concern may not have been as relevant as it would have been had I developed the survey from scratch.
Conclusions

Most graduate mental health students who participated in the study had worked with clients who had a history of NSSI. Academic instruction, clinical training and clinical supervision did not adequately prepare students for effectively assessing or treating this group of clients. Overall, participants’ perceptions of NSSI and individuals who engage in self-injury largely matched contemporary understanding of NSSI in the professional mental health field. Results suggest that graduate mental health programs should strengthen training and supervision on NSSI.
References


Appendix A

Classification of the project 221-09 Treating non-suicidal self-injury: Experience of graduate mental health students by Pacific University Internal Review Board

30 November 2009

Dear Genevieve Arnaud, Psy.D., Ph.D. and Margot Schuerman, M.Sc.,

Thank you for submitting your project plans to the IRB and thus allowing Pacific University to comply with federal regulations regarding research activities involving human subjects.

Based upon the materials submitted, your project (221-09, Treating non-suicidal self-injury: Experience of graduate mental health students) has been classified as follows:

☐ Not IRB jurisdiction
  - Please refer to the explanation below.

☐ Eligible for IRB exemption
  - See explanation for decision and any required modifications to achieve this classification

☐ Expedited review
  - Please refer to the explanation below.

☐ Full board review
  - Please refer to the explanation below.
  - Your documents will be reviewed by the full board its next meeting; feedback will arrive under separate cover after the meeting minutes are transcribed and collated.

Explanation:

This proposal plans a methodology that qualifies for an exemption from the formal IRB review process as per 45 CFR 46.0101(b). Specifically:

Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, UNLESS
a. information obtained is recorded in such a manner that subjects can be identified, directly or through identifiers linked to the subjects AND
b. any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability or reputation.

The clarity and completeness of the proposal allows the exemption to be granted. The project may begin as soon as notice from the IRB is received.

Sincerely,

[Signature]

The Pacific University IRB Co-Chairs
Philip Schot, Ph.D., Associate Professor of Exercise Science
Hannu Laukkanen, O.D., M.Ed., Clinical Professor of Optometry
Appendix B

Survey of Experiences of Graduate Mental Health Students in Treating Nonsuicidal Self-Injury

Informed consent

Study Title - Treating non-suicidal self-injury: Experience of graduate mental health students

Study Personnel - Principal Investigator: Margot Schuerman, M.Sc., M.A., Pacific University, School of Professional Psychology, mschuerman@pacificu.edu; Faculty Advisor: Genevieve Arnaut, Psy.D., Ph.D., Pacific University, School of Professional Psychology, arnaut@pacificu.edu, (503)954-7614, 503)352-2613.

Study Location and Dates - The study is expected to begin following IRB proposal and end in August 2010. All study information will be collected via Survey Monkey (www.surveymonkey.com), a specialized tool for online surveys. The researchers of this study are associated with Pacific University School of Professional Psychology, in Hillsboro, Oregon.

Study Invitation and Purpose - You are invited to participate in a study on the experience of graduate students in clinical psychology, counseling psychology and social work with treating non-suicidal self-injury. This study is being conducted by Margot Schuerman (Principal Investigator, Student), and Genevieve Arnaut (Faculty Advisor, Faculty member.) The purpose of this study is to better understand graduate mental health students’ preparation for and clinical experience with treating non-suicidal self-injury.

Study Materials and Procedures - In this study, you will be asked to complete a brief demographic survey. Once this is complete, you will be asked to answer a survey to assess your preparation for and clinical experience with treating self-injurious clients. It should take less than 30 minutes to complete the study.

Participant Characteristics and Exclusionary Criteria - To participate, you must be at least 18 years of age and a graduate student in clinical psychology, counseling psychology, or social work. If you are below the age of 18, or if you are not a graduate student in clinical psychology, counseling psychology or social work, please exit this survey immediately.

Anticipated Risks, Steps Taken to Avoid Them, and Adverse Event Reporting Plan - Your participation in this project involves no foreseeable risks. None of the measures should cause any discomfort. If discomfort occurs, you should stop the participation immediately and contact the researchers. You do not have to answer any question or engage in any task that you do not wish to perform. If you experience continued discomfort as a result of the study procedure you should stop your participation immediately and contact Genevieve Arnaut, Psy.D., Ph.D., at (503) 352-2613 and the Pacific University Institutional Review Board at (503) 352-1478.
Anticipated Direct Benefits to Participants and Participant Payment - There are no direct benefits for your participation. Your participation, however, will allow researchers to gain a better understanding of graduate mental health students’ preparation for and clinical experience with treating self-injurious clients. You will not receive payment for your participation. However, if you complete the survey you will be given the choice to enter your name into a drawing for one of six amazon.com gift certificates worth $25 each.

Medical Care and Compensation In the Event of Accidental Injury - During your participation, it is important to understand that you are not a Pacific University clinic patient or client, nor will you be receiving medical care as a result of your participation in this study. If you are injured during your participation and it is not due to negligence by Pacific University, the researchers, or any organization associated with the research, you should not expect to receive compensation or medical care from Pacific University, the researchers, or any organization associated with the study.

Promise of Privacy - The results of your participation will be kept in an anonymous manner. Your name will not be collected as part of the survey. Following completion of the survey you will be offered an opportunity to enter your name into a drawing for one of six amazon.com gift certificates. If you choose to do so, you will be asked to enter your email address in a separate survey which is not associated with data collected in the first survey. The records of your participation will be kept private and will be available only to the researchers. If the results are presented or published, information that could make it possible to identify you will not be included or will be modified to safeguard your anonymity. All research data and results will be stored securely.

Voluntary Nature of the Study - Your decision whether or not to participate will not affect your current or future relations with Pacific University. There are no costs to you for your participation other than the time involved in completing the survey. If you decide to participate, you are free to not answer any question or to withdraw at any time without prejudice or negative consequences. If you withdraw early, you will not be eligible to enter your name into the drawing for one of six amazon.com gift certificates each with a value of $25.

Contacts and Questions - The researcher(s) will be happy to answer any questions you may have at any time during the course of the study. Complete contact information for the researchers is noted on the first page of this form. Please contact the faculty advisor if you have questions. If you are not satisfied with the answers you receive, please call Pacific University’s Institutional Review Board, at (503) 352-1478 to discuss your questions or concerns further. All concerns and questions will be kept in confidence.

Statement of Consent - I have read and understand the above. All my questions have been answered. I am 18 years of age or over and agree to participate in the study. Since this is an on-line survey, signatures cannot be obtained. By clicking “NEXT” I understand I will be taken to the study and that my continued participation in the survey denotes my
consent. If I choose not to participate or to withdraw from participation, I can close the web page at anytime.

Survey

Demographic information

1. What is your age category?
   (a) 20-25
   (b) 26-30
   (c) 31-40
   (d) 41-50
   (e) Over 50

2. What is your gender?
   (a) Male
   (b) Female
   (c) Transgendered

3. How would you describe your ethnicity?
   (a) African American
   (b) Asian American
   (c) European American
   (d) Latino American
   (e) Middle Eastern American
   (f) Pacific Islander
   (g) Bi ethnic (please describe):
   (h) Multicultural/ Third culture (please describe):
   (i) Other (please describe):

4. Are you an international student?
   (a) No
   (b) Yes. Which country/ countries are you from?:

Academic information

5. In what region of the United States is the college or university at which you are studying?
   (a) Northeast
   (b) Southeast
   (c) Midwest
   (d) Southwest
   (e) West coast
   (f) Alaska / Hawaii
   (g) Other (please describe):
6. How would you describe the university or institute at which you are studying?
   (a) State University
   (b) Private University
   (c) Free-standing School of Professional Psychology
   (d) Online Institute
   (e) Other *(please describe)*:

7. What degree program are you enrolled in?
   (a) MA/MS Clinical Psychology
   (b) MA/MS Counseling Psychology
   (c) MA Social Work
   (d) Ed.D. Counseling Psychology
   (e) Ph.D. Clinical Psychology
   (f) Psy.D. Clinical Psychology
   (g) Ph.D. Counseling Psychology
   (h) Other *(please describe)*:

8. In which year of the program are you currently enrolled?
   (a) First
   (b) Second
   (c) Third
   (d) Fourth
   (e) Fifth
   (f) Other *(please describe)*:

9. What is the highest degree you have obtained?
   (a) BA/BS in psychology
   (b) BA/BS with a psychology minor
   (c) MA/MS Clinical Psychology
   (d) MA/MS Counseling Psychology
   (e) Ph.D. (please specify field):
   (f) Other *(please describe)*:

10. In what therapeutic technique(s) have you received formal training? *(check all that apply)*
    (a) None
    (b) Cognitive behavior therapy
    (c) Dialectical behavior therapy
    (d) Existential therapy
    (e) Family therapy
    (f) Gestalt therapy
    (g) Interpersonal Group therapy
    (h) Mindfulness-based therapy
    (i) Multisystemic therapy
    (j) Psychodynamic therapy
Other (please describe):

11. Which year of clinical training are you in?
   (a) First clinical placement
   (b) Second clinical placement
   (c) Third clinical placement
   (d) Fourth clinical placement
   (e) Pre-doctoral internship
   (f) I am not yet doing clinical placement
   (g) Other (please describe):

The following questions ask you - as a clinician-in-training - about your experiences with and perceptions of mental health in clinical populations, with a focus on self-injury. For the purposes below, self-injury is defined as non-socially sanctioned but mutilating behaviors performed with the intention of inflicting harm on one’s body without the obvious intention of committing suicide. Although most often associated with the term “cutting”, self-injurers use a wide array of practices to hurt themselves such as (but not limited to) intentional carving or cutting of the skin and subdermal tissue, scratching, burning, ripping or pulling skin or hair, swallowing toxic substances, bruising, and breaking bones. Piercing and tattooing, unless done with the express purpose of inflicting harm, are not considered self-injury for the purposes of this survey, even if they are considered self-injurious behaviors in your clinical placement.

Group 1 – Participants without clinical experience

1. Have you noticed an increase among the general population in self-injurious behaviors in the past several years? (Speculation is perfectly acceptable here.)
   (a) I have not noticed an increase
   (b) I have noticed an increase. If you have noticed an increase in self-injurious behaviors in the past several years, to what do you attribute the increase? (Again, speculation is fine here.)

2. In your degree program, have you received formal classroom training on self-injurious behavior?
   (a) Yes. If yes, please describe the training received.
   (b) No

3. In your degree program, have you attended specialized training (e.g., colloquia) on self-injury?
   (a) Yes. If yes, please describe the training attended.
   (b) No

4. Have you attended any other professional training on self-injury?
   (a) Yes. If yes, please describe
   (b) No
5. How well-informed about self-injurious behaviors do you consider yourself?
   (a) Very well informed
   (b) Somewhat informed
   (c) A little informed
   (d) Not at all informed

6. Generally speaking, how comfortable are you or do you expect yourself to be with treating clients who practice self-injurious behaviors?
   (a) More comfortable than with other clients
   (b) As comfortable as with other clients
   (c) Less comfortable than with other clients
   (d) I am not sure

7. How familiar are you with the literature on non-suicidal self-injury?
   (a) Not familiar
   (b) Slightly familiar
   (c) Moderate familiar
   (d) Highly familiar

8. Based on your understanding of non-suicidal self-injury, with which of the following statement do you agree? (Check all that apply)
   (a) Self-injurious behavior does not have to be addressed directly because it is a symptom of other disorders
   (b) Self-injurious behavior only needs to be addressed when it hinders treatment progress
   (c) Self-injurious behavior is important because it provides a “clue” to underlying issues
   (d) Self-injurious behavior is highly destructive and should therefore be eliminated
   (e) Eliminating self-injurious behavior should be a goal of therapy
   (f) I do not agree with any of the above statements

9. Based on your understanding of non-suicidal self-injury, with which of the following statement do you agree? (Check all that apply)
   (a) Clients should be asked about self-injurious behavior even if there is little evidence of it
   (b) Clients should be asked about self-injurious behavior only if there is clear evidence of it
   (c) Asking self-injurious clients to sign and adhere to “no harm” contracts is an important element of treatment
   (d) Clients who with self-injurious behavior, are likely to have Borderline Personality Disorder
   (e) I do not agree with any of the above statements

10. Based on your understanding of non-suicidal self-injury, with which of the following statement do you agree? (Check all that apply)
    (a) Self-injury is an addictive behavior
(b) Self-injury is a manipulative behavior
(c) Self-injury is a functional coping mechanism
(d) I do not agree with any of the above statements

11. Based on your understanding of non-suicidal self-injury, with which of the following statement do you agree? *(Check all that apply)*

(a) Self-injurious behavior usually develops in isolation
(b) Self-injurious behavior can be contagious
(c) Some clients self-injury in groups of 2 or more
(d) Self-injury most often occurs in private
(e) I do not agree with any of the above statements

12. With which self-injury assessment instruments are you familiar? *(check all that apply)*

(a) Suicide Attempt Self-Injury Interview (SASII; Linehan, Comtois, Brown, Heard, & Wagner, 2006)
(b) Self-Injurious Thoughts and Behaviors Interview (SITBI; Nock, Holmberg, Photos, & Michel, 2007)
(c) Suicidal Behaviors Questionnaire (SBQ; Linehan, 1981)
(d) Self-Harm Behavior Questionnaire (SHBQ; Gutierrez, Osman, Barrois, & Kopper, 2001)
(e) Functional Assessment of Self-Mutilation (FASM; Lloyd, Kelley & Hope, 1997)
(f) Inventory of Statements About Self-Injury (ISAS; Glenn & Klonsky, 2007)
(g) Self-Injury Motivation Scale (SIMS; Osuch, Noll, & Putnam, 1999)
(h) Firestone Assessment of Self-Destructive Thoughts (FAST; Firestone & Firestone, 1996)
(i) Deliberate Self-Harm Inventory (DSHI; Gratz, 2001)
(j) Self-Harm Inventory (SHI; Sanstone, Wiederman, & Sanstone, 1998)
(k) Other *(Please describe)*:

13. What types of additional training / information would be helpful for you in assessing and treating self-injurious clients? *(check all that apply)*

(a) Classroom training
(b) Specialized training (e.g., colloquia)
(c) Clinical training
(d) Grand rounds
(e) Specialized supervision
(f) Role-plays
(g) Reading materials
(h) Audio-visual materials
(i) Other *(please specify)*:

14. Is there anything else you would like to share about how you regard and/or treat self-injurious behavior in your clients?

You have now successfully completed the survey, and will be given the opportunity to participate in a drawing for one of six amazon.com gift certificates worth US$25.00 each.
By clicking yes you will be taken to a separate survey to enter your contact email address. These contact details are separate from and can not be associated with the answers provided in the survey on non-suicidal self-injury.

15. Would you like to enter your name into a drawing for one of six amazon.com gift certificates worth US$25.00 each?
   (a) Yes
   (b) No

Group 2 – Participants with clinical experience

1. Which description best fits your current clinical placement?
   (a) Child Clinic
   (b) Community mental health
   (c) Department/ School Clinic
   (d) Forensic/ Criminal Justice (prison/jail)
   (e) Medical Clinic (hospital)
   (f) Inpatient Psychiatric Hospital
   (g) Outpatient Psychiatric Clinic/ Hospital
   (h) University Counseling Center/ Student Mental Health
   (i) School
   (j) VA Medical Center
   (k) Other (please describe):

2. What age groups do you work with in your current clinical placement/ internship?
   (check all that apply)
   (a) 0-5
   (b) 6-12
   (c) 13-17
   (d) 18-65
   (e) 65+

3. Do the waiting or treatment rooms of the institution at which you are doing your clinical placement/ internship contain literature for clients on mental health disorders other than self-injury, such as depression, anxiety, or eating disorders?
   (a) Yes
   (b) No
   (c) Not sure

4. Do the waiting or treatment rooms of the institution at which you are doing your clinical placement/ internship contain literature for clients on self-injurious behavior?
   (a) Yes
   (b) No
   (c) Not sure
5. In your experience, which of the following statements are true for the institution at which you are doing your clinical placement? *(check all that apply)*
   (a) All of the clinicians here see clients who self-injure at some point or another
   (b) Very few of the clinicians I work with see self-injurious clients
   (c) Most self-injurious clients in the institute are referred to me
   (d) Most self-injurious clients in the institute are referred to a particular person or particular persons in our institute, but I am not that person
   (e) Not sure

6. Approximately what percentage of your current clients engage in self-injurious behaviors?
   (a) None
   (b) Less than 5%
   (c) 5% - 10%
   (d) 10% - 20%
   (e) 20% - 30%
   (f) 30% - 40%
   (g) 40% - 60%
   (h) 60% - 80%
   (i) 80% - 100%
   (j) Not sure

7. How would you characterize the incidence of clients with self-injurious behaviors in the clients you have seen to date?
   (a) Decreased substantially
   (b) Decreased a little
   (c) No change
   (d) Increased a little
   (e) Increased substantially
   (f) Not sure

8. Have you noticed an increase among the general population in self-injurious behaviors in the past several years? *(Speculation is perfectly acceptable here.)*
   (a) I have not noticed an increase
   (b) I have noticed an increase. *If you have noticed an increase in self-injurious behaviors in the past several years, to what do you attribute the increase? (Again, speculation is fine here)*

9. In your degree program, have you received formal classroom training on self-injurious behavior?
   (c) Yes. *If yes, please describe the training received.*
   (d) No

10. In your degree program, have you attended specialized training (e.g., colloquia) on self-injury?
    (e) Yes. *If yes, please describe the training attended.*
11. At your current or previous training site(s), have you received training on self-injury?
   (a) Yes. If yes, please describe the type of training site and the content of the training received
   (b) No
   (c) Not applicable

12. Have you attended any other professional training on self-injury?
   (a) Yes. If yes, please describe
   (b) No

13. How well-informed about self-injurious behaviors do you consider yourself?
   (a) Very well informed
   (b) Somewhat informed
   (c) A little informed
   (d) Not at all informed

14. How familiar are you with the literature on non-suicidal self-injury?
   (a) Not familiar
   (b) Slightly familiar
   (c) Moderate familiar
   (d) Highly familiar

15. Generally speaking, how comfortable are you or do you expect yourself to be with treating clients who practice self-injurious behaviors?
   (a) More comfortable than with other clients
   (b) As comfortable as with other clients
   (c) Less comfortable than with other clients
   (d) I am not sure

16. Does the institute at which you are doing your clinical placement/internship possess a protocol or set of recommendations for managing mental health disorders other than self-injury, such as depression, anxiety or eating disorders?
   (a) Yes
   (b) No
   (c) Not sure

17. Does the institute at which you are doing your clinical placement/internship possess a set of recommendations for managing self-injurious clients or behaviors?
   (a) Yes. If yes, please describe:
   (b) No
   (c) Not sure

18. Does the institute at which you are doing your current clinical placement/internship incorporate routine screening for self-injurious behaviors in the client’s intake?
19. Has your current or any of your past supervisor(s) raised the topic of self-injurious behavior?
   (a) Yes
   (b) No

20. Has your current or any of your past supervisor(s) provided training on self-injurious behavior?
   (a) Yes
   (b) No

21. Does (did) your current/ past supervisor(s) appear comfortable discussing self-injurious behaviors?
   (a) Yes
   (b) No
   (c) Not sure

22. How many clients have you treated whom you know to have engaged in self-injurious behavior, as defined in this survey, in all of your training placements?
   (a) None
   (b) 1
   (c) 2-5
   (d) 6-10
   (e) 11-20
   (f) More than 20

23. Based on your understanding of non-suicidal self-injury, with which of the following statement do you agree? (Check all that apply)
   (a) Self-injurious behavior does not have to be addressed directly because it is a symptom of other disorders
   (b) Self-injurious behavior only needs to be addressed when it hinders treatment progress
   (c) Self-injurious behavior is important because it provides a “clue” to underlying issues
   (d) Self-injurious behavior is highly destructive and should therefore be eliminated
   (e) Eliminating self-injurious behavior should be a goal of therapy
   (f) I do not agree with any of the above statements

24. Based on your understanding of non-suicidal self-injury, with which of the following statement do you agree? (Check all that apply)
   (a) Clients should be asked about self-injurious behavior even if there is little evidence of it
(b) Clients should be asked about self-injurious behavior only if there is clear evidence of it
(c) Asking self-injurious clients to sign and adhere to “no harm” contracts is an important element of treatment
(d) Clients who with self-injurious behavior, are likely to have Borderline Personality Disorder
(e) I do not agree with any of the above statements

25. Based on your understanding of non-suicidal self-injury, with which of the following statement do you agree? (Check all that apply)
   (a) Self-injury is an addictive behavior
   (b) Self-injury is a manipulative behavior
   (c) Self-injury is a functional coping mechanism
   (d) I do not agree with any of the above statements

26. Based on your understanding of non-suicidal self-injury, with which of the following statement do you agree? (Check all that apply)
   (a) Self-injurious behavior usually develops in isolation
   (b) Self-injurious behavior can be contagious
   (c) Some clients self-injure in groups of 2 or more
   (d) Self-injury most often occurs in private
   (e) I do not agree with any of the above statements

27. With which self-injury assessment instruments are you familiar? (check all that apply)
   (a) Suicide Attempt Self-Injury Interview (SASII; Linehan, Comtois, Brown, Heard, & Wagner, 2006)
   (b) Self-Injurious Thoughts and Behaviors Interview (SITBI; Nock, Holmberg, Photos, & Michel, 2007)
   (c) Suicidal Behaviors Questionnaire (SBQ; Linehan, 1981)
   (d) Self-Harm Behavior Questionnaire (SHBQ; Gutierrez, Osman, Barrois, & Kopper, 2001)
   (e) Functional Assessment of Self-Mutilation (FASM; Lloyd, Kelley & Hope, 1997)
   (f) Inventory of Statements About Self-Injury (ISAS; Glenn & Klonsky, 2007)
   (g) Self-Injury Motivation Scale (SIMS; Osuch, Noll, & Putnam, 1999)
   (h) Firestone Assessment of Self-Destructive Thoughts (FAST; Firestone & Firestone, 1996)
   (i) Deliberate Self-Harm Inventory (DSHI; Gratz, 2001)
   (j) Self-Harm Inventory (SHI; Sanstone, Wiederman, & Sanstone, 1998)
   (k) Other (Please describe):

28. What types of additional training / information would be helpful for you in assessing and treating self-injurious clients? (check all that apply)
   (a) Classroom training
   (b) Specialized training (e.g., colloquia)
   (c) Clinical training
   (d) Grand rounds
(e) Specialized supervision
(f) Role-plays
(g) Reading materials
(h) Audio-visual materials
(i) Other (please specify):

29. Is there anything else you would like to share about how you regard and/or treat self-injurious behavior in your clients?

You have now successfully completed the survey, and will be given the opportunity to participate in a drawing for one of six amazon.com gift certificates worth US$25.00 each. By clicking yes you will be taken to a separate survey to enter your contact email address. These contact details are separate from and can not be associated with the answers provided in the survey on non-suicidal self-injury.

30. Would you like to enter your name into a drawing for one of six amazon.com gift certificates worth US$25.00 each?
   (a) Yes
   (b) No

**Group 3 – Participants with clinical experience with clients who engage in NSSI**

1. How many clients have you treated whom you know to have engaged in self-injurious behaviors, as defined in this survey, in the LAST YEAR?
   (a) None
   (b) 1
   (c) 2-5
   (d) 6-10
   (e) 11-20
   (f) More than 20
   (g) Not sure

2. Approximately how long ago did you first encounter a client who practiced self-injurious behaviors?
   (a) Within the last year
   (b) Between 1 and 2 years ago
   (b) Between 2 and 3 years ago
   (c) Between 3 and 4 years ago
   (d) Other (please describe):

3. In general, what is the gender breakdown of self-injuring clients you have seen in your clinical work?
   (a) All or largely female
   (b) All or largely male
   (c) Equally split by gender
   (d) Other (please describe):
4. In your professional experience, how often do self-injurious behaviors present with:

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<th>Sometimes</th>
<th>Infrequently</th>
<th>Never</th>
<th>Not sure</th>
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<td>5</td>
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<td>History of Childhood Trauma other than sexual abuse</td>
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<td>2</td>
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<td>Other (please specify):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

5. How often is self-injury the primary reason your self-injurious clients seek help?
   (a) All of the time  
   (b) Most of the time  
   (c) Some of the time  
   (d) A little of the time  
   (e) None of the time  
   (f) Not sure

6. Generally speaking, how difficult to treat do you find clients who practice self-injurious behaviors, even if treatment focus is not specific to self-injurious behavior?
   (a) More difficult than other clients  
   (b) About the same as other clients  
   (c) Less difficult than other clients  
   (d) Not sure

7. If stopping self-injurious behaviors is a therapeutic goal, what technique(s) do you find work(s) best in achieving this goal? (check all that apply)
   (a) Cognitive behavior therapy  
   (b) Dialectical behavior therapy  
   (c) Multisystemic therapy
(d) Hypnosis
(e) Family therapy
(f) Interpersonal group therapy
(g) Medication
(h) None work very well
(i) Other (please specify): ________________

8. Have you changed your approach to treating self-injurious behavior over time?
   (a) Yes. If yes, “How have you changed your approach?”
   (b) No

9. How often do you note self-injurious practices in a client’s chart?
   (a) Always
   (b) Almost always
   (c) Sometimes
   (d) Almost never
   (e) Never

10. With which self-injury assessment instruments are you familiar? (check all that apply)
    (a) Suicide Attempt Self-Injury Interview (SASII; Linehan, Comtois, Brown, Heard, & Wagner, 2006)
    (b) Self-Injurious Thoughts and Behaviors Interview (SITBI; Nock, Holmberg, Photos, & Michel, 2007)
    (c) Suicidal Behaviors Questionnaire (SBQ; Linehan, 1981)
    (d) Self-Harm Behavior Questionnaire (SHBQ; Gutierrez, Osman, Barrois, & Kopper, 2001)
    (e) Functional Assessment of Self-Mutilation (FASM; Lloyd, Kelley & Hope, 1997)
    (f) Inventory of Statements About Self-Injury (ISAS; Glenn & Klonsky, 2007)
    (g) Self-Injury Motivation Scale (SIMS; Osuch, Noll, & Putnam, 1999)
    (h) Firestone Assessment of Self-Destructive Thoughts (FAST; Firestone & Firestone, 1996)
    (i) Deliberate Self-Harm Inventory (DSHI; Gratz, 2001)
    (j) Self-Harm Inventory (SHI; Sanstone, Wiederman, & Sanstone, 1998)
    (k) Other (Please describe):

11. In thinking about your approach to clients who self-injure, which of the following statements are typically true for you? (check all that apply)
    (a) I do not address self-injurious behavior directly because I see it as a symptom of other disorders
    (b) I address self-injurious behavior only when it gets in the way of other progress
    (c) I see self-injurious behavior as a “clue” to underlying issues and thus consider it important.
    (d) I see it as a highly destructive behavior that must be eliminated
    (e) I think stopping the behavior should be a goal of therapy
    (f) None of the statements above are typically true for me
12. In thinking about your approach to clients who self-injure, which of the following statements are typically true for you? *(check all that apply)*
   (a) I routinely ask about self-injurious behavior even if there is little evidence of it
   (b) I ask about self-injurious behavior only if I see clear evidence of it
   (c) I ask my clients to sign “no harm” contracts and require that they adhere to it
   (d) When a client presents with self-injurious behavior, I assume it is likely the client has Borderline Personality Disorder
   (e) None of the statements above are typically true for me

13. In thinking about your approach to clients who self-injure, which of the following statements are typically true for you? *(check all that apply)*
   (a) I see self-injury as an addictive behavior
   (b) I think of self-injury as a functional coping mechanism
   (c) I see self-injury as a manipulative behavior
   (d) None of the statements above are typically true for me

14. In thinking about your approach to clients who self-injure, which of the following statements are typically true for you? *(check all that apply)*
   (a) I think that self-injurious behavior can be contagious
   (b) I do not think the behavior is contagious, I think it usually develops in isolation
   (c) I suspect or know that some clients self-injure in groups of 2 or more
   (d) I think it rare for self-injurious clients to self-injure in groups of 2 or more; I think it occurs most often in private
   (e) None of the statements above are typically true for me

15. If stopping self-injury is a therapeutic goal, how effective is therapy in helping a client stop self-injuring?
   (a) Very effective
   (b) Somewhat effective
   (c) Not at all effective
   (d) Not sure

16. Based on your clinical experience, how addictive do you perceive self-injurious behavior to be?
   (a) Very addictive
   (b) Somewhat addictive
   (c) Not addictive

17. In your professional experience, what are the seven reason(s) clients most commonly give for their self-injurious behavior? *(Check up to seven)*
   (a) Self-punishment for being bad/ having bad thoughts
   (b) Communication of emotional distress
   (c) Release unbearable tension
   (d) Reduction of emotional pain by creating physical pain
(e) Expression of frustration/ anger with significant others
(f) Take revenge on significant others
(g) Distraction from unpleasant memories/ thoughts
(h) Stop feeling empty and alone
(i) Stop feeling numb/ out of touch
(j) Gaining sense of being in control
(k) Coping with feelings of anxiety and depression
(l) Stop suicidal ideation/ attempt
(m) Change body image/ appearance
(n) Get care or attention from other
(o) Following group norms
(p) Desire to feel numb
(q) Desire to feel pain
(r) Shock people
(s) For excitement
(t) Out of curiosity
(u) Other (please specify):

18. With which statements do you agree? (check all that apply)
   (a) Most of my peers know enough about self-injurious behavior to treat it effectively
   (b) Most of my supervisors know enough about self-injurious behavior to provide effective supervision
   (c) Self-injury is a subject clinicians-in-training generally need to know more about
   (d) I know enough about self-injurious behavior to treat it effectively
   (e) I am aware of resources for referring a self-injurious client I cannot successfully treat
   (f) I do not agree with any of the above statements

19. What types of additional training / information would be helpful for you in assessing and treating self-injurious clients? (check all that apply)
   (a) Classroom training
   (b) Specialized training (e.g., colloquia)
   (c) Clinical training
   (d) Grand rounds
   (e) Specialized supervision
   (f) Role-plays
   (g) Reading materials
   (h) Audio-visual materials
   (i) Other (please specify):

20. Is there anything else you would like to share about how you regard and/or treat self-injurious behavior in your clients?

You have now successfully completed the survey, and will be given the opportunity to participate in a drawing for one of six amazon.com gift certificates worth US$25.00 each. By clicking yes you will be taken to a separate survey to enter your contact email address.
These contact details are separate from and cannot be associated with the answers provided in the survey on non-suicidal self-injury.

21. Would you like to enter your name into a drawing for one of six amazon.com gift certificates worth US$25.00 each?
(a) Yes
(b) No
Appendix C

Invitation to program representatives and students to participate in the survey

Dear (name of program representative),

I hope this email finds you well, and I appreciate you taking time out of your busy schedule to read this note. My name is Margot Schuerman. I am a doctoral student at Pacific University School of Professional Psychology in Hillsboro, Oregon, and I am currently collecting data for my thesis under the supervision of Genevieve Arnaut, Psy.D., Ph.D. I obtained your email address from your university website or by contacting your university.

The purpose of the study is to explore graduate clinical psychology, counseling psychology, and social work students’ preparation for and experience with treating non-suicidal self-injury. Participation will take less than 30 minutes and the data will be collected using a web-based survey. I would greatly appreciate your time in forwarding the email below to all the graduate clinical psychology students in your program. Participation in the study is voluntary, and participants may opt out of the study at any time by exiting the survey.

This study has been reviewed and approved by Pacific University's Institutional Review Board. Questions concerning your rights as participant in this research may be addressed to Dr. Genevieve Arnaut, Faculty Advisor at (503)352-2613 (email arnaut@pacificu.edu) or to the Pacific University Institutional Review Board at (503)352-1478 (email: irb@pacificu.edu). All concerns and questions will be kept in confidence. A copy of the IRB approval is attached for your easy reference.

To maximize the chance of reaching as many students as possible, I may send a follow-up email within the next 2 months. If you do not wish to receive that email, please let me know and I will remove you from my mailing list.

If you have any other questions or concerns, please feel free to contact me via email as well. Thank you for your time and help.

Sincerely,

Margot Schuerman, M.Sc., M.A.
Doctoral Student
Pacific University School of Professional Psychology
Hillsboro, OR 97123
mschuerman@pacificu.edu
Recruitment email to be forwarded to students

My name is Margot Schuerman. I am a doctoral student in clinical psychology at Pacific University, Oregon, and I am currently collecting data for my thesis under the supervision of Genevieve Arnaut, Psy.D., Ph.D. The purpose of the study is to explore graduate clinical psychology, counseling psychology, and social work students’ preparation for and experience with treating non-suicidal self-injury. Participation in the study will take less than 30 minutes and the data will be collected using a web based survey. Participation is voluntary, and you may opt out of the study at any time by exiting the survey.

You will have the option of entering into a drawing for one of six amazon.com gift certificates worth $25.00. Please copy the following URL into your web browser or follow the link:

www.surveymonkey.com/s/nssi

Thank you for your time and help. Please feel free to forward this email to anyone who would be interested in participating in this web survey.

Sincerely,

Margot Schuerman, M.Sc., M.A.
Doctoral Student
Pacific University School of Professional Psychology
Hillsboro, OR 97123
mschuerman@pacificu.edu

This study has been reviewed and approved by Pacific University’s Institutional Review Board. Questions concerning your rights as participant in this research may be addressed to Dr. Genevieve Arnaut, Faculty Advisor at (503)352-2613 (email arnaut@pacificu.edu) or to the Pacific University Institutional Review Board at (503)352-1478 (email: irb@pacificu.edu). All concerns and questions will be kept in confidence.
Appendix D

Survey of Practices in Detecting and Treating Self-Injury in College Populations

(Whitlock et al., 2009)

1. In what region is the college or university for which you currently work?
   (a) Northeast
   (1) Southeast
   (2) Midwest
   (3) Southwest
   (4) West coast
   (5) Alaska / Hawaii
   (6) Other: ______________

2. How would you describe the college or university for which you work (check all that apply):
   (1) Liberal arts college
   (2) Ivy League
   (3) State University
   (4) Community College
   (5) Other: ______________

3. What is the size of the student population of the College or University for which you work? (graduates and undergraduates combined)
   (1) Less than 1,000
   (2) 1,000 – 5,000
   (3) 5,001 – 10,000
   (4) 10,001 – 20,000
   (5) over 20,000

4. Which most accurately reflects your professional identity?
   (1) Clinical psychologist
   (2) Counseling psychologist
   (3) Psychiatrist
   (4) Mental health professional
   (5) Social worker
   (6) Student personnel administrator
   (7) Professional counselor
   (8) Other: __________________

5. What is the highest degree you have obtained?
   (1) M.D
   (2) Psy.D.
   (3) Ed.D
   (4) Doctorate: Clinical/Counseling Psychology Ph.D.
6. In what therapeutic technique(s) have you received formal training? (check all that apply)
   (1) Cognitive behavior therapy
   (2) Dialectical behavior therapy
   (3) Multisystemic therapy
   (4) Hypnosis
   (5) Family therapy
   (6) Interpersonal group therapy
   (7) Other: ________________________

7. How many years of clinical experience (not including internships) have you had? (Practicing and supervising experience combined.)
   (1) Less than 1 year
   (2) 1 to 2 years
   (3) 3 to 4 years
   (4) 5 to 7 years
   (5) 8 to 10 years
   (6) Over 10 years

8. How long have you been in your current position?
   (1) Less than 1 year
   (2) 1 to 2 years
   (3) 3 to 4 years
   (4) 5 to 7 years
   (5) 8 to 10 years
   (6) Over 10 years

The following questions ask you about your experiences with and perceptions of mental health in college populations, with a focus on self-injury. For the purposes below, self-injury is defined as non-socially sanctioned but mutilating behaviors performed with the intention of inflicting harm on one’s body without the obvious intention of committing suicide. Although most often associated with the term “cutting”, self-injurers use a wide array of practices to hurt themselves such as (but not limited to) intentional carving or cutting of the skin and subdermal tissue, scratching, burning, ripping or pulling skin or hair, swallowing toxic substances, bruising, and breaking bones. Piercing and tattooing, unless done with the express purpose of inflicting harm, are not considered self-injury.
In your professional role as a practicing clinical therapist in a University setting:

9. How would you characterize the incidence of adolescent and young adult clients with mental health disorders in your overall client population over the past 5 years? (If you do not have 5 years of experience, please answer in terms of your experience to date.)
   (1) Decreased substantially
   (2) Decreased a little
   (3) No change
   (4) Increased a little
   (5) Increased substantially

10. Do the waiting or examination rooms of the health services facility of the institution for which you currently work contain literature for clients on mental health disorders, such as depression, anxiety, or eating disorders?
   (1) Yes
   (2) No
   (3) Some of these, but not all
   (4) I am not sure

11. In your experience, which of the following statements are true for the University Counseling Services with which you work? (check all that apply)
   (1) All of the therapists here see clients who self-injure at some point or another
   (2) Very few of the therapists I work with see self-injurious clients
   (3) Most self-injurious clients in the Counseling Center are referred to me
   (4) Most self-injurious clients in the Counseling Center are referred to a particular person in our practice, but I am not that person

12. Approximately what percentage of your current clients engage in self-injurious behaviors?
   (1) 80% - 100%
   (2) 60% - 80%
   (3) 40% - 60%
   (4) 30% - 40%
   (5) 20% - 30%
   (6) 10% - 20%
   (7) 5% - 10%
   (8) Less than 5%
   (9) None

13. How would you characterize the incidence of adolescent and young adult clients with self-injurious behaviors in your overall client population over the past 5 years? (If you do not have 5 years of experience, please answer in terms of your experience to date.)
   (1) Decreased substantially
   (2) Decreased a little
   (3) No change
   (4) Increased a little
(5) Increased substantially

14. Have you noticed an increase among the GENERAL POPULATION in self-injurious behaviors in the past several years? (Speculation is perfectly acceptable here.)
   (1) I have not noticed an increase
   (2) I have noticed an increase
   (3) I do not know

15. If you have noticed an increase in self-injurious behaviors in the past several years, to what do you attribute the increase? (Again, speculation is fine here.)

16. Have you ever attended a professional training or Continuing Education (CE) session on self-injury?
   (1) Yes
   (2) No

   If yes, “When was the last time you attended a training or CE on self-injury?”
   (1) Within the last month
   (2) Within the last 6 months
   (3) Within the last year
   (4) Within the last 2 years
   (5) Over 2 years ago

   If yes, “Was the training required?”
   (1) Yes
   (2) No

17. Did you receive any formal instruction on self-injury in your clinical training degree program?
   (1) Yes
   (2) No

18. How well-informed about self-injurious behaviors in the young adult population do you consider yourself?
   (1) Very well informed
   (2) Somewhat informed
   (3) A little informed
   (4) Not at all informed

19. How many young adult clients have you treated whom you know to be engaged in self-injurious behavior, as defined in this survey, in your experience as a mental health professional?
   (1) None
   (2) 1
   (3) 2-5
   (4) 6-10
   (5) 11-20
   (6) More than 20
If (1) selected, skip to Question 43

20. How many young adult clients have you treated whom you know to be engaged in self-injurious behaviors, as defined in this survey, in the LAST YEAR?
   (1) None
   (2) 1
   (3) 2-5
   (4) 6-10
   (5) 11-20
   (6) More than 20

If (1) selected, skip to Question 22

21. What proportion of these self-injurious clients did you come into contact with through your work in a University setting?
   (1) All of them
   (2) Most of them
   (3) Some of them
   (4) A few of them
   (5) None of them

22. Does the University or College for which you work possess a set of recommendations for managing self-injurious clients or behaviors?
   (1) Yes
   (2) No
   (3) I am not sure

23. Approximately how long ago did you first encounter an adolescent or young adult client who practiced self-injurious behaviors within or outside of a University setting?
   (1) Within the last year
   (2) 2-3 years ago
   (3) 4-5 years ago
   (4) 6-10 years ago
   (5) Over 10 years ago

24. Generally speaking, how professionally comfortable are you with treating adolescent and young adult clients who practice self-injurious behaviors?
   (1) More comfortable than with other patients
   (2) As comfortable as with other patients
   (3) Less comfortable than with other patients
   (4) I am not sure

   If (3) selected, “Why do you think you are less comfortable treating adolescent and young adult clients who practice self-injurious behaviors?”

25. In general, what is the gender breakdown of the self-injurers you have seen in your work with young adult and adolescent populations?
26. How often is self-injury the primary reason your self-injurious clients seek help?
   (1) All of the time  
   (2) Most of the time  
   (3) Some of the time  
   (4) A little of the time  
   (5) None of the time  
   (6) I am not sure

27. In your professional experience, how often do self-injurious behaviors present with:

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<th>Condition</th>
<th>Nearly Always</th>
<th>Sometimes</th>
<th>Infrequently</th>
<th>Never</th>
<th>Not sure</th>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Disordered Eating</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>History of Sexual Abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Suicidality</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>History of Childhood Trauma other than sexual abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Other (please specify): 1 2 3 4 5

28. If you indicated “other” in the previous question, please specify what you mean by “other.”

29. Generally speaking, how difficult to treat do you find adolescent and young adult clients who practice self-injurious behaviors, even if treatment focus is not specific to self-injurious behavior?
   (1) More difficult than other clients  
   (2) About the same as other clients  
   (3) Less difficult than other clients  
   (4) I am not sure

30. If stopping self-injurious behaviors is a therapeutic goal, what technique(s) do you find work(s) best in achieving this goal? (check all that apply)
   (1) Cognitive behavior therapy  
   (2) Dialectical behavior therapy  
   (3) Multisystemic therapy  
   (4) Hypnosis  
   (5) Family therapy
(6) Interpersonal group therapy
(7) Medication
(8) None work very well
(9) Other: ________________

If (7) selected, “What medication(s) do you typically recommend for helping clients who self-injure stop their behavior?

31. If you selected more than one therapeutic technique, how do you choose which one to use?

32. Have you changed your approach to treating self-injurious behavior over time?
   (1) Yes
   (2) No
   (3) I don’t know
   If yes, “How have you changed your approach?”

33. In thinking about your approach to adolescent and young adult clients who practice self-injurious behaviors, which of the following statements are typically true for you? (check all that apply)
   (1) I avoid addressing self-injurious behavior directly since I see it as a symptom of other disorders
   (2) I ask my clients to sign “no harm” contracts and require that they adhere to it
   (3) I address it only when it gets in the way of other progress
   (4) I see it as a highly destructive behavior that must be eliminated
   (5) I routinely ask about self-injurious behavior even if there is little evidence of it
   (6) I ask about self-injurious behavior only if I see clear evidence of it
   (7) I think of it as a functional coping mechanism
   (8) How often I see impulses to injure as a “clue” to underlying issues and thus see them as important.
   (9) When a client presents with self-injurious behavior, I assume it is symptomatic of Borderline Personality Disorder
   (10) I don’t think stopping the behavior should be a goal of therapy

34. How often do you note self-injurious practices in a client’s chart?
   (1) Always
   (2) Almost always
   (3) Sometimes
   (4) Almost never
   (5) Never
   (6) Other ________________

35. Is there anything else you would like to share about how you regard and/or treat self-injurious behavior in your adolescent and/or young adult clients?

36. If stopping self-injury is a therapeutic goal, how effective is therapy in helping a client stop self-injuring?
(1) Very effective
(2) Somewhat effective
(3) Not at all effective
(4) Not sure

37. In your professional opinion, how important is it for self-injurious youth to be removed from the general university/college population?
(1) Very important
(2) Somewhat important
(3) Not very important
(4) Not at all important
(5) Not sure

38. Based on your clinical experience, how addictive do you perceive self-injurious behavior to be?
(1) Very addictive
(2) Somewhat addictive
(3) I wouldn’t describe it as addictive

39. In your professional experience, which of the following are likely to be true for the College or University for which you work? (check all that apply)
(1) I suspect or know that self-injurious behavior is contagious on campus
(2) I do not think the behavior is contagious, I think it usually develops in isolation
(3) I suspect or know that some self-injurious students self-injure in groups of 2 or more
(4) I think it rare for self-injurious students to self-injure in groups of 2 or more; I think it occurs most often in private

40. In your professional experience, what are the most common reasons clients give for ceasing their self-injurious behavior?

41. With which statements do you most agree? (check all that apply):
(1) Most of my colleagues know enough about self-injurious behavior to treat it effectively
(2) Self-injury is a subject those of us who work with young adults and adolescent generally need to know more about
(3) I know enough about self-injurious behavior to treat it effectively
(4) I am aware of resources for referring a self-injurious client I cannot successfully treat

42. Does the University or College for which you work possess a protocol or set of recommendations for managing depression related disorders?
(1) Yes
(2) No
43. What types of additional information would be helpful for you in assessing and treating self-injurious clients?

44. Do the waiting or examination rooms of the health services facility for which you currently work contain literature for clients on self-injurious behavior?
   (1) Yes
   (2) No
   (3) I am not sure

45. Do you also have a private practice?
   (1) Yes
   (2) No

46. Did the questions apply to your professional experience? Why or why not?

47. If you had difficulty answering certain questions, which questions gave you difficulty and why?

48. Do you think the survey questions will generate adequate information for understanding clinical practices in detecting and treating self-injury in college populations? If not, why not?

49. Do you recommend additional content/questions? If so, please list them here:

50. Please provide any additional comments here:

51. If you have the time or inclination, please express your thoughts and beliefs on why people are self-injuring (including what reasons you may have encountered in your practice), and why this behavior seems to be increasing in prevalence. Also, do you think there has been an increase in mental health problems in general? Why or why not?

52. If you are interested in participating in future areas of this research project and you are willing to be contacted at a later date, please provide your e-mail address.

Please feel free to contact Dr. Janis Whitlock, Principal Investigator, at jlw43@cornell.edu with any additional comments, questions or concerns. Thank you!