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Self-Injury in the Schools: A Survey of Educators

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SELF-INJURY IN THE SCHOOLS: A SURVEY OF EDUCATORS

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SELF-INJURY IN THE SCHOOLS: A SURVEY OF EDUCATORS

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Self-injury (SI) is a growing concern for professionals working in educational settings who desire more information on SI and express a lack of confidence in working with youth who self injure (Carlson, DeGreer, Deur, & Fenton, 2005; Heath, Toste, & Beettam, 2008). A sample of 263 teachers from a small, rural Kentucky county completed a survey (response rate of 45.5%) designed to address educators' knowledge of SI, training needs, and knowledge of school response plans for working with youth who self-injure.

A 20-item measure developed by Jeffery and Warm (2002) assessed SI knowledge. Educators evidenced significantly lower scores on the knowledge measure than school psychologists (Beld, 2007), and professionals working in a medical setting (Jeffrey & Warm, 2002) with the exception of psychiatrists. Analysis of the response patterns of the educators on the knowledge measure indicated 11 out of 20 items evidenced serious inaccurate understandings of basic fact and myths, prevalence, relationship of SI to psychopathology and suicide, and media influences. There were no gender differences when comparing self-rated knowledge of SI; however, female educators evidenced greater mean scores on the knowledge measure.

Females evidence significantly greater knowledge of SI than males. There is no relation between knowledge of SI and the amount of experience working with youth who self-injure for this sample. Knowledge of SI and amount of experience working with students who SI was not correlated. Further, educators who report knowledge of school plans did not report higher confidence in helping students.

Descriptive information regarding knowledge of SI and school response plans, confidence, and training indicate the majority of educators in this sample do not have any experience working with youth who self-injure. Further, most lacked knowledge of a school response plan and did not know the existence of or steps included in the district's school response plan. A majority of participants indicated never attending in-service training on SI; however, they did indicate an interest in receiving more information on SI.

Results support the need for districts to educate staff on school response plans and/or to develop a specific school response plan for dealing with youth who engage in SI. Also supported are training needs regarding the school plan, basic knowledge of SI, and extended areas of SI such as media and suicide. Lastly, follows the discussion of practical implications, limitations, and suggestions for future research in relation to results.

Introduction

There has been an increased interest in self-injurious behaviors in the media and literature in the past several years (White Kress, 2003). School counselors have also seen an increasing number of young adults who exhibit self-injurious behaviors (White Kress, Gibson, & Reynolds, 2004). With growing frequency, middle and high school students evidence a form of self-injury (SI) that does not fit current classifications of SI. The type of SI noted in this population is different from SI reported prior to 2000. Youth who engage in this behavior, identify themselves by such slang terms as "cutters," "kookie cutters," "rainbow cutters," and "emo cutters," among others. This form of SI is evident in various forms of popular media including magazines, television, movies, and internet (Walsh, 2006).

SI is also a growing trend that professional staff in schools faces with increasing frequency (Galley, 2003; Lieberman 2004; Ross & Heath, 2002). In that this less serious form of self-injury is distinguishable from other classifications of SI, and necessitates differential treatment, it is important for school officials to know about this form of SI and be properly equipped to handle the growing number of students who engage in this behavior. Information is limited about teacher knowledge of SI. However, there are indications that educators express a desire for more information and training on SI (Heath, Toste, & Beettam, 2006). In order to identify and properly respond to youth who self-injure, school officials must have adequate training and knowledge about SI, confidence in working with these youth, and familiarity with the school response plan for

dealing with youth who self-injure (Kanan, Finger, & Plog, 2008; Lieberman & Poland, 2007).

The following literature review will first provide a basis for the current investigation exploring teacher knowledge of SI. The review provides information on definitions, prevalence, classification, and associated features of SI with an emphasis on the less serious form of SI that is the focus of this investigation—common self-injury (CSI). Next, a review of what is known about SI by various disciplines will be provided along with a presentation of a measure used to assess SI knowledge developed by Jeffery and Warm (2002). A review of recommended procedures for responding to youth who self-injure will provide a basis to interpret existing school plans and procedures. The review concludes with a rationale for the research questions and hypotheses that direct the current investigation.

Literature Review

SI is behavior that is associated with a variety of clinical disorders and associated features. Classification systems categorize the more serious forms of SI historically recognized in literature. Professionals are noting with increasing frequency youth who self-injure that do not evidence a clinical disorder and do not fit existing classification systems. This newer group of individuals who evidence SI provides the bulk of the increases in prevalence noted in the past decade. This latter group of youth who self-injure will be the focus of the present investigation.

Definition of Self-Injury

Simeon and Favazza (2001) defined self-injurious behaviors as "all behaviors involving the deliberate infliction of direct physical harm to one's own body without any intent to die as a consequence of the behavior" (p. 1). There are various forms of self-injurious behaviors socially accepted by society that are common among American college students, such as tattooing and body piercing which can make it difficult to distinguish between socially deviant SI and socially sanctioned SI (White Kress, 2003). Socially deviant SI occurs in response to psychological crises and demonstrates a sense of disconnection and alienation from others (White Kress, 2003). In contrast, professionals under safe and sterile conditions provide piercing and tattoos. The intent of these body modifications is generally to enhance or improve upon one's appearance, not to modify consciousness or reduce psychological distress, which is the intent of self-injury (Walsh, 2006).

It is also important to distinguish SI from suicide. The intent of suicide is to terminate consciousness, and the intent of SI is to modify it (Walsh, 2006). SI is

distinguishable from suicide in regards to potential lethality, frequency of behavior, multiple methods, level of psychological pain, constriction of cognition, and psychological aftermath. Individuals whose intent is suicide often employ a high lethality method such as shooting oneself with a firearm, jumping from extreme heights, suffocation, drowning, and ingesting poisonous substances. Those who self-injure engage in low lethality behaviors such as cutting or burning oneself. These low lethality behaviors typically do not result in death. Those who self-injure can engage in the behavior hundreds of times over one or more years; it is rare that someone attempts suicide at such a high rate. Walsh (2006) notes that individuals who attempt suicide not only do so less often, but also the preferred method of multiple attempts is often overdose on medication. Walsh and Frost (as cited in Walsh, 2006) report that over 70% of adolescents report using multiple methods to self-injure. The use of multiple methods can be due to preference, such as a person who may engage in cutting when anxious or burning when angry. It may also be due to circumstances, for example, people who often engage in burning may not have a lighter or match during the need to self-injure, so they engage in self-hitting instead.

In terms of psychological pain, those who are suicidal desire a permanent escape due to the experience of intense psychological discomfort. Individuals who engage in SI also experience intense psychological pain or discomfort; however, it is not to the extent of those considering suicide. Since engaging in SI offers a means of interrupting and reducing the pain, the psychological discomfort of a self-injurer is temporary and flexible versus the permanent and unchangeable nature of the pain of those with suicidal ideation. Constrictive cognition is another characteristic of people who are in suicidal crisis. They

view life or their circumstances in an all-or-nothing manner, in which they believe they

must experience the pain or end the pain through suicide. Those who self-injure do not

view their lives in an all-or-nothing manner; instead, they recognize choices are available,

one of them being to engage in SI. There is also a difference in the psychological

aftermath for suicide and self-injurious behaviors. Individuals who survive a suicide

attempt often report feeling worse after the attempt. Their failed attempt has in no way

relieved their psychological distress. Persons engage in SI due to its effectiveness to

reduce psychological distress immediately. Although self-injurious behaviors may lead

to death or behaviors may resemble suicidal behaviors, it serves a different purpose and is

independent from suicide. However, people who self-injure are more likely to

contemplate or attempt suicide and suicidality is more prevalent in this group (Laye-

Gindhu & Schonert-Reichl, 2005; Whitlock & Knox, 2007; Whitlock, Powers, &

Eckenrode, 2006).

Classification of Self-Injury

Simeon and Favazza (2001) identify four types or categories of self-injurious

behaviors: stereotypic, major, compulsive, and impulsive. These categories comprise a

classification system that distinguishes between the four types of SI based on the severity

of tissue damage, frequency, pattern of the SI, and associated clinical disorders.

Stereotypic SI includes behaviors such as hair pulling, nail biting, head banging, face

slapping, and lip and hand chewing that are repetitive in nature. Disorders and conditions

linked to the stereotypic classification are mental retardation, Prader-Willi syndrome,

autism, Tourette's syndrome, Cornelia de Lange, and Lesch-Nyhan syndrome. Major SI

is a more severe and life threatening form and involves such behaviors as castration, eye

enucleation, and limb amputation. Noted with major SI are severe psychosis, severe

personality disorders, intoxication, and transsexualism. Compulsive SI involves

behaviors such as hair pulling, skin picking, and nail biting. Individuals with disorders

such as trichotillomania or stereotypic movement disorder are associated with this form

of SI. The compulsive category of SI is repetitive in nature and results in mild to

moderate tissue damage. The impulsive SI category involves episodic behaviors such as

skin cutting, skin burning, and self-hitting. Individuals with borderline and antisocial

personality disorders, history of abuse and trauma, post-traumatic stress disorder, and

eating disorders often evidence this type of SI.

Walsh (2006) conceptualizes a classification of SI different from that of Simeon

and Favazza's (2001) classification. Walsh utilizes Simeon and Favazza's categories of

stereotypic and major SI; however, he departs in terms of the compulsive and impulsive

SI categories. Walsh states that Simeon and Favazza's classification of impulsive versus

compulsive SI is problematic in that many examples of self-injurious behaviors do not

clearly fit either category. According to Walsh, SI is fluid in nature; he notes many

clients who have presented impulsive and compulsive self-injurious behaviors

simultaneously. Walsh feels that Simeon and Favazza's (2001) category system is best

for research purposes; however, fast-paced environments such as schools need a different

classification system.

Walsh further contends that not all individuals who engage in SI have a clinical

disorder. Those individuals with no clinical diagnosis often appear to lack appropriate

self-coping skills and use SI as a coping mechanism to deal with psychological distress.

Walsh uses the term "Common Self-Injury" (CSI) to refer to this group of individuals

that do not seem to fit within Simeon and Favazza's (2001) classification system. The most frequent methods of CSI employed by individuals, and the focus of the current investigation are cutting, hair pulling, burning oneself, self-hitting, self-piercing and tattooing, and bone breaking (Carlson, DeGeer, Deur, & Fenton, 2005; Walsh 2006).

  Previously, SI was strongly associated with sexual and physical abuse, eating disorders, and clinical mental disorders, but this association seems to be less strong in more recent reports of SI. Still, the strength of this association seems to distinguish between CSI and traditional classifications of SI. CSI does not evidence the history of prior abuse, eating disorders, and mental disorders in as great a frequency. Walsh (2006) coined the term CSI to identify this new group of youth of middle and high school students who self-injure. These youth also possess areas of strength in regard to family, school, and social networking, in which they may perform well academically, have a solid group of friends, and strong family relationships and support. Although areas of strength are present among youth with CSI, these youth clearly lack the appropriate coping skills needed to deal with negative emotional distress. Unlike youth in clinical populations, they are also more likely to give up or discontinue engaging in the behavior after six months to two years, particularly in response to treatment. Many individuals who fit the CSI category engage in the behavior with their group of friends; however, if the group disengages in the behavior they may do so as well, with or without receiving treatment (Walsh, 2006; Whitlock, Eckenrode & Silverman, 2006).

Prevalence

Despite the fact that there are no large-scale epidemiological estimates of SI, small convenience-based samples of adolescents and young adults provide some rough indications of prevalence in the United States. Ross and Heath (2002) report that 13.9% of high school students report engaging in self-injurious behaviors at least one time a day. Another study surveyed military recruits (*n* = 1,986) to assess SI in a nonclinical adult population and found that 4% of the participants had a history of SI (Klonsky, Oltmanns, & Turkheimer, 2003). These results are consistent with the findings of Briere and Gil (1998) where 4% evidence a history of SI (*n* = 927). In 2006, 17% of college students from three large universities reported they had engaged in SI (Whitlock, Eckenrode et al., 2006).

Recent data indicate that these rates may be underestimates. Yates, Tracy and Luthar (2008) investigated SI in two privileged or affluent large-scale samples of adolescents from the West (*n* = 1,036; cross-sectional data) and East (*n* = 245; longitudinal data) coasts of the United States. The cross-sectional West coast sample evidenced SI rates of 37.2%. The East coast longitudinal sample evidenced a 26.1% rate for SI. Statistics from Britain support that SI is of concern, with a 65% increase in SI from 2002-2004, which resulted in estimates that 1 in 10 teens engage in the behavior (Young People and Self-Harm: A National Inquiry, 2004). In 2002, a survey of 6,020 students at 41 schools in England indicated that 13.2% of students reported a lifetime history of deliberate SI compared to 8.6% the previous year (Hawton, Rodham, Evans, & Weatherall, 2002). These studies support that a significant number of adolescents and young adults engage in SI and that self-injury rates are increasing.

Associated Features and Functions of Self-injury

The onset of SI typically occurs in late childhood to early adolescence. However, children as young as elementary school-age engage in self–injury (Whitlock, Powers et al., 2006). Although some research indicates that SI is more common in females than males (Simeon & Favazza, 2001; Yates et al., 2008; Zila & Kiselica, 2001), some investigations note equivalent rates (Klonsky et al., 2003; Whitlock, Eckenrode et al., 2006). Gender differences in method of SI are also noted. Males are more likely to burn and hit themselves while females are more likely to cut themselves (Laye-Gindhu & Schonert-Reichl, 2005).

SI has been associated with certain clinical diagnoses, although the presence of SI does not mean the presence of a clinical diagnosis. Adult and adolescent clinical populations note a higher frequency of SI (20% and 40-80% respectively; Klonsky & Muehlenkamp, 2007). SI is one possible symptom of borderline personality disorder noted in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision (DSM-IV-TR;* American Psychiatric Association, 2000). Other diagnoses noted in higher frequency in populations who self-injure include depression, posttraumatic stress disorder, anxiety, eating disorders, substance use disorders, and risk-taking behaviors (Walsh 2006).

Individuals who engage in SI may evidence higher rates of abuse. Fifty-three percent of a college population that self-injured (*n* = 490) also reported physical, sexual, and/or emotional abuse (Whitlock, Eckenrode et al., 2006). Favazza and Conterio (1989) found similar results in their study of females who habitually self-injure, with 62% reporting previous sexual and/or physical abuse. It is important to note that while child

abuse may play a role in some individuals' SI, many who self-injure have not been abused (Klonsky & Muehlenkamp, 2007).

Adolescents who engage in CSI often feel shame and maintain secrecy in order to avoid attention and embarrassment (Lieberman & Poland, 2007). SI is an act that creates a sense of shame for people who perform this behavior due to its socially deviant nature. The act of SI is not socially acceptable; therefore, individuals typically perform it alone and reveal it to only a few individuals (Walsh, 2006). The socially unacceptable nature of the behavior creates a propensity for marginalization of those who self-injure. Fear of rejection motivates many individuals who self-injure to lie about or hide their wounds and scars and tend to not openly discuss their self-injurious behaviors.

Individuals who engage in SI report engaging in the behavior in order to cope with and relieve emotional distress. Klonsky (2007) reviewed 18 studies that examined the functions of SI and identified seven main functions of SI. Those seven functions included affect-regulation, anti-dissociation, anti-suicide, interpersonal boundaries, interpersonal-influence, self-punishment, and sensation seeking. In 11 of the studies, affect-regulation was the most frequently endorsed as a reason for engaging in SI.

Nock and Prinstein (2005) discuss a theoretical model that proposes four functions of SIB that differ along two dichotomous dimensions: contingencies for SI that are automatic (within oneself) versus social, and reinforcement that is positive (giving of a favored stimulus) versus negative (removal of aversive stimulus). Within these two dimensions, they identify four functions of SIB reported by youth. The functions include automatic negative reinforcement (e.g., "To stop bad feelings"), automatic positive reinforcement (e.g., "To feel something, even if it's pain"), social negative reinforcement

(e.g., "To avoid doing something unpleasant you do not want to do"), and social positive reinforcement (e.g., "To get attention").

Professionals' Knowledge about Self-Injury

General knowledge of SI is evident in the mental health professions. SI is an associated feature with some clinical disorders (e.g., autism, mental retardation, borderline personality disorder). However, professionals' understanding of the newer less lethal form of SI that Walsh (2006) refers to as CSI is of concern. Jeffrey and Warm (2002) assessed service providers' (*n* = 96) accurate and inaccurate perceptions about the nature and causes of SI through a 20-item questionnaire. Jeffrey and Warm's results indicate that medical workers (*n* = 27) and psychiatrists (*n* = 9) have a poorer understanding of SI than psychologists (*n* = 19) and social care workers (*n* = 25). Using Jeffrey and Warm's measure, Beld (2007) found school psychologists (*n* = 73) have a similar level of knowledge as that of all professionals in Jeffrey and Warm's study.

Beld analyzed response patterns to some additional factual questions about SI and identified that over a third of the sample evidence a high frequency of inaccuracy on some factual knowledge despite the fact that the groups' mean scores were equivalent to a sample of individuals who self-injure (Warm, Murray, & Fox, 2002). For example, 71% of the sample identified SI as indistinct from pathology, while 92% underestimated the percent of the population engaging in SI. The connection of SI with internet usage evidences a less than desirable (70% criterion) accuracy in the areas of prevalence of SI in media, accessibility of internet forums and accessibility of information about SI in media. Other items not evidencing 70% accuracy and thus categorized as problematic

include recognition that wound excoriations is a form of SI, belief that SI is a clinical diagnosis, the contagious nature of SI, and self reports of suicide are SI.

Research on educators' knowledge about SI is limited; studies are small, descriptive, and exploratory in nature. Roberts-Dobie and Donatelle (2007) examined school counselors' experience with and knowledge of SI. The study utilized surveys from 443 members of the American School Counselor Association. School counselors view themselves as the most appropriate contact for youth who self-injure; however, they do not self-report a high level of knowledge. Only 6% of counselors feel they are very knowledgeable in assisting students who self-injure, 74% feel they are moderately knowledgeable, and 20% identify themselves as not very knowledgeable. For this group, experiences working with someone who self-injures as well as working with a greater number of youth who self-injure are associated with greater knowledge.

Carlson et al. (2005) assessed the knowledge of SI in a sample of 150 teachers drawn from three Midwestern high schools. Results of the survey indicate that the majority (64%) of teachers did not feel knowledgeable about SI or confident in responding to a student who self-injures (57%). However, participants who had previous experience (68%) with youth who self-injure felt more knowledgeable and confident in responding than those who had no experience. Despite the lack of confidence in knowledge of SI, a majority of the teachers correctly responded to questions intended to measure their knowledge of self-cutting. A majority (76-87%) of teachers correctly identified the age of onset and that SI is a form of cutting and not a suicide attempt. However, discrepancies are evident in teacher knowledge of accurate characteristics of SI. Fifty-seven percent believe that self-cutting is a minor problem, and 63% say that

youth engage in SI to seek attention. Only 21% identified youth who self-injure as having high academic success.

Heath et al. (2006) surveyed a convenience sample of 50 high school teachers attending graduate classes to investigate level of knowledge, self-perceived knowledge, and attitudes regarding SI. Regarding teachers' current knowledge of adolescent SI, 66% of teachers correctly identified the age of onset and 72% correctly identified cutting as the most common form of SI. However, only 12% correctly identified prevalence of SI with 78% of the responses to prevalence indicating an underestimate. Survey results regarding self-perceived knowledge indicate that 20% of the teachers report they feel knowledgeable, while 50% did not feel knowledge about adolescent SI. Out of those percentages, male teachers indicate significantly greater perceived knowledge scores than female teachers. Concerning attitudes of teachers concerning SI, 22% agreed (incorrect response) and 66% disagreed (correct response) with the statement that students who self-injure are "just trying to get attention." Forty-eight percent agreed that the idea of students cutting themselves is horrifying. This sample evidences correct understanding, as only 14% agreed with the often wrongly believed statement that SI is a suicidal behavior. Thirty-four percent agreed that SI is a symptom of a mental disorder. Teachers also answered an open-ended question to address any additional information about their experiences with SI that researches needed to know. The major themes that emerged were the need for training and dissemination of information on SI and the increasing prevalence and the school context. Many of the teachers felt that they were not well equipped and needed more training. They also indicated concern about contagion and the growing numbers of students engaging in SI in the schools (Heath et al., 2006).

The studies reviewed indicate that even when educators have basic knowledge of SI and for some, experience working with individuals who self-injure, they lack confidence in working with students who engage in the behavior. Educators' inaccurate conceptions of and attitudes toward SI could potentially lead to students being under identified and handled improperly or insensitively. This research supports the need for schools to recognize the increase in SI and respond appropriately by equipping educators with sufficient knowledge and confidence necessary to deal with increasing numbers of students engaging in SI.

School Response to Self-Injury

With a growing number of children engaging in SI in the schools, the secret nature of the behavior, and the high probability of contagion, it is vital that school officials are equipped to deal with these youth. In the classroom, youth who engage in CSI appear to be "normal" and blend in with the student population; therefore, it is also crucial that educators have accurate knowledge of SI. School psychologists and counselors, as mental health professions employed in schools, can and do provide some aspects of an effective school-based response system for youth who self-injure. However, school plans should employ a collaborative approach that it involves school officials, parents, students, and the community (Kanan et al., 2008; Lieberman, 2004; Onacki, 2005; Roberts-Dobie & Donatelle, 2007). Onacki indicates that school protocols should include internal (school training & programming) and external (community involvement) plans.

A first step toward an effective plan involves the awareness and knowledge of educators and school officials. In order to identify youth who self-injure, educators must

be knowledgeable of the physical and emotional signs of the behavior. Second, it is important to educate students on reporting SI properly. Lieberman (2004) cautions that student education should not focus on the why and how of SI due to the contagion effect, but rather focus on seeking help for themselves or others, signs of emotional distress and risk behaviors, alternative coping strategies, and identifying the trained school officials. Third, school officials are to provide appropriate support for students. They are to respond in a manner that is non-isolating by avoiding criticizing or overreacting. Once referred to an appropriate official, such as the counselor or school psychologist, suicidality of the student should be assessed (Kanan et al., 2008; Lieberman & Poland, 2007). Another important aspect of the school plan is to notify and involve the parents. Parent notification should include reporting the behavior and the measures already taken to support the student along with additional resources to assist the student outside of school premises. Parents need to receive information about community resources, but also the school should collaborate with community-based supports by obtaining permission to communicate with the student's outside treatment source.

School plans for dealing with SI should also include short-term safety interventions; however, there is no consensus on the specific nature of these plans. Kanan et al. (2008) does not suggest the utilization of no-harm contracts, as self-injurers are unable to make such an agreement until they acquire alternate methods of coping. However, Lieberman (2004) recommends a no-harm contract that provides alternatives to SI. He stipulates that when students sign no-harm contracts they should also agree to utilize provided alternatives and seek out a specified adult when they have the urge to self-injure while at school. The last component for an effective plan is to control for

contagion effect. Activities on school premises should be restricted in detail and focused on self-injurious behaviors. Identification of more than one student should prompt individual, not group, responses. Schools should also monitor or refrain from showing movies or televisions shows which display self-injurious behaviors to avoid triggering effects in individuals who presently or no longer engage in the behaviors.

The school district involved in the present investigation employs a generic plan of action for students who engage in SI. The plan does not specifically address SI; however, it does specifically address suicide. School officials who are responsible for responding to youth who self-injure include the school psychologist, school counselor, school nurse, principal, and/or a social worker affiliated with the school. There are multiple steps of action included in the district's school response plan for suicide. General staff should keep the student under continuous adult supervision and contact the appropriate designated school official. Once the counselors or other mental health professionals have assessed the student, deemed the situation to be an emergency, and believe the student is in imminent danger, they are to contact the student's parents or guardians and make appropriate recommendations for treatment. If the student already receives therapy, parents should receive a recommendation to make immediate contact with the therapist. If the student is not currently receiving therapy services, then parents receive mental health resource information. To allow the school to communicate freely with the treating agency, parents should sign a release of information form. If the parent is unavailable or uncooperative, school personnel contact the Cabinet for Families and Children to intervene on behalf of the student. Next, school personnel should complete a follow-up with the family, student, or treating agency to ensure the provision of adequate care for

the student. Teachers should receive notification and monitor the student's behavior.

Lastly, on behalf of the student, school personal should document the incident and all

actions taken.

A no-harm contract is also an option in the school response plan. The no-harm

contract requires the student to agree not to harm themselves for a certain period of time,

make social/family contact with specified individuals, rid all things from their presence

that they could use to harm or kill themselves, and contact specified individuals if they

have a strong urge to hurt themselves. If the specified individuals are not available, they

are to call the Suicide Crisis Hotline immediately. Although the school plan addresses

suicide and not SI, it does contain components that are effective in dealing with youth

who self-injure such as designation of appropriate school officials, solicitation of parent

and community involvement, and utilization of a short-term intervention plan in the form

of a no-harm contract. However, the plan does not control for contagion effect, which is

an important aspect of addressing SI in the school. This school district's lack of a

specific plan to address SI is not out of the norm. Beld (2007) found that 70% of school

psychologists report that their employing school districts have a general plan for dealing

with SI; only 7.9% report their districts have a plan specifically for SI. However, 30% of

school districts do not use a plan or the school psychologists do not know if there is a

plan.

Purpose of the Study

SI is a growing concern for professionals who work with youth who self-injure.

CSI is different from other forms of SI in that it is not as frequently associated with

clinical disorders and youth who engage in CSI appear to evidence adequate academic

and social functioning. Surveys of teachers indicate that they are seeing an increase in students who engage in SI; it is therefore important for them to have sufficient knowledge, skills, and confidence in working with these youth. Previous research shows that educators evidence some knowledge of SI, but lack confidence. Although the reviewed research indicates that personal experience with youth who evidence SI is associated with greater knowledge of SI, educators do not report high levels of knowledge and confidence. Educators' lack of knowledge and confidence may be problematic in that it can hinder their effectiveness in identifying students who self-injure and providing them with adequate support.

The two reviewed investigations of teacher knowledge and attitudes about SI consist of small, convenience samples. The studies have only conducted research at the high school level. The present study looks at a sample of 263 educators and improves sampling by collecting data at the elementary, middle, and high school levels. School response plans for SI are another important component in effectively supporting students who self-injure. Beld's (2007) data shows that even school psychologists are not fully aware of their school's response plan. The literature reviewed did not investigate teachers' knowledge of school response plans. Kentucky schools are required to have a crisis response plan or procedures; however, educator knowledge of these plans is necessary for appropriate implementation. It is unknown whether knowledge of response plans in the case of SI is a factor in teacher confidence with SI. While knowing what to do and acting upon that knowledge are separate variables, it stands to reason that knowledge of procedures and plans may increase confidence in that it provides guidance and boundaries.

This research offers further insight into educators' perceptions and knowledge of SI and knowledge of school response plans. A survey of the educational staff in a small school district in the Western region of Kentucky provides a relatively large sample of educators. Jeffrey and Warm's (2002) measure, along with responses to survey items yield a measure of educator knowledge, indication of confidence in working with youth who SI, and perceptions of SI. In addition, there is an assessment of educators' knowledge of their schools' response plans. The research questions and hypotheses are as follows:

Research Question 1. What do educators know about self-injury?

Hypothesis One: Educators will evidence significantly lower scores on the SI knowledge measure than that exhibited by professionals working in a medical setting (Jeffery & Warm, 2002) and school psychologists Beld (2007).

Hypothesis Two: Males will report significantly higher self-rated knowledge of SI than females.

Hypothesis Three: Teachers who report higher level of experience with youth who self-injure will score higher on the knowledge measure than teachers with low levels of experience.

Hypothesis Four: There will be a strong positive correlation between educators' scores on the knowledge measure and the extent of their experience working with youth who SI.

Research Question 2. What do educators know about their school's response plans?

Hypothesis Five: Educators who report knowledge of school response plans will evidence greater confidence than educators who report no knowledge of response plans.

Method

Description of Respondents

Participants for the study are educational staff ($n = 578$) of a school district in the Western region of Kentucky. The district contains 10 elementary schools, three middle schools, and two high schools and serves approximately 8,786 students. The sample of consists of 263 (45.5%) certified educators who completed and returned the survey. Tables 1 and 2 contain descriptive statistics for the demographic variables. The majority of the participants are Caucasian (86.6%), female (75.2%), and work at the elementary level (43.7%); this is comparable to district statistics. The participants' ages range from 20- to 66-years-old. About half of the participants are 20- to 40-years-old ($n = 135$), the other half of the participants fall in the 41- to 66-year-old range. The largest group is the 20-30 (28.5%) age range. Many participants (30.8%) report having 0-5 years of experience as an educator and are classified as General Education Teachers (66.2%). A large number of participants (45.6%) report having a Rank II/Masters Degree. The participants' report of time employed in the current school district ranges from less than a year to 40 years, with half of the participants (50.2%) employed 6 years or less.

Table 1

Demographic Characteristics of Participants

Characteristic	Sample %(*n*)	District %(*N*)
Race (*n* = 262)		
Caucasian	86.6(227)	87.9(508)
African-American	10.3(27)	11.6(67)
Other	3.0(8)	0.5(3)
Gender (n = 262)		
Female	75.2(197)	79.9(462)
Male	24.8(65)	20.1(116)
School Level (*n* = 263)		
Elementary	43.7(115)	53.9(312)
Middle	19.8(52)	22.2(128)
High	36.5(96)	23.9(138)
Age (*n* = 263)		
20-30	28.5(75)	
31-40	22.8(60)	
41-50	23.6(62)	
51-60	22.1(58)	
61+	3.0(8)	

Table 2

Professional Experiences and Certification

Characteristic	Sample %(*n*)
Years of Experience (*n* = 263)	
0-5	30.8(81)
6-10	19.0(50)
11-15	14.8(39)
16-20	10.6(28)
21-30	16.3(43)
31+	8.4(22)
Job Classification (*n* = 263)	
General Education Teacher	66.2(174)
Special Education Teacher	17.1(45)
Instructional assist./teacher aid	0.4(1)
Guidance Counselor	5.3(14)
Principal/Assist. Principal	1.9(5)
Other Teachers	5.7(15)
Speech Language Pathologist	1.5(4)
School Nurse	0.8(2)
Curriculum Specialist	1.1(3)

Table 2 (continued)

Characteristic	Sample %(*n*)
Level of Certification (*n* = 261)	
Rank Ia/Doctorate Degree	1.9(5)
Rank I/Masters Degree	26.4(69)
Rank II/Masters Degree	46.0(120)
Rank III/Bachelors Degree	24.9(65)
Rank IV/96 to 128 Semester Hours	0.8(2)
Time Employed in District (*n* = 263)	
<1-6	50.2(132)
7-14	23.9(63)
15-25	22.9(60)
26-40	3.0(8)

Procedure

The school district superintendent granted permission to solicit the participation of the faculty (see Appendix A). The dissemination of the survey took place during a school faculty meeting at one of the high schools. The participants completed the survey while the researcher waited to collect each form. The elementary schools, middle schools, and the other high school, received surveys in their faculty mailboxes. Teachers had one week to complete the survey and return it to their guidance counselor. The collection of surveys from each school occurred at the end of each week; however,

surveys turned in later were still accepted. Once the participants completed the survey, they had the option to turn in their contact information in order to be included in a raffle to win one of two $50 Wal-Mart gift cards. The participants' survey information is separate from their contact information. The Human Subjects Review Board of Western Kentucky University approved all procedures (see Appendix B).

Instrument

The survey that was developed addresses the research questions and hypotheses identified in the literature review (see Appendix C). The survey consists of four sections: demographic information, knowledge of SI, experience and training in working with youth who self-injure, and knowledge of school response plans in regards to SI. The first portion of the survey, questions 1-8, asks for demographic, employment, and educational information of the respondents. The second section contains questions to assess knowledge of SI utilizing Jeffrey and Warm's (2002) 20-item questionnaire on accurate and inaccurate perceptions about the nature and causes of self-harm (question 9). Participants respond to the questions on a 5-point Likert scale (strongly disagree, disagree, unsure, agree, and strongly agree). Beld (2007) added several more questions to those developed by Jeffrey and Warm to reflect contemporary understandings (questions 9-10). Responses to these items are consistent with Jeffrey and Warm's 5-point Likert scale and extend the content to cover such topics as suicide, psychopathology, and associated features. Respondents answered questions regarding current understanding of SI such as onset age, percentage of population, popular media, relationship to psychopathology, and contagion (questions 11-13). The third section of the survey obtains information regarding respondent experience and training in working

with youth who self-injure (questions 14-31). The fourth section of the survey assesses

educators' knowledge of a school response plan for dealing with students who self-injure

(questions 32-35). These questions are based on those developed by Beld (2007) for use

with school psychologists but reworded for appropriateness for use with educators, and

are based on best practices for school crisis response plans for SI (Lieberman & Poland,

2007; Walsh 2006).

Jeffrey and Warm (2002) provided face validity for the knowledge measure

through a review by a clinical psychologist and a number of mental health workers.

Jeffrey and Warm found the internal consistency to be a coefficient alpha of .75 and a

split-half reliability of .84 for their medical professionals ($n = 114$). Beld's (2007) sample

of 64 consisting of school psychologists' responses to Jeffrey and Warm's 20-item

measure yielded coefficient alpha and split-half coefficients of .69.

Six school psychologists and three senior undergraduate psychology students

conducted an expert content validity and readability review analysis to check for clarity,

readability, adequacy of response options, and grammar. The reviewers made

recommendations for revision of grammatical errors (n = 3) and clarity of questions and

response options (n = 6). The survey utilized all recommendations for grammar and

clarity.

Results

Response Rate

Data collection took place over a 5-week period from the end of April to the last

week of May. The overall response rate for the survey was 45.5% with 263 responses to

the 578 disseminated surveys. This study utilized all returned surveys. It is important to

note that although there were 263 surveys returned, not all respondents answered every

question. Therefore, the number of respondents per question varies. Response rates also

varied across elementary (36.8%), middle (39.8%), and high school (70.2%) levels. The

demographic statistics for the respondents as regards to race, gender, and school level are

very similar to that of the entire district (see Table 1). Therefore, the sample appears to

be representative of the district.

Hypothesis One

To test the hypothesis that educators will evidence significantly lower scores on

the SI knowledge measure than that exhibited by school psychologists and medical

professionals, the mean score for this educator sample was calculated and compared to

Beld's (2007) school psychology sample and Jeffrey and Warm's (2002) medical

professional sample. Survey question 9 contains the 20 items on the knowledge measure.

Recoding of the reversed items created consistent scaling across the items with high

scores indicative of correct responses (1 = Strongly Disagree; 2 = Disagree; 3 = Unsure; 4

= Agree; 5 = Strongly Agree). Totaled scores on the 20 items were computed to create a

knowledge score that has a potential range from 20 to 100. The knowledge measure

evidenced good item reliability with a Cronbach's Coefficient Alpha of .71. The mean

score for the sample was 68.83 with a range from 52 to 89 and a standard deviation of

6.23 (*n* = 224). A series of one-sample *t* tests compared the mean score for the current

sample to the mean scores obtained by Beld (2007) and Jeffrey and Warm (2002). A

Bonferoni correction for the number of comparisons established a significance level of *p*

= .008. All but one of the mean score comparisons yielded significant mean differences

(see Table 3) with the current sample of educators evidencing a significantly lower mean

score than all of the comparison groups with the exception of psychiatrists. Effect sizes

for the comparisons ranged from .15 to 1.69 with the largest being that of psychology

workers in Jeffery and Warm's (2002) study. Therefore, results indicated partial support

of Hypothesis One.

Table 3

Mean Group Comparisons on Knowledge Measure

Group	M	t	d
Psychiatrist	69.78	-2.27	.15
Medical Workers	71.00	-5.20*	.35
Psychology Workers	79.37	-25.31*	1.69
Social Care Workers	77.16	-20.00*	1.34
Self-injurers	70.81	-4.75*	.32
School Psychologist	79.11	-24.69*	1.64

Note. The mean for the sample of educators is 68.83.

p < .01.

Additional analyses examined for differential performance on the knowledge

measure by school level. First, item reliabilities computed for each school level were

determined to be adequate with coefficient alphas ranging from .68 to .77. Next, follows

a comparison of the mean scores on the knowledge measure between all school levels

(see Table 4). A series of independent samples *t* tests yielded non-significant results

verifying no significant differences on the knowledge score based on school level for this

sample of educators. This analysis provides support for analyzing the results on the total

sample. Computation of the rest of the results uses the total sample of educators.

Table 4

Descriptives for Knowledge Measure by School Level

School Level	*N*	*M*	SD	α
Elementary	103	68.69	5.85	.68
Middle	44	69.39	7.12	.77
High	77	68.71	6.25	.70

Additional items examined educators' knowledge of SI in relation to areas such as

psychopathology, suicide, tattoos and piercings, media, age of onset, and percentage of

population (questions 10-13). In regards to psychopathology, the most frequent response

(45.2%) was "unsure" to the question "SI is a precursor to psychopathology." A majority

of the respondents (51.7%) answered "unsure" to the question "SI is distinct from

psychopathology," and 58.6% agreed or strongly agreed that SI can be a feature

associated with psychopathology. For tattoos and body piercings, a majority of the

participants did not agree that they were indicative of a problem with SI (81.0%), 59.7 %

did not agree that they were only indicative of SI if a person does it themselves, and

71.4% agreed that they were distinct from SI. Most participants (53.6%) were unsure if

students who self-injure are most often from middle to upper-middle class homes. In

regards to SI and the media, a majority of the respondents (53.4%) agreed that SI is

evident in the popular media, internet forums about SI are easily accessible (65.0%), the

media has become a mechanism for spreading information about SI (61.6%), and that SI

can be contagious (52.1%). Fifty-four percent of participants agreed that SI is a form of

suicide, while 55.0% agreed that SI is distinct from suicide. Many participants (43.0%)

answered "unsure" to the question "SI is a precursor to suicide" and 46.8% were unsure

that individuals who self-injure are suicidal.

Analysis of the response frequency patterns for the sample on the twenty items on

the knowledge measure and added questions identified good, poor, or problematic

understandings of SI. Beld (2007) utilized a 70% criterion to determine good, poor, and

problematic understanding in that a 70% criterion was neither too strict nor lenient. A

classification of good understanding consists of items in which the sample frequencies for

response ratings of three and four (agree and strongly agree) are >70%. A classification

of poor understanding consists of items that have sample frequencies of >70% for ratings

of one, two, and three (strongly disagree, disagree and unsure). Problematic

understanding consists of items that do not reach the 70% classification level as either

poor or good. On the 20 items from the knowledge measure, responses patterns for three

of the questions indicate poor understanding of SI, six reflect a good understanding, and

11 items indicate a problematic understanding of SI. Five of the added questions indicate

a poor understanding, two indicate a good understanding, and 10 questions fell within the

problematic category (see Table 5).

Table 5

Understanding of Self-Injury (SI) for Sample

Question	*M*	Understanding	
		Inaccurate[a]	Accurate[b]
Poor Understanding of SI[a]			
SI is a manipulative act[d].	2.46	89.3%	10.7%
SI is attention seeking[d]	2.26	90.6%	9.3%
SI is a sign of madness/mental illness[d].	2.69	75.4%	24.6%
SI is a precursor to psychopathology	2.67	86.3%	12.6%
SI is distinct from psychopathology	2.92	77.2%	21.7%
SI feature associated with psychopathology	2.39	93.2%	4.6%
SI often seen in middle to upper-middle class homes	2.73	86.3%	12.6%
Percentage of population engaging in SI	2.88	81.8%	14.4%
Good Understanding of SI[b]			
SI is a form of communication[d]	3.97	14.7%	85.2%
SI is a "woman's problem"[d]	4.24	8.9%	91.0%
SI is a release for anger[d]	3.88	18.3%	81.7%
SI is an expression of emotional pain[d]	4.05	9.8%	90.2%

Table 5 (continued)

Question	M	Understanding	
		Inaccurate[a]	Accurate[b]
Good Understanding[b]			
SI is a coping strategy[d]	3.78	20.5%	79.5%
Tattoo/piercings have problem with SI	3.91	17.5%	81.0%
SI provides distraction from thinking[d]	3.67	29.9%	70.1%
SI is distinct from tattooing/body piercing	3.67	25.8%	71.4%
Problematic Understanding[c]			
SI provides a way of staying in control[d]	3.37	41.5%	58.5%
People "grow out of" engaging in SI[d]	3.59	42.9%	57.2%
SI obtains/promotes feelings of euphoria[d]	3.52	44.6%	55.4%
Best to make people who engage in SI stop[d]	3.34	55.8%	44.2%
Engage in SI have been sexually abused[d]	3.36	59.7%	40.2%
SI helps deal with problems[d]	3.23	48.2%	51.8%
SI helps maintain a sense of identity[d]	3.23	59.8%	40.2%
Engage in SI suffer from Munchausen's[d]	3.71	37.9%	62.1%
SI provides an escape from depression[d]	3.11	64.3%	35.7%
Engage in SI should be in psychiatric hospitals[d]	3.70	34.8%	65.2%
SI is a form of suicide	3.43	44.2%	54.0%
SI is a precursor to suicide	3.08	67.0%	31.6%
SI is a failed suicide attempt[d]	3.70	30.4%	69.7%

Table 5 (continued)

Question		*M*	Inaccurate[a]	Accurate[b]
			Understanding	

Problematic Understanding[c]

Question	*M*	Inaccurate[a]	Accurate[b]
Individuals who engage in SI are suicidal	3.24	59.7%	38.8%
SI is distinct from suicide	3.42	42.1%	55.6%
Tattoos/piercings SI if done to self	3.55	38.7%	59.7%
SI is evident in popular media	3.33	44.5%	54.4%
Internet forums about SI easily accessible	3.72	33.8%	65.0%
Media spreads information about SI	3.52	37.3%	61.6%
SI can be contagious	3.29	44.8%	53.2%
Age people begin to engage in SI	2.28	57.0%	40.3%

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

[a] Poor Understanding of SI = Inaccurate frequencies $\geq$ 70%.

[b] Good Understanding of SI = Accurate frequencies $\geq$ 70%.

[c] Problematic Understanding of SI = Inaccurate and Accurate frequencies < 70%.

[d] Item from knowledge of SI measure (Jeffery & Warm, 2002).

Hypothesis Two

The second hypothesis predicted that males would report significantly higher self-rated knowledge of SI than females. Respondents selected one of the following four response options to the question of how knowledgeable they are about SI: know nothing, somewhat knowledgeable, knowledgeable and very knowledgeable. Statistical analysis consisted of a two-way contingency table [gender (2) x knowledge rating (4)] and chi square analysis. Gender was not found to be significantly related to perceiving a higher amount of knowledge of SI, χ^2 (2, N = 187) = 5.30, p = .15. The effect size was small, V = .168. This non-significant relationship between gender and perceived knowledge of SI was further explored through comparison of mean scores on the knowledge measure. A comparison of male (n = 65; M = 63.17) and female (n = 197; M = 68.82) group means using an independent t test was significant $t(221)$ = -4.85, p = .00. The effect size for the comparison equals 0.7. Thus, females have a significantly higher knowledge score than do males.

Hypothesis Three

The third hypothesis predicted that teachers who report a higher level of experience with youth who self-injure would score significantly higher on the knowledge measure than teachers reporting low levels of experience. First, an examination occurred of the responses to the three questions dealing with the amount of experience working with youth who self injure. The majority of the respondents had no experience working with youth who self-injure in the last year (64.3%), have never had a student report that another student was self-injuring (59.3%) or had a student report their own SI to them (66.5%). Those that reported some type of experience most frequently reported directly

working with one student (see Table 6).

Table 6

Participants' Experience with Students Who Self-Injure

Experience	N	% Total	% Experienced[a]
Students Directly Reporting SI ($n = 256$)			
0	175	68.4	
1	32	13.7	39.5
2-3	23	9.0	28.4
>3	26	10.3	32.1
Total for 1 or more	81		
Students Concerned about Another Student ($n = 262$)			
0	156	59.5	
1	45	17.2	42.5
2-3	49	18.7	46.2
>3	12	4.6	11.3
Total for 1 or more	106		
Students Directly Worked with in Current Year ($n = 260$)			
0	169	65.0	
1	43	16.5	47.3
2-3	30	11.5	33.0
>3	18	6.9	19.8
Total for 1 or more	91		

[a]Percentages based on number of respondents indicating experience with > 1 student.

Based on the response pattern to the items in Table 6, the basis for determining experience consisted of responses concerning how many students educators have worked with during the present school year (question 18). A series of independent samples *t* test compared the mean score for those who have worked with one student ($n = 43$; $M = 69.40$), two to three students ($n = 29$; $M = 66.66$); $t(70) = 1.04$, $p = .30$, and more than three students ($n = 19$; $M = 69.74$); $t(60) = -.16$, $p = .87$. The last comparison was two to three students compared to greater than three students, $t(46) = -.90$, $p = .37$. Due to incomplete responses to the knowledge measure, the number of respondents is slightly lower than reported in Table 6. Data did not support Hypothesis Three, as all comparisons yielded non-significant results. This indicates no significant difference in knowledge based on amount of experience directly working with students who self-injure. All effect sizes were small, ranging from .01 to .12.

To compare if any experience versus no experience has an impact on knowledge, the sample was regrouped into two groups (Experience, $n = 91$; $M = 68.59$; No Experience, $n = 169$; $M = 66.82$). An independent samples *t* test comparing the means was non-significant $t(258) = -1.39$, $p = .17$. This indicates no significant difference in knowledge of SI between educators who have or have not had experience working with youth who self-injure. The effect size was .09.

Hypothesis Four

The computation of a Pearson *r* correlation coefficient tested the hypothesis that a strong positive correlation will exist between educators' scores on the knowledge measure and the extent of experience with youth who self-injure. The sample's experience with youth who self-injure was ascertained through a series of three questions

dealing with number of students they have worked with who engage in SI, number of students who directly reported SI to them, and the number of students who have come to them concerned about another student.

The correlation was computed between educators' knowledge of SI, as measured by the knowledge measure, and an experience variable (combination of questions 16-18). The experience variable is the sum of the response codes across the three items. Scaling of the response codes created lower numerical values for lower experience and higher values for higher experience. The mean of experience for the sample was 4.93 with a range from 1 to 15 students and a standard deviation of 2.51 ($n = 262$). The correlation ($r = .11$) is non-significant, indicating no significant relationship between educators' knowledge of SI and their experience with students who engage in SI. The correlation of knowledge and experience was also computed separately for elementary ($r = .07$), middle ($r = .20$), and high school ($r = .12$) levels. There was no significant relationship between knowledge and experience across the school levels.

Knowledge, Confidence and Training

Descriptive analysis for questions (14 to 30) dealing with knowledge of SI, confidence, and training needs were analyzed for trends and patterns. There were several questions in this section were respondents indicated more than one response or gave no response, because of this frequencies may be less or greater than 100%. The following text identifies these questions as "multiple responses accepted" questions.

Participants indicated they did not first become aware of SI knowledge through scholarly resources (multiple responses accepted). The largest number of the participants first became aware of SI through the media (31.5%). Additional areas of initial

awareness of SI include journal or professional newsletter (5.3%), lecture or training session (9.5%), experience working with youth who self-injure (17.4%), students, or youth (16.7%), and colleagues and/or friends (10.2%). Twenty-one of the participants (8.0%) reported they had no knowledge of SI prior to the survey. Participants next indicated their main source of information on SI (multiple responses accepted). Respondents indicated media as their main source of information on SI (39.9%), followed by experience working with youth who self-injure (12.5%), interaction with students (10.3%), lecture/training sessions (7.6%), journal/professional newsletters (6.5%), and other (5.7%). Fourteen of the participants (5.3%) indicated they have received no information about SI.

Many participants (40.7%) estimated that more than 10 students engaged in SI in their district during the present school year. Forty-one percent of participants were unsure if SI is a problem in their school, followed closely by those participants who disagreed or strongly disagreed (36.9%). Only 19% agreed or strongly agreed that SI is a problem in their school building. As regards to the district as a whole, the majority of the participants were unsure if SI is a problem for students in their county (54.4%). Twenty-seven percent of participants agreed or strongly disagreed, and 17% disagreed or strongly disagreed. When asked how frequently the participant referred students for SI, 97.3% responded with "very rarely" or "never," while 1.5% indicated "daily" or "monthly." No one indicated referring students on a weekly basis.

Participants indicated all the forms of SI they have seen or have been reported to them (see Table 7). Scratching (58.9%) was the form most frequently reported, followed by cutting (51.3%) and punching, hitting self (47.5%). Frequencies for all other forms of

SI was less than 30%. Next, participants indicated the most common, second most common, and third most common forms of SI they have seen or been reported to them by students. Participants indicated cutting was the most common form (36.5%), scratching is the second most common (19.4%), and picking at scabs to interfere with healing is third with 9.5%. Participants also indicated if they were able to recognize the signs of SI in a student. The majority of the participants were unsure (56.7%), while 38.5% indicated yes, and only 4.6% indicated no.

Table 7

Forms of Self-Injury Seen by or Reported to Participants

Form	N	Percent
Cutting	135	51.3
Scratching	155	58.9
Burning	42	16.0
Punching, hitting (self or objects)	125	47.5
Breaking bones	6	2.3
Pulling out hair	60	22.8
Picking at scabs to interfere with healing	77	29.3
Banging body parts on objects	47	17.9
Ingesting harmful materials	22	8.4
None	90	34.2
Other	8	3.0

Note. "Other" refers to Safety pinning through skin, holding breath, piercing skin, pinching self, biting, and pencil eraser burns.

Participants indicated their confidence level in helping a student who engages in SI. Approximately two thirds of the participants indicated that they felt "somewhat confident," "confident" or "very confident" (67.6%), while one third indicated they felt "not at all confident." When asked how comfortable they were with the thought of SI, a little over half of the participants (53.2%) indicated they were "very comfortable" or "comfortable" and 46.8% indicated a degree of discomfort.

Regarding training needs, over three fourths of the sample indicated some level of interest (88.2%) in receiving more information on SI. When asked if they have attended any type of in-service training on SI, the majority of the participants indicated "no" (95.4%) while on 4.2% indicated "yes." Out of the 23 participants who have attended a professional training on SI, 17% attended within the last calendar year, 47.9% attended one to five years ago, and 34.87% attended > 6 years ago. The majority of participants (84.4%) have never attended a professional training on SI. When asked to select all options that would help them in feeling more confident in assisting students who self-injure, 56.3% to 64.6% indicated a set plan dealing specifically with student who SI. Twenty-four percent chose talking with other professionals who work with students who self-injure, 4.2% indicated that nothing would help and 1.1% indicated other options of watching informational videos and receiving reading materials on SI. When asked if they feel they have the skills or knowledge to assist a student who self-injures, only 8% indicated that "yes, I could it all on my own." A majority of the participants (59.7%) indicated they had some skills or knowledge, but would need additional help and support. Thirty-seven participants indicated they did not have the skills or knowledge to assist students.

Participants indicated all training or resources they have available (see Figure 1). The most frequently reported resource indicated by participants is outside resources (33.1%) such as local treatment groups and credible websites.
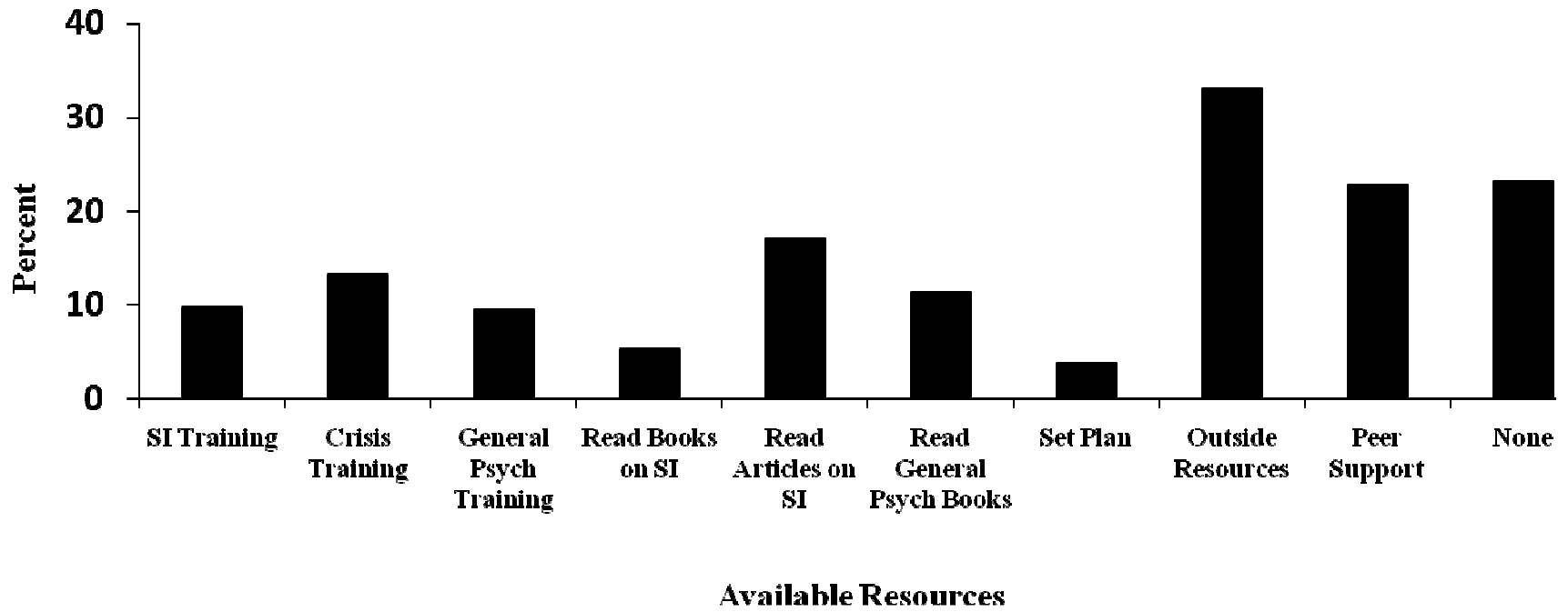
Figure 1.Training and resources educators indicate are available on SI.

Educator Knowledge of School Response Plans

Descriptive examination of questions addressed what the educators know about their districts' procedures for working with youth who self-injure (questions 32-35). Educators' knowledge of school response plans as regards to professionals responsible for responding to youth who self-injure, type of plan utilized (generic vs. specific), and actions included in response plan are compared to the district's current crisis response plan.

Participants first indicated their primary role in assisting students who self-injure (multiple responses accepted). The majority of participants indicated referring students to a professional with a mental health background (70.7%). Participants then selected all professionals who are responsible for responding to youth who self-injure in their school/district. The majority of participants reported mental health professionals in the school (school counselor, 78.3%; school psychologist, 71.5%), followed by the school nurse (60.1%) as the responsible professionals. Forty-five percent indicated family resource worker, 29.3% indicated school therapist, and only 9% indicated other (principal/teacher) or they did not know. When asked about the districts' response plan for dealing with students who self-injure, the majority of participants responded, "don't know" (71.9%), 3.5% responded with "specific plan" or "inclusive plan," and 10.4% indicated "no specific plan utilized." Only 13.3% of participants indicated the correct response of a "generic plan." Lastly, participants indicated all of the options/actions included in their school response plan to SI. The majority (57.8%) of the respondents indicated they do not know the steps included in their plan. However, other respondents were not fully aware of all steps included in the plan. The response rates were much

lower across the following options: talk to student (27%), call parents (25.1%), refer to

school administrator (16.7%), refer to school nurse (23.6%), refer to school mental health

staff (17.9%), encourage outside mental health support (13.7%), refer to police (3.0%),

send student to hospital (4.9%), develop academic/counseling supports (11.4%), and

document incident (21.7%).

Hypothesis Five

To test the hypothesis that that educators who report knowledge of school

response plans will evidence more confidence in helping students who self-injure than

educators who report no knowledge of a response plan, a two-way contingency table and

chi-square statistic were computed. Confidence is determined from the response to

question 23 asking "how confident would you be in helping a student who self-injures

seek appropriate help?" Knowledge of response plans obtained from question 34, asked

respondents to select their district's response plan from a list. Analysis of frequencies to

question 23, which asked how confident they were in helping a student who engages in SI

seek appropriate help, indicated a skewed distribution with fewer responses to the

confident ($n = 33$) and very confident options (n = 9) when compared with the somewhat

confident option ($n = 136$). Therefore, confidence responses were recoded into two

groups; low confidence (somewhat confident response) and high confidence (confident

and very confident responses). Knowledge of response plan data was recoded into two

groups to make a correct (generic plan response) and incorrect (all other responses). This

hypothesis was not supported; knowledge of a response plan and confidence was not

found to be significantly related, χ^2 (1, $N = 177$) = .00, $p = .98$. The effect size is small, V

= .076.

Discussion

The present investigation explored the knowledge of a sample of 263 educators regarding SI, training needs, and school response plans and how to respond to youth who self-injure in a school/educational setting. In addition, gender differences in SI knowledge were explored. The response rate of 45.5% is adequate and represents educators across elementary, middle, and high school levels. The sample's demographics (gender and race) are proportionately comparable to that of the district and state; however, the sample composition is rural in nature.

Hypothesis One

Hypothesis One predicted that educators evidence less knowledge of SI than school psychologists and medical professionals. Hypothesis One obtained partial support. All but one comparison group (psychiatrists) evidenced a significantly greater mean knowledge score than that of the educators in the sample. These findings are not surprising in that medical workers and school psychologists work more frequently and directly with these individuals in their professional practice. The therapeutic relationship these professionals build with youth who self-injure provides the opportunity for these professionals to acquire knowledge about SI that psychiatrist may not have the opportunity to obtain (Jeffery & Warm, 2002). Educators and psychiatrists are less likely to build an intimate, therapeutic relationship with these individuals and may account for their lower scores and similarity in knowledge of SI. However, it is concerning to note that psychiatrists have no greater SI knowledge than educators do.

When examining participants' responses to the Jeffery and Warm's (2002) SI knowledge measure, participants' scores indicate they are somewhat knowledgeable

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about SI with a mean score of 68.83. However, analysis of the frequencies to knowledge

measure items indicated 14 of the 20 items had poor (three items) or problematic

understanding of SI (11 items). For example, most participants agreed that SI is a

manipulative act. While Lieberman and Poland (2007) indicate that SI is associated with

shame and secrecy and most avoid attention and embarrassment, many educators agreed

that SI is "attention seeking." Although SI is associated with various clinical disorders,

engaging in SI does not indicate that one has a clinical disorder; however, participants

agreed that SI is a sign of madness/mental illness. These response patterns indicate the

presence of inaccuracies that need clarification among educators in order for them to

adequately identify and help students who Self-injure.

Participants also indicated poor (five questions) and problematic (10 questions)

understanding on additional areas of SI. Most participants disagreed or were unsure that

SI is "often seen in middle to upper-middle class homes." Most participants indicated

that individuals who engage in SI have a history of sexual abuse and suicide attempts.

While that is true for some individuals who self-injure, many youth who engage in SI in

schools evidence no history of prior abuse or clinical mental disorders and possess many

personal and family strengths (Walsh 2006). On questions pertaining to SI and its

relationship to psychopathology, most participants disagreed or were unsure that SI is

precursor to and distinct from psychopathology. Only a few respondents were able to

identify the percentage of individuals who engage in SI. Responses to these additional

questions further identify poor and problematic understanding of SI, indicating that

educators need training to extend beyond basic facts and myths to other related areas of

SI. Overall, educators do not have a good knowledge base of SI as their responses

indicate significant inaccuracies, which can lead to poor treatment or insensitive responses that may escalate SI incidents (Heath et al., 2008).

Hypothesis Two

Hypothesis Two examined if male educators rate their perceived knowledge of SI higher than that of female educators. Although not a direct comparison, this hypothesis attempted to further explore the findings of Heath et al. (2006) that male teachers indicated significantly greater perceived knowledge than did female teachers. Current data did not support this hypothesis. Male teachers indicated no greater self-ratings of knowledge of SI than the female teachers' self-ratings of knowledge of SI. One possible explanation is the proportion of males to females. In this sample, females out number males three to one, while in Heath et al. (2006), the ratio is two to one. An additional analysis explored gender differences in actual knowledge of SI for this group and found that the mean knowledge score for females was significantly higher than males. However, this measured difference in knowledge did not translate into a difference in perceived knowledge for this sample.

Hypothesis Three

Hypothesis Three examined whether educators who report a higher level of experience with youth who self-injure will score higher on the knowledge measure than educators who report low levels of experience. Data did not support Hypothesis. Educators with more experience evidenced no significantly greater mean knowledge score than those with less experience. An additional comparison of those who have had some level of experience versus those who have had no experience also evidenced no significant difference in knowledge of SI. Despite these results, prior research has shown

that any experience as well as working with increasing amount of self-injurers is associated with greater knowledge (Roberts-Dobie & Donatelle, 2007). One possible explanation is that most participants in this sample report they first became aware of SI through media sources and indicated the media was their main source of information, not experience working with students who self-injure as noted by Roberts-Dobie and Donatelle (2007). Therefore, it is reasonable that experience with youth who self-injure did not affect the educators' SI knowledge scores, as this sample's main source of information was not youth who self-injure.

Hypothesis Four

Hypothesis Four examined whether there was a strong positive correlation between educators' scores on the knowledge measure and the extent of experience with youth who self-injure. This hypothesis derives from Beld's (2007) finding that most school psychologists became knowledgeable of SI through experience rather than training. For this sample, there is no correlation between scores on knowledge measure and amount of experience. As discussed previously, experience does not seem to be a source of information regarding SI for this sample as the majority of their knowledge of SI has come from other sources such as the media.

Hypothesis Five

Hypothesis Five examined whether educators who report knowledge of school response plans will evidence more confidence in helping students who self-injure than educators who report no knowledge of a response plan. Data did not support hypothesis Five, in that there is no significant relationship between knowledge of a response plan and confidence in helping students who self-injure. One explanation for this is the

skewed distribution of responses. A majority of those with low confidence (63.3%) did not correctly identify or know if there is a response plan. However, many participants who have high confidence (20.3%) also did not correctly identify the plan or know of a response plan. This sample also has a large proportion of educators (30.8%) that are young in their teaching career and most (50.2%) are relatively new to the district, which may have influenced these findings.

Limitations

A limitation of the study is perhaps the relatively low response rate of 45.5%. One reason for the low response rate may be due to the dissemination of surveys during the last month of school. During this time, educators were extremely busy with state testing and tying up end of the year tasks. The dissemination of surveys at faculty meetings versus placing them in faculty mailboxes may have produced a higher response rate. Surveys were able to given out at one of the high schools, which produced a high response rate at that school of 98.6%.

An additional limitation of the study may be that some questions were difficult to interpret or poorly worded as many respondents selected multiple responses for questions that needed a single response. Responses to some questions were unusable as many participants incorrectly completed the item.

Practical Implications

The strength of this study is the large sample of participants when compared to other studies based on 50 to 150 participants. In addition, the sample closely matches the district in terms of race and gender and roughly approximates Kentucky's ethnicity statistics (Caucasian = 90.1%, African-American = 7.3%, and Other = 0.9%). However,

compared to national statistics, this sample is not representative of ethnicity in terms of minority versus Caucasian proportions. Therefore, generalizability to other educator populations is limited. An additional strength is the fact that data collection took place across elementary, middle, and high school. Previous studies have only collected data at the high school level.

Another implication of the present study is that while educators have some knowledge of SI, they hold many misconceptions and have problematic understandings of SI. These misconceptions and problematic understandings could lead educators to provide insensitive and ineffective assistance to students who self-injure. Due to the educators overall low self-rated confidence, their lower level of knowledge, and the majority indicating an interest in receiving information on SI, it appears that school-wide trainings would be beneficial to provide educators with proper and current knowledge of SI. Based on respondents' answers to questions on knowledge of SI, it appears that training should focus on addressing SI and suicide, the contagion effect, and SI and psychopathology.

An additional implication of the study is the districts' need for a specific plan for dealing with students who self-injure as well as staff training on the plan. A majority of the participants indicated never working with students who self-injure. However, the fact that 34.5% percent indicated working with these students makes the need for a specific plan necessary. Although the current generic plan utilized by the district has most of the components of an effective school response for SI, it fails to address the contagion effect, which is a crucial component to effectively dealing with students who self-injure. Once schools employ a specific and more comprehensive plan for dealing with students who

self-injure, students are more likely to receive adequate assistance. A majority of the

participants have also indicated a lack of knowledge of the current response plan. This

information indicates the need for staff to have training on the school response plan.

Even if educators are aware of a plan, they must know what the plan is and how to put it

in place for it to be truly effective. As stated previously, the fact that many of the

responding educators are new to the county and young in their professional careers may

influence their low knowledge of response plans. However, the need still exists for

educators to be knowledgeable in this area.

Further Research

　　　While the results of this study provide information about educators' knowledge of

SI and experience in encountering and working with students who self-injure, the county

of the present investigation is a small rural county and experience with SI was not

commonly encountered as noted in studies conducted in suburban and large urban areas.

Other studies have examined educators' knowledge and experience with SI in suburban

and large urban area; however, their samples have not been as large as in the current

study. Therefore, it would be beneficial to replicate this study with larger samples across

metropolitan, urban, and suburban areas to assess knowledge and experience with SI in

areas where educators more frequently exposed to individuals who self-injure.

　　　Lastly, an interesting finding was that the main source of information on SI for

these respondents was from the media. Other studies support knowledge about SI

growing from experiences working with youth who self-injure (Carlson et al., 2005;

Heath et al., 2008). This finding needs further investigation to determine to see if it holds

true for other samples.

Overall, the knowledge that educators have contains many inaccurate understandings of SI; however, many wish to obtain further knowledge about SI. Exploration of training content and methods for use with educators is a topic needing study. Training on SI may have an impact on educators' confidence, awareness and overall effectiveness in working with individuals who SI. This ultimately will benefit individuals who SI who are often misunderstood, therefore, driven to conceal their SI rather than seek alternative means of coping.

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Appendix A

School District Approval Letter

CHRISTIAN COUNTY PUBLIC 🔥 SCHOOLS

POST OFFICE BOX 609 • 200 GLASS AVENUE • HOPKINSVILLE, KY. 42241   PHONE (270) 887-1300

To Whom It May Concern,

Jacquetta Butts has been granted permission by the Christian County School System to administer her survey to our faculty pertaining to self-injury in the schools, for the 2007-2008 school year. We understand that it would be at the faculties' discretion to participate in the survey. Please feel free to contact me with additional questions at 270-887-7004.

Sincerely,

Patty Grable

Patty Grable
Director of Special Education

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Appendix B

Human Subjects Review Board Approval Letter

WESTERN KENTUCKY UNIVERSITY

The Spirit Makes the Master

Western Kentucky University
1906 College Heights Blvd. #11026
Bowling Green, KY 42101-1026

In future correspondence please refer to HS08-172, April 16, 2008

Jacquetta Butts
c/o Dr. Elizabeth Jones
Psychology
WKU

Dear Jacquetta:

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

1. In addition, the IRB found that you need to orient participants as follows: (1) signed informed consent is required; (2) Provision is made for collecting, using and storing data in a manner that protects the safety and privacy of the subjects and the confidentiality of the data. (3) Appropriate safeguards are included to protect the rights and welfare of the subjects.

   This project is therefore approved at the Expedited Review Level until August 31, 2008.

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

Sincerely,

Sean Rubino, M.P.A.
Compliance Manager
Office of Sponsored Programs
Western Kentucky University

cc: HS file number Butts HS08-172

Appendix C

Survey

Self-Injury Survey

Please indicate your responses by filling in the blanks or circling your response choice.

1) Age:_____

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

3) What is your gender?
   A. Male
   B. Female

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

5) What is your current job classification?
   A. General education teacher
   B. Special education teacher
   C. Instructional assistant/teacher aid
   D. Guidance counselor
   E. Principal
   F. Other: _____

6) What is your present level of professional preparation/certification?
   A. Rank Ia/Doctorate Degree
   B. Rank I/Masters Degree plus 30 hours
   C. Rank II/Masters Degree
   D. Rank III/Bachelors Degree
   E. Rank IV/ 96 to 128 semester hours

7) How long have you been employed in this school district? _____

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

For the questions below the term self-injury will be used. Self-mutilation, self-harm, deliberate self-harm, deliberate self-mutilation, and cutting are other terms used to identify this behavior.

9) Based on your knowledge of self-injury please answer the following questions by placing an "X" in the box under your response:	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Self-injury is a form of communication.					
Self-injury is a sign of madness/mental illness.					
Self-injury provides a way of staying in control.					
Self-injury provides distraction from thinking.					
People who self-injure will "grow out of it" eventually.					
Self-injury is a manipulative act.					
Self-injury can obtain/promote feelings of euphoria.					
Self-injury is a "woman's problem."					
Self-injury is a release for anger.					
Self-injury is an expression of emotional pain.					
The best way to deal with people who self-injure is to make them stop.					
People who self-injure have been sexually abused.					
Self-injury is a failed suicide attempt.					
Self-injury helps individuals deal with problems.					
Self-injury is a coping strategy.					
Self-injury is attention-seeking.					
Self-injury helps a person maintain a sense of identity.					
Everybody who self-injures suffers from Munchausen's Disease (self-inflicted injuries that are calculated to produce specific symptoms that will lead to medical hospital admissions).					
Self-injury provides escape from depression.					
People who self-injure should be kept in psychiatric hospitals.					
Self-injury is a form of suicide.					
Self-injury is a precursor to suicide.					
Individuals who self-injure are suicidal.					
Self-injury is distinct from suicide.					

10) Indicate your agreement with the following statements about self-injury by placing an "X" in the box under your response:	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Self-injury is a precursor to psychopathology (A serious emotional disturbance).					
Self-injury is distinct from psychopathology (A serious emotional disturbance).					
Self-injury can be a feature associated with psychopathology (A serious emotional disturbance).					
Individuals who have body piercings and/or have tattoos have a problem with self-injury.					
Tattoos and/or body piercing are only indicative of self-injury if the person does it to themselves.					
Self-injury is distinct from tattooing and/or body piercing.					
Students who self-injure are most often from middle to upper-middle class homes.					

Self-Injury Defined:

For the purposes of the rest of the survey, please use the following definition for self-injury:

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

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

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

12) At what age do most people begin to engage in self-injury?
   A. Below 9 years
   B. 9-12
   C. 13-15
   D. 16-19
   E. 20-23
   F. Over 23

13) Please indicate your agreement with the following statements by placing an "X" in the box under your response:

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Self-injury is evident in the popular media (internet, music, movies, TV, magazines).					
Internet forums (message boards, chat rooms, and blogs) specifically about self-injury are easily accessible.					
The media (TV, movies, music, internet) has become a mechanism for spreading information about self-injury.					
Self-injury can be contagious, spreading from person to person (word of mouth, modeling).					
Self-injury is a problem in my school(s).					
Self-injury is a problem for students in Christian County.					

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

15) Which outlet has been your main information source on self-injury?
   A. Journal/Professional newsletters
   B. Lecture/Training sessions
   C. Media (popular press, TV, internet)
   D. Interaction with students in my school
   E. Experience working with students who self-injure.
   F. Have received no information about self-injury,
   G. Other:_____

16) On estimate, how many students directly reported self-injury to you during the last school year (2007-2008)?
    A. None
    B. 1
    C. 2-3
    D. 4-6
    E. 7-10
    F. >10

17) How many times has someone come to you concerned about another student who engages in self-injury?
    A. 0
    B. 1
    C. 2-3
    D. 4-6
    E. 7-10
    F. >10

18) On estimate, how many students who engage in self-injury have you worked with during the present school year (2007-2008)?
    A. 0
    B. 1
    C. 2-3
    D. 4-6
    E. 7-10
    F. >10

19) How many students do you estimate engaged in self-injury this school year (2007-2008) in Christian Co. Schools?
    A. None
    B. 1
    C. 2-3
    D. 4-6
    E. 7-10
    F. >10

20) What forms of self-injury have you seen or have been reported to you by students?	What are the three most frequent forms of self-injury that you have seen or have been reported to you by students?
Circle all that apply:	Rank your responses by placing a 1, 2 or 3 beside the form of self-injury. (1 = most often; 2 = second most common; 3 = third most common)
A. Cutting	A. _____ Cutting
B. Scratching	B. _____ Scratching
C. Burning	C. _____ Burning
D. Punching, hitting (self or objects with the body)	D. _____ Punching, hitting (self or objects with the body)
E Breaking bones	E. _____ Breaking bones
F. Pulling out hair	F. _____ Pulling out hair
G. Picking at scabs to interfere with healing	G. _____ Picking at scabs to interfere with healing
H. Banging body parts on objects	H. _____ Banging body parts on objects
I. Ingesting harmful materials	I. _____ Ingesting harmful materials
J. Other:_____	J. _____ Other:_____
K. None (skip to question 22)	K. None (skip to question 22)

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

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

23) Given your current knowledge of self-injury, how confident would you be in helping a student who self-injures seek the appropriate help?
    A. Not at all confident
    B. Somewhat confident
    C. Confident
    D. Very confident

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

25) What would assist you in feeling more confident in assisting students who reveal they self-injure? (Circle all that apply)
- A. More training
- B. A set plan for dealing with students who self-injury (such as a school policy or procedure)
- C. A more specific plan for dealing with students who self-injury
- D. Talk with other professionals who work with students who self-injury
- E. Other:_____
- F. Nothing

26) Do you feel like you have the skills or knowledge to know how to assist a student who self-injures? (Assist means to provide supportive help as opposed to therapeutic, counseling, or mental health services/assistance)

- A. No, I do not feel like I have any skills/knowledge
- B. Somewhat, but I would need help
- C. Yes, I have some skills/resources and would seek additional support in some instances
- D. Yes, I could do it all on my own

27) What training or resources do you have available? (Circle all that apply)

- A. Training on self-injury specifically
- B. Crisis response training (not for self-injury specifically)
- C. Training in general psychological issues
- D. Have read books on self-injury
- E. Have read an article(s) in a professional journal on self-injury
- F. Have read books on general psychological issues
- G. Have a set crisis plan to follow
- H. Have access to outside resources for information (Local treatment groups/facilities, credible websites)
- I. Professional peer support
- J. None

28) Have you attended any type of in-service training on self-injury?
- A. Yes
- B. No

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

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

31) On estimate, how frequently do you refer students for self-injury?
   A. Daily
   B. Weekly
   C. Monthly
   D. Very rarely
   E. Never

32) If a student comes to you indicating they self-injure, what is your primary role in assisting the student?
   A. Individual therapy/counseling
   B. Refer student to a professional in community (ex: therapist, social worker, hospital)
   C. Refer to a professional in the school with a mental health background (ex: school psychologist, counselor)
   D. Be able to provide a student with information (ex: books or pamphlets on self-injury, website addresses for support groups)
   E. Develop academic and/or counseling support within the school
   F. Contact parents
   G. No role

33) Which professional(s) are responsible for responding to youth who self-injury in your school/district? (Select all that apply)
   A. School psychologist
   B. School family resource worker
   C. School counselor
   D. School nurse
   E. School therapist
   F. Other: _____
   G. Don't know

34) Does your district have a specific plan for dealing with students who self-injure, or do you have a generic plan used for a variety of student related crisis/problems?
   A. Specific plan (addresses self-injury specifically, separate from other response plans)
   B. Inclusive plan (addresses self-injury specifically, but is part of larger response plan)
   C. Generic plan (have a general emergency/crisis response plan to address issues like self-injury, but response to self-injury not specified)
   D. No specific plan utilized
   E. Don't know

35) Which of the following options/actions are included in your school response to self-injury? (Select all that apply)
   A. Assess/ Talk to student
   B. Call parents
   C. Refer student to school administrator
   D. Refer student to school nurse
   E. Refer student to school mental health staff
   F. Encourage student/parent to seek mental health support outside of school
   G. Refer student to police
   H. Send student to hospital/medical care center
   I. Ask student/parent for permission to develop academic and/or counseling supports within the school itself
   J. Document incident
   K. Do not know what steps are included in the plan

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

Thank you for participating in this study!

If you wish to participate in the raffle for one of two $50 Wal-mart gift cards, please fill out the attached contact information form and turn it in with your survey.