COUNSELOR SELF-EFFICACY, WORK EXPERIENCE, AND EDUCATIONAL BACKGROUND AS PREDICTORS IN WILLINGNESS TO TREAT AND SEEK ADDITIONAL TRAINING TO WORK WITH NON-SUICIDAL SELF-INJURY CLIENTS

by

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To my mother and father,

Sharron and Clarence Russell.

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Tobi Y. Russell

ABSTRACT

COUNSELOR SELF-EFFICACY, WORK EXPERIENCE, AND EDUCATIONAL BACKGROUND AS PREDICTORS IN WILLINGNESS TO TREAT AND SEEK ADDITIONAL TRAINING TO WORK WITH NON-SUICIDAL SELF-INJURY CLIENTS

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The aim of the research was to understand how counselor self-efficacy (CSE) influences willingness to treat non-suicidal self-injury (NSSI) clients, as well as willingness to seek out training to learn about NSSI. Research has shown that NSSI clients are viewed by counselors as one of the most difficult types of clients to treat and counselors report a lack of knowledge of how to confidently work with NSSI clients. However, CSE for both community and school counselors and whether it predicts willingness to work with NSSI clients or to obtain training about NSSI has not been examined in the literature. The current study used a non-experimental, quantitative design to look at the relationship between CSE, willingness to treat NSSI clients, and willingness to participate in NSSI training. The results found significant differences between CSE and willingness to work with NSSI clients, but no significant differences between CSE and willingness to obtain NSSI training. The clinical implications, limitations and future research recommendations for counselors are discussed.

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LIST OF ABBREVIATIONS

CSE	Counselor self-efficacy
NSSI	Non-suicidal self-injury

CHAPTER ONE

INTRODUCTION

This chapter will introduce the concept of non-suicidal self-injury (NSSI) and how self-efficacy may influence how counselors work with clients engaged in NSSI. First, an overview of NSSI and the various types of self-injury will be explained. Next, the scope of the problem of NSSI will be discussed by reviewing epidemiological and prevalence statistics. The consequences for individuals who do not receive an optimal standard of care for NSSI will be reviewed. Next, the chapter will review the challenges for counselors working with the NSSI population. The chapter highlights how self-efficacy of counselors influences their engagement and treatment of clients as well as a thorough description of the model of self-efficacy developed by Albert Bandura. The chapter concludes with operational definitions of the types of NSSI as well as the constructs examined in this investigation. The study seeks to explore how counselor self-efficacy and other factors may impact counselor willingness to work with NSSI clients and how it may impact their desire to learn about how to work with NSSI clients.

Overview of Non-suicidal Self-Injury (NSSI)

Self-injury broadly defines a category of behaviors that occur along a continuum. One end of the spectrum includes behaviors that are intended to adorn the body (tattooing, piercing) or those that are culturally dependent (healing rituals, rites of passage) (Osuch, Noll, & Putnam, 1999). On the other end of the spectrum are those behaviors that include cutting or burning (Bigard & Rapaport, 2006; Osuch, Noll, &

Putnam, 1999). Yet another definition of self-injury is the deliberate, direct destruction of body tissue resulting in tissue damage without conscious suicidal intent (Kakhnovets et al., 2010; White-Kress, Gibson, & Reynolds, 2004). There are many names that this type of self-injurious behavior has been given: cutting, self-harm, self-mutilation, self-attack, parasuicide, deliberate non-fatal act, symbolic wounding and self-inflicted violence (Purington & Whitlock, 2013). These are acts where an individual intentionally alters or destroys body tissue for purposes that are not primarily aesthetic nor socially sanctioned (Purington & Whitlock, 2013). This study is concerned with counselors that work with clients that engage in self-injury defined as the purposeful destruction of body tissue without conscious suicidal intent (Kakhnovets et al., 2010; Favazza, 1998).

Cutting, burning, scratching or skin-picking, interference with wound-healing, breaking one's own bones, pulling out hair on the body to an extreme degree are all considered self-injurious behavior (Henslin & Clark, 2014). Self-injury was previously not a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision (DSM-IV-TR: American Psychiatric Association, 2000), but it has been included in the DSM 5 (DSM 5: American Psychiatric Association, 2014) under "conditions for further study". Conditions for further study are not intended for clinical use because they are not listed under Section II of DSM 5. The proposed criteria set in DSM 5 is called Non-suicidal Self-Injury. The description of this proposed criteria set states that in the last year, the individual has to have engaged in intentional self-inflicted damage to the surface of their body on five or more days. This self-inflicted damage is likely to cause bleeding, bruising, or pain with the expectation that the injury will lead to

only minor or moderate physical harm. Another criterion is that the individual engages in the self-injurious behavior with one or more of the following expectations: to obtain relief from a negative feeling or thought, to resolve an interpersonal difficulty, and/or to induce a positive feeling. The intentional self-injury must be associated with at least one of the following: interpersonal difficulties or negative feelings or thoughts; prior to engaging in self-injury there is a period of preoccupation with the intended behavior that is difficult to control; and/or thinking about self-injury that occurs frequently, even when it is not acted upon. The self-injurious behavior is not socially sanctioned (e.g. piercing, tattooing, cultural ritual), is not restricted to picking a scab or biting nails; the behavior causes clinically significant distress in important areas of functioning; and does not exclusively occur during psychotic episodes, delirium, substance intoxication or withdrawal, neurodevelopmental disorder, or medical condition. The addition of self-injurious behavior in the DSM 5 reflects how widespread the practice has become (DSM 5: American Psychiatric Association, 2014).

Types of Self-Injury

Efforts have been made to categorize self-injury by the degree of bodily harm inflicted and the rate and pattern of the behavior. Four categories of self-injury have been proposed, with the first three being directly tied to specific psychological disorders (Miller & Brock, 2010; Simeon & Hollander, 2001). The categories are major, stereotypic, compulsive, and impulsive self-injury. Major self-injury includes acts that have a significant amount of damage to body tissue (e.g., eye enucleation, castration, and limb amputation). Major self-injury can be life-threatening and often results in bodily

damage that is irreversible. This form of self-injury tends to happen in isolated incidents rather than repetitively. It is associated with psychotic disorders, delusions, and hallucinations (Miller & Brock, 2010; Walsh & Rosen, 1988). Major self-injury has been associated with intoxication, depression, mania, personality disorders and transsexualism (Simeon & Hollander, 2001). The theme of major self-injury tends to be religious or sexual in nature (Miller & Brock, 2010; Simeon & Hollander, 2001).

Stereotypic self-injury is commonly exhibited in head-banging, biting, scratching, punching and other behavioral acts that are often rhythmic and repetitive in nature. The behaviors usually occur in the presence of other people and may occur multiple times in a day with mild to serious consequences (Miller & Brock, 2010; Stein et al., 1998). Stereotypic self-injury is associated with intellectual disability, autism, and other developmental disorders such as Lesch-Nyhan syndrome, Cornelia de Lange syndrome and Prader-Willi syndrome (Favazza, 2011, Miller & Brock, 2010; Simeon & Hollander, 2001).

Compulsive self-injury is when someone engages in ritualistic acts that happen multiple times a day. There is typically mild to moderate tissue damage. Individuals are often not consciously aware of their behavior. Examples of compulsive self-injury include trichotillomania (compulsive hair-pulling), chronic and extensive onychophagia (nail biting), and onychotillomania (compulsive skin picking and scratching). Compulsive self-injury tends to be associated with stereotypic movement disorders and Tourette's Disorder (Miller & Brock, 2010).

Impulsive self-injury is the most common form of self-injury and includes skin cutting, burning, carving, interfering with wound healing, bone breaking, self-hitting, and needle sticking (Favazza, 2011; Miller & Brock, 2010; Simeon & Hollander, 2001). Impulsive self-injury can be episodic or repetitive and results in mostly low lethality or damage to tissue. Episodic self-injury refers to behavior that occurs every so often among individuals who may not identify themselves as "cutters" or "burners". Repetitive self-injury refers to behavior that is a primary preoccupation for an individual and they identify themselves as a "cutter" or "burner" and may even feel addicted to the behavior (Miller & Brock, 2010).

Rate and Frequency of Non-suicidal Self-Injury (NSSI)

Self-injury is a significant and concerning phenomenon that counselors working in community and school environments encounter (Kerr, Muehlenkamp, & Turner, 2010). Rates of self-injurious behavior for adults ranged from four percent to 23% (Cipriano, Cella and Contrufo, 2017; Andover, 2014; Briere & Gil, 1998). Generally, prevalence rates of NSSI in adolescents fall somewhere between seven and a half and 24.5% (Cipriano, Cella and Contrufo, 2017, Sornberger et al, 2012, Hilt et al, 2008) and between 12.8% and 38.9% among university students (Cipriano, Cella and Contrufo, 2017; Kuentzel et al., 2012, Gratz, Conrad, & Roemer, 2002).

Jacobson and Gould (2007) completed a critical review of the literature. This review initially included 3000 articles, but ultimately only included 25 articles that were specific to self-injury without suicidal intent. The researchers had three goals for this review. First, Jacobson and Gould (2007) wanted to provide education to clinicians

working with adolescents about the phenomenology and risk factors of NSSI. The second purpose was to provide a critical review of the empirical research regarding adolescents engaging in NSSI, specifically focusing on how NSSI differs from suicide attempts (Jacobson & Gould, 2007). Last, the goal of the study was to highlight the areas most in need of further investigation related to NSSI (Jacobson & Gould, 2007). To determine the prevalence of behavior, it is necessary to utilize representative, non-referred, community samples (Jacobson & Gould, 2007). Eight studies (Muehlenkamp & Gutierrez, 2007, 2004; Whitlock, Eckenrode, & Silverman, 2006; Laye-Gindhu & Schonert-Reichl, 2005; Ross & Heath, 2003; Zoroglu, Tuzun, Sar et al., 2003; Briere & Gil, 1998; Garrison et al., 1993) met that criteria.

Only one of the aforementioned studies looked at a nationally represented sample of adults (Briere & Gil, 1998). Participants were chosen through a national sampling service that generated a stratified, random sample of the United States, based on geographical location of registered owners of automobiles and individuals with listed telephones. Briere and Gil (1998) sent the Trauma Symptom Inventory (TSI) to 1,442 subjects with deliverable addresses, 855 returned substantially completed surveys. An additional 72 individuals who returned surveys after the TSI standardization was completed were also included, yielding a total 927 subjects. The mean age of the full sample was 46 years (SD= 17; range= 18-90). Most of the subjects were married (56%), followed by separated or divorced (17%) and single (18%). In the total sample of participants, 50% were male, and 75% were white, 11% black, seven percent Hispanic, three percent Asian, two percent Native American, and two percent “other.”

Self-mutilation in this study was assessed by subjects' responses to TSI item 48 ("Intentionally hurting yourself [e.g., by scratching, cutting, or burning] even though you weren't trying to commit suicide"), rated on a scale of 0 (never) to 3 (often) over the last six months. In this sample of 927 individuals, the data yielded a six-month prevalence rate of 4%. Of this group of 927 respondents, there were 390 individuals that were attending sessions in a clinical setting. The clinical sample data yielded a six-month prevalence rate of 21% (Briere & Gil, 1998).

Andover (2014) conducted a study where the purpose was to assess the criteria of NSSI Disorder in the DSM-5 in a community sample of adults from the United States. The study also was meant to provide an investigation of differences between individuals with and without a diagnosis of NSSI and NSSI history. Participants were recruited using Amazon's Mechanical Turk (MTurk; http://www.MTurk.com). MTurk is an online marketplace where jobs are posted, and workers select and complete jobs for pay. Recruitment for MTurk was considered passive because workers found the survey using search terms such as "psychology, psychiatry, coping, life events, stress, self-injury, self-harm, NSSI, and self-mutilation" (Andover, 2014). Workers who met the study qualifications could access a brief description of any study they were interested in, and they could contact the researcher for additional information. The qualifications for this study were restricted to workers in the United States who were at least 18 years of age and had a 95% completion rate for other surveys on MTurk. In total, 564 MTurk workers participated in this study (Andover, 2014). 16 workers failed one or more validity checks and were not included in the study so the final sample consisted of 548 participants.

Participants ranged in age from 18 to 73 years (M=35.70, S.D.=12.23). Just under half of the sample was comprised of females (46.5%, n=255). Regarding ethnicity, 79.7%, (n=437) reported their race as white, and 6.8% (n=37) reported their ethnicity as Latino/a, 17.7%, (n=92) reported being in college.

The results indicated that 23% of adults in this study reported engaging in self-injury at least once. Twenty percent (20.8%) of those with an NSSI history reported engaging in NSSI on five or more days in the past year (DSM-V Criterion A). Two-thirds of the sample of self-injurers (66.4%) endorsed at least one of the three reasons for NSSI (DSM-V Criterion B). Over 80% of the sample (82.4%) endorsed at least one of three associated features of NSSI (DSM-V Criterion C) (Andover, 2014). The study also explored differences in clinical variables among participants with no NSSI history (n=400), those with an NSSI history who did not meet criteria for NSSI Disorder (n=111), and those with NSSI Disorder (n=14). The participants without any NSSI history reported using more problem-solving strategies than those diagnosed with a NSSI Disorder. Interestingly though, there was no difference in the use of social support seeking strategies between individuals diagnosed with a NSSI disorder and those with no NSSI history (Andover, 2014). Lastly, the study identified differences in NSSI characteristics and functions and whether those with NSSI Disorder differed from those with an NSSI history, but not NSSI Disorder. Results determined that those with NSSI Disorder were significantly more likely than those with a NSSI history only to report that the NSSI behavior interfered with their functioning.

Regarding function of the behavior, those participants with NSSI Disorder reported engaging in the behavior for more autonomic functions than those without the disorder (Andover, 2014).

Gratz, Conrad, and Roemer (2002) studied the etiology of self-harm by examining the relationships between deliberate self-harm behavior in adulthood and the following risk factors: (a) childhood physical and sexual abuse, (b) childhood neglect and other disruptions in attachment (i.e., childhood separation and loss), (c) perceived quality of attachment to caregivers, and (d) dissociation. 159 students from undergraduate psychology courses at a diverse urban university participated in this study. 26 participants were excluded due to missing data. The final sample of 133 participants ranged in age from 18 to 49, with a mean age of 22.73 years (SD= 6.17). 67 percent of these participants were female. The racial background of participants consisted of 62% White/Caucasian, 18% were Asian, 10% were Black/African American, five percent were Hispanic, and five percent were of another racial background. Participants were predominantly single (83%) and heterosexual (96%) (Gratz, Conrad and Roemer, 2002). One of the findings that the authors reported was that 38% of the sample reported a history of self-injury, 18% reported self-injuring more than 10 times in the past, and 10% reported self-injuring more than 100 times in the past (Gratz, Conrad & Roemer, 2002). The most significant predictor of NSSI among women in the study was dissociation. Other risk factors for women in the study included insecure paternal attachment, childhood sexual abuse, maternal and paternal emotional neglect (Gratz, Conrad & Roemer, 2002).

The most significant predictor of NSSI among men in the study was childhood separation (specifically childhood separation from their fathers) and dissociation (Gratz, Conrad & Roemer, 2002).

Kuentzel et al. (2012) conducted a prevalence study utilizing the Deliberate Self-Harm Inventory (DSHI). A sample of 5,691 college students was used in this analysis. All participants were undergraduates enrolled in psychology courses at a large Midwestern university. Thirty percent were men (n = 1,697) and 70% were women (n = 3,983); 10 students did not indicate their gender. The sample was diverse, with 42% identifying as Caucasian (n = 2,407), 29% identifying as African American (n = 1,650), nine percent identifying as Arab or Middle Eastern (n = 509), eight percent identifying as Asian (n = 469), three percent identifying as Multiracial (n = 178), three percent identifying as Hispanic (n = 158), three percent identifying as Other (n = 150), one percent identifying as Pacific Islander (n = 55), and four-tenths of a percent identifying as Native American (n = 24). 90 participants declined to provide their ethnicity. Mean age was 22.2 years (SD = 6.35, range 16–92 years); the modal age was 18 years (Kuentzel et al., 2012). Results indicated that 12.8% of the sample reported engaging in self-injury at least once in their lives.

Hilt et al. (2008) examined non-suicidal self-injury (NSSI) in a community sample of young adolescent girls. They recruited 57% of the sample from two public middle schools and the remaining 43% from community advertisements in school newsletters, local malls, and newspapers. Participants included 94 girls (49% Hispanic; 25% African American) aged 10-14 years old who completed questionnaires regarding

self-injurious behavior and other constructs of interest. 56% of the participants (n = 53) reported engaging in NSSI during their lifetime (Hilt et al., 2008).

Sornberger et al. (2012) studied self-injurious behavior from a gender difference perspective. Data were collected from a sample of 7,126 high school students in the greater Kansas City metropolitan area. Participants were asked to complete a survey on health-related behaviors. The sample consisted of 3,623 females (50.8%) and 3,503 males (49.2%), ranging in age from 11 to 19 years (M = 14.92; SD = 1.61). The participants were in grades 6 through 12 across 11 school districts in the greater Kansas City metro area, which included 13 high schools and 18 middle schools. Of the total sample, 1,859 participants (26.1%) indicated that they had ever physically hurt themselves on purpose and 115 did so with suicidal intent (Sornberger et al., 2012). Results indicated that 32.1% of females and 16.6% of males engaged in NSSI at least once in their lives. Females were more likely than males to report cutting and scratching. Males were more likely to report burning, banging their head and punching themselves. Females were more likely to injure their arms and legs, while males were more likely to injure their chest, genitals and face (Sornberger et al., 2012).

As stated earlier, 21% of the clinical population has engaged in non-suicidal self-injurious behavior (Briere & Gil, 1998) which makes it critically important for counselors to be prepared to work with this population. The aforementioned studies have yielded some crucial indicators for counselors to understand. First, demographically NSSI is reported more by females than males and ethnically by Caucasians than any other race. The area of the body that individuals self-injure also differs by gender with females more

likely to injure their arms and legs; males more likely to injure their chest, genitals and face. There are differences between those with a diagnosable NSSI disorder and those with a history of engaging in NSSI specifically as it relates to problem-solving strategies. The gender differences between risk factors for NSSI are that females are influenced by dissociation and males are influenced by childhood separation. It is important that counselors understand the NSSI population so that when these clients come into the clinical setting for help, they feel understood.

Consequences for Deficient Non-suicidal Self Injury Treatment

There is a gap in the literature regarding the consequences for individuals that do not receive treatment for NSSI versus those who do receive treatment. Additionally, there does not appear to be a great deal of research on individuals who do not receive appropriate treatment for NSSI. However, there was an international study that was done by Ystgaard et al. (2009) in several countries. Not only was the study one of the first to investigate adolescents who deliberately harm themselves and differences between those who receive help and those who do not, but it is the first study where a comparison was made between those who receive help from social networks and those who receive no help. The study looked at deliberate self-harm (DSH) in general and was not specific to NSSI behavior. A standardized self-report questionnaire was completed by 30,532 adolescents aged 14-17 in Australia, Belgium, England, Hungary, Ireland, the Netherlands, and Norway. Deliberate self-harm was reported by 1660 participants in the year prior to the study. Nearly half (48.4%, n=803) of the participants had not received any help following DSH, 32.8% (n=545) had received help from their social network

only and 18.8% (n=312) from health services (N=203 had gone to a hospital). Cross-national comparisons yielded similar findings except for results from Hungary.

Interestingly, results from the study showed that adolescents who had been in contact with health services following DSH often reported a wish to die, lethal methods, alcohol/drug problems and DSH in the family compared to those who had not (Ystgaard et al, 2009). However, those who received no help or help from their social network only also seemed to struggle.

The most reported methods of deliberate self-harm were NSSI (1040; 62.6%) and overdose (495; 29.9%), 76 (4.6%) reported both NSSI and overdose. Other methods included consumption of alcohol (74; 4.4%), consumption of recreational drugs (67; 4.1%), self-battery (56; 3.4%), jumping (39; 2.4%), hanging (31; 1.8%), burning (18; 1.1%), suffocation (14; 0.9%), starvation (10; 0.6%), sniffing (9; 0.5%), ingestion of non-ingestible substances or objects (8; 0.5%), shooting (5; 0.3%), drowning (4; 0.2%), electrocution (2; 0.1%), and stopping medication (2; 0.1%) (Ystgaard et al., 2009).

A higher percentage of boys (17.4%) compared to girls (10.5%) had gone to a hospital following their most recent DSH episode (Ystgaard et al., 2009). Adolescents usually do not contact health services when they engage in DSH, but are referred often by adults who recognize the concerns. The study discovered that to develop adequate outreach programs, efforts to increase the awareness of DSH and related mental health issues among professionals in medical and social services and in school were strongly recommended.

Increased understanding of DSH, how to identify adolescents at risk of DSH and how to arrange appropriate support and treatment were deemed to be likely to reduce the rates of DSH and suicide based on the study results (Ystgaard et al., 2009).

Little has been researched regarding the effectiveness of components of treatment for NSSI. However, Garisch et al. (2017) wrote a paper published in the New Zealand Journal of Psychology regarding an overview of assessment and treatment strategies used with NSSI, specifically with adolescents. The section of the paper that highlighted the importance of having effective treatment for NSSI discussed some of the common concerns that arise in treatment.

These concerns include when clients are hesitant to disclose NSSI behavior because they are afraid of being judged negatively. Therefore, it is important that counselors are skilled in validation and non-judgmental responses throughout all phases of assessment and intervention. Second, NSSI clients struggle with expressing their emotional experience which makes it important that counselors are skilled in being able to utilize functional behavioral assessments (Garisch et al, 2017). Clients may also be strongly connected to their NSSI behavior and therefore have low motivation to stop. The authors suggested that counselors need to be able to develop or create ambivalence and use techniques to encourage self-directed change. Adopting a role of curious observer and Socratic questioner can prevent resistance. Garisch et al. (2017) stated that it is important to focus on the need that NSSI serves for the client and develop alternative coping strategies. Counselors need to have a strong awareness of safety, given the risk and relationship to suicidal behaviors. Counselors also need to have a comfort level with

this population but also self-efficacy to understand their limits of confidentiality; specifically, the client may not want others to know about their self-injury, but the clinician may need to disclose for client safety (Garisch et al., 2017). For younger individuals engaging in NSSI, counselors must be comfortable in communicating with family members about what to do to keep their loved one safe (Garisch et al., 2017).

These components highlight what has been seen to be helpful for clients, however research has shown that this population is difficult for counselors to work with in treatment. The next section will look at what is known about the specific challenges counselors face when working with the NSSI population.

Challenges for counselors working with NSSI

Counselors have reported struggles in working with the NSSI population regarding knowing what to do to assess and treat these clients. There has not been a great deal of research done on the area of counselor struggles with the NSSI population. However, in one study that surveyed a listserv of over 700 college and university counseling center directors, Whitlock et al. (2009) set out to assess the perceptions of college and university mental health providers regarding NSSI behavior among their students. They looked at perceived trends in NSSI behavior, NSSI client characteristics, school protocols for responding to NSSI behavior, reasons for perceived increases in NSSI and treatment approaches to NSSI. There were 318 individuals that participated in the survey and 28 of those were eliminated because they were located outside of the United States. 63.8 % identified themselves as counseling or clinical psychologists, 12.1% stated that they were professional counselors, 11% identified as social workers,

6.9% were non-specified mental health professionals, and 6.2% were marked as other. Whitlock et al. (2009) reported that more than half (54%) of their participants identified clients who self-injure as the most difficult to treat (Whitlock et al, 2009; Hoffman & Kress, 2010). When they were asked what about working with the population made them uncomfortable, 40.2% indicated that they were mostly worried about the potential lethality of NSSI. They were also concerned about awareness of NSSI with 10% stating that they were not at all or only a little informed about NSSI, 61.2% felt they were somewhat informed and only 28.8% felt they were well informed about NSSI. Lastly, a quarter of the participants identified NSSI as very addictive, 55% thought it was somewhat addictive, 14% did not see NSSI as addictive (Whitlock et al., 2009).

Hoffman and Kress (2010) reiterated what the Whitlock et al. (2009) study reported, specifically that mental health professionals see NSSI as one of the most frustrating behaviors that clients exhibit. One reason that the authors indicated was individuals engaging in NSSI had not only a variety of mental health concerns, but developmental and personal contexts that contributed to triggering and maintaining the behavior. Another reason that was discussed was the possibility of health risk with this population, such as infection or cutting an artery. Yet another reason for frustration for providers is that clients typically do not see the behavior as something they want to stop doing initially (Hoffman and Kress, 2010). The countertransference that counselors can experience related to client self-injury is also important to address because of the possibility of interference in making treatment decisions and/or interacting with clients in an effective manner (Hoffman & Kress, 2010).

The therapeutic relationship can be damaged if clients feel judged by their counselor. Whisenhunt, Stargell and Perjessy (2016) discussed that it is very emotionally challenging for counselors to work with NSSI clients. A variety of feelings such as helplessness, sadness, anger, and diminished professional self-confidence are common responses to NSSI (Whisenhunt, Stargell & Perjessy, 2016). Individuals who self-injure commonly have histories of trauma, eating disorders, anxiety, depression or suicidal ideation. Because the symptomatology can be complex with this population, counselors may begin to doubt their clinical competence to work with the NSSI population (Whisenhunt, Stargell & Perjessy, 2016). Given the real and perceived challenge in working with NSSI clients, it is important that counselors have a sense of confidence, otherwise known as self-efficacy, in working with this population.

Self-Efficacy

Self-efficacy theory, developed by Albert Bandura, is concerned with an individual's beliefs in their capabilities to demonstrate skills and/or behaviors. There are four core factors that impact a person's self-efficacy: performance accomplishments (performing the skills), vicarious experience (observing the skills being performed), verbal persuasion (receiving encouragement and support) and physiological states (regulating emotions/arousal). There are three theoretical outcomes that come out of self-efficacy theory which include approach vs. avoidance, performance, and persistence (Bandura, 1977, 1993).

Performance accomplishments focus on an individual increasing their self-efficacy when they have successes in dealing with difficult situations. Conversely, when

individuals have repeated failures, their self-efficacy can be lowered (Bandura, 1977, 1993).

Vicarious experience is when an individual observes another individual performing a particular activity that they have anxiety about practicing. This gives the observer the perception that they can perform the activity as well if they persist in the efforts necessary to achieve their goal (Bandura, 1977, 1993).

Verbal persuasion is the idea that positive compliments and encouragement given from an external source is a motivator for the individual. The individual begins to believe that they can achieve goals in challenging situations because they are told that they possess the capabilities (Bandura, 1977, 1993).

Emotional arousal refers to the individual's stress level, anxiety level and tension about the situation. High arousal tends to negatively impact performance therefore individuals most likely achieve greater results when they are less anxious (Bandura, 1977, 1993).

Approach/Avoidance

The first theoretical outcome of self-efficacy theory is approach vs. avoidance. Approach behavior is when we decide to try a task and avoidance behavior is when we decide not to give an activity a try (Betz, 2000). Patterns are formed when the individual continually avoids the stressful activity which provides less opportunities to develop coping strategies. This lack of knowledge about the feared situation can inadvertently cause the person to have a realistic basis for their fear and avoidance of the situation (Bandura, 1977).

Performance

The second theoretical outcome of self-efficacy theory is performance or how the individual fares on a specific task. A structured environment where the individual can perform successfully despite their inadequacies typically utilizes preliminary modeling of threatening activities, graduated tasks, enactment over graduated time intervals, joint performance with a skilled person, protective aids to reduce consequences and variation in threat severity (Bandura, 1977, 1993). When the protections are removed, individuals can develop a sense of personal efficacy and ultimately reduce/eliminate fears of engaging in the behavior (Bandura, 1977).

Persistence

The last theoretical outcome of self-efficacy theory is persistence. Persistence is when an individual continues to pursue the goal despite obstacles, failures, or external negative messages (Betz, 2000). An important part of this outcome is that individuals believe that even when a task is difficult, it can be mastered when there is determined persistence (Bandura, 1977, 1993).

Theoretically, self-efficacy influences whether an individual chooses to engage in specific behaviors or persist in them. An individual's thoughts and/or actions can influence the relationship of the individual and their behavior. Furthermore, the interaction between the individual, their behavior and their environment is reciprocal with each component triggering change within the others. There is believed to be a connection between the perceptions of one's preparedness and their self-efficacy. The more prepared someone feels that they are for an activity or situation, the greater their self-efficacy

(Sawyer, Peters & Willis, 2013). Research findings have shown a relationship between self-efficacy and performance. The greater a counselor's self-efficacy is, the better their performance will be in working with clients (Sawyer, Peters & Willis, 2013).

Counselor Self-Efficacy

Self-efficacy is generally defined as one's belief in their ability to perform specific tasks (Goreczny et al., 2015). Self-efficacy is important when it comes to counselors because if counselors believe in their ability to adequately help their client, they are more likely to seek out strategies and to practice those strategies in session. Anxiety about a situation seems to be most common when entering a new situation and reduces the personal self-efficacy because the individual appraises that situation as a threat (Gray & McNaughton, 2003). When self-efficacy beliefs are low, individuals put less effort into an activity, do so for shorter periods of time, and experience greater anxiety about failure (Kozina et al., 2010). More self-efficacious counselors may be more likely to convey their view of how counseling is progressing (e.g., through strategic use of process comments and session summaries) (Lent et al., 2006). Counselor self-efficacy (CSE) has been shown to help counselors engage with their clients. Counselor perceptions of themselves and their skills impact their counseling competence. CSE can influence the delivery of therapeutic services including the techniques and the therapeutic relationship. Among school counselors, social support and a feeling of personal accomplishment regarding their work increased their self-efficacy and reduced burnout. Reduced burnout helps counselors to be able to engage with their clients more effectively.

McCarthy (2014) conducted a study with 166 rehabilitation counselors to determine if there was a relationship between self-efficacy for counseling skills and client outcomes in rehabilitation counseling. Participants were employed by state vocational rehabilitation counseling programs in Nevada, Arizona, West Virginia, Wisconsin, and Rhode Island. The efficacy for counseling skills did not predict the rehabilitation counselors' successful case closures. However, the efficacy for performing microskills and efficacy in dealing with challenging client behaviors significantly predicted successful client outcomes. The rehabilitation counselor's perceived self-efficacy to use their microskills and manage difficult client behaviors has an influence on the client being able to change their beliefs about their abilities. The perceived self-efficacy of the rehabilitation counselor also may be important for engaging the client in the counseling process (McCarthy, 2014).

Training on assessment and intervention, including discussions about motivations for self-harm, instruction in the use of therapeutic strategies and stories from lay experts about NSSI experiences are extremely important. This training seems to lead to higher self-efficacy and higher self-efficacy seems to lead to more empathic understanding toward NSSI clients, confidence in being able to identify and treat the NSSI behavior, and closer therapeutic relationships with NSSI clients (Kool et al., 2014).

Since efficacy expectations are clearly linked to the performance of various tasks, it follows that self-efficacy is essential to the acquisition and mastery of the complex set of component skills that make up the nature of counseling and therapy performance (Kozina et al., 2010). A study of 25 practicum cohort masters' level students in

counseling psychology was conducted at a large university in the United States, 20 agreed to participate in the study and were assessed two times during the semester using the Counseling Self-Estimate Inventory (COSE). At the time of the first assessments, students had an average of 39 hours of practicum, 39 hours of group supervision and 14 hours of direct client contact. At the time of the second assessment, students had received an additional 24 hours of practicum and group supervision, as well as 16 more hours of direct client contact (Kozina et al., 2010). One of the limitations of the study was the small sample size, however despite the small number, there was an increase in counselor self-efficacy with knowledge, practice in micro skills and clinical practice. There were no significant changes in the four remaining factors that were studied, which included process, handling difficult behaviors, cultural competence and values. It is believed that these factors all take additional experience, supervision, diverse clientele and exploration of biases and attitudes. The implications of this study were that beginning practitioners required a greater amount of support because they experience anxiety and other emotions that reduce their self-efficacy (Kozina et al., 2010).

Studies on counselor self-efficacy have shown that increases in counselor self-efficacy beliefs can occur within a relatively short period of training (Kozina et al., 2010). Higher counselor self-efficacy was associated with more congruence between client and counselors' perceptions of how well the session went (Lent et al., 2006). Research also shows that counselors evaluate their skills with more positive self-appraisal when they can perform the skills necessary in a novel situation (Sipps, Sugden & Faiver, 1988). These results are consistent with the idea that when one develops and engages in

the behaviors expected of them, they develop the cognitive self-schema that is consistent with their performance (Sipps, Sugden & Faiver, 1988). The general concept of the benefit of counselor self-efficacy is further studied in its relationship to education/training and NSSI.

A recent study by Giordano et al. (2020) sought to investigate the experience of clinicians working with clients engaging in self-injury. The sample included 94 clinicians with master's degrees, specialist degrees and doctoral degrees. The clinicians were in varying fields of counseling. They ranged in experience level from one year to more than 30 years. The results regarding counselor education and competence when it comes to NSSI yielded the following: Counselors gained knowledge regarding NSSI from continuing education (e.g., conference presentations, workshops, seminars), which was endorsed by 55 (58.5%) clinicians. On-the-job training was endorsed by 47 (50.0%) clinicians, followed by graduate coursework, endorsed by 42 (44.7%) clinicians; self-study endorsed by 38 (40.4%) clinicians; and internships, endorsed by 28 (29.8%) clinicians. Three (3.2%) clinicians reported they had never received NSSI training. Clinicians further reported how competent they felt addressing NSSI in counseling. Four (4.3%) clinicians felt extremely incompetent, eight (8.5%) felt somewhat incompetent, 10 (10.6%) felt neither competent or incompetent, 54 (57.4%) felt somewhat competent, and 17 (18.1%) felt extremely competent. One (1.1%) clinician did not respond to this item. Overall, clinicians primarily received NSSI training via continuing education workshops and on-the-job experiences (Giordano et al, 2020).

Roberts-Dobie and Donatelle (2007) specifically looked at school counselors to study the experience, knowledge, and needs of school counselors as it related to students' NSSI behaviors. Participants for the study were identified from a random drawing using a membership list of the American School Counselor Association (ASCA), the nation's largest school counseling professional organization. One thousand counselors were randomly selected and invited to participate in the study. These counselors were selected through systematic sampling to complete a confidential questionnaire on NSSI in the school. The 42-item questionnaire, based on a comprehensive review of literature, included eight multiple-choice demographic questions, eight multiple-choice questions about the school setting, eight questions regarding counselor confidence in working with self-injurers, three questions regarding counselor knowledge of self-injury, and nine questions regarding counselor experiences working with students who self-injure (Roberts-Dobie and Donatelle, 2007).

The participants identified themselves as being the most appropriate contact for students engaging in NSSI, however they did not report high levels of knowledge on the topic. Only two percent of the respondents had never heard of self-injury. There was no demographic difference between the counselors who had heard of self-injury and those who had not. Participants who had heard of NSSI were asked to assess how knowledgeable they believed themselves to be on a scale of 1 (not at all knowledgeable) to 7 (extremely knowledgeable) on 3 knowledge measures: knowledge about the root causes of self-injury, symptoms of self-injury, and treatment of self-injury (Roberts-Dobie and Donatelle, 2007). In a composite score of the three measures, only six percent

of counselors identified themselves as highly knowledgeable in working with self-injurers (a score of 6 or 7), 74% identified themselves as moderately knowledgeable (a score of 3, 4, or 5), and 20% identified themselves as not very knowledgeable in their ability to work with self-injurers (a score of 1 or 2) (Roberts-Dobie and Donatelle, 2007).

Participants were also asked to rate on a scale of 1 (not at all confident) to 7 (extremely confident) their confidence in providing services related to self-injury as a measure of efficacy expectations. The efficacy expectations were highest when counselors were referring students to outside resources and lowest when counselors were providing group counseling to students who self-injure. This suggested that the counselors felt more comfortable referring the students out rather than delivering the services themselves (Roberts-Dobie and Donatelle, 2007). In a composite score of the efficacy expectation measures combined, only 17% of counselors had high efficacy expectation scores (a score of 6 or 7), 73% had moderate scores (a score of 3, 4, or 5), and 10% had low scores (a score of 1 or 2). Scores increased significantly as the knowledge composite score (a combination of the 3 knowledge measures) increased. Because the efficacy expectations composite score and the knowledge composite score were highly correlated ($r = .80$, $p < .01$), the results suggested that as counselor knowledge increased, efficacy expectation levels also increased (Roberts-Dobie & Donatelle, 2007).

331 counselors that participated in the study responded to an open-ended question regarding the resources they needed to successfully work with students who self-injure. The responses were coded into 6 categories: counselor training, school policy, education,

community connections, tangible support, and cooperation. The need that counselors requested the most was building their own knowledge and skills. Counselors requested general information, in-service training, and published research. In training, they were looking for specific strategies for prevention, identification, intervention, and referral (Roberts-Dobie & Donatelle, 2007).

The studies above highlight some key components of understanding how counselor self-efficacy impacts counselors' willingness to work with or seek training for NSSI. First, the studies show that counselor self-efficacy influences the delivery of counseling services, the techniques and the therapeutic relationship. Second, in a variety of settings, including rehabilitation counseling and schools, when counselors had efficacy in performing the micro skills needed and dealing with challenging client behaviors, there was a strong correlation to successful outcomes. Third, when counselors had training in assessment and intervention, it led to them becoming more empathic with their clients. This means that when counselors felt like they had the tools, they were willing to work with clients in an effective manner. Lastly, according to the Roberts-Dobie and Donatelle (2007) study, when counselors were asked what resources they needed to be successful, they said they wanted to build knowledge and skills. This is a hopeful sign that there is an awareness about counselor self-efficacy and its impact on working with clients in general, but also specifically for NSSI clients.

Summary

This study intends to clarify the problem of non-suicidal self-injury (NSSI), the rate of NSSI and how self-efficacy may impact how counselors approach working with

NSSI clients and seek out information to do so effectively. Self-injury ranges on a continuum from cutting and burning one's skin to eye enucleation, limb amputation and castration. Self-injury is the deliberate, direct destruction of body tissue resulting in tissue damage without conscious suicidal intent (Kakhnovets et al., 2010; White-Kress, Gibson, & Reynolds, 2004).

The prevalence of non-suicidal self-injury has been growing for well over a decade. 21% of the clinical population presents with self-injurious behavior, either as a focal point of treatment or an underlying symptom behavior (Kress & Hoffman, 2008; Briere & Gil, 1998). Approximately two million individuals report engaging in non-suicidal self-injury at least once in a year. Clients who engage in NSSI tend to struggle with emotion regulation and reaching out for help. This provides a significant challenge to counselors in the therapeutic session and often counselors report countertransference, feelings of frustration, or viewing these clients as manipulative and difficult. Counselor self-efficacy with this population would be uniquely important because counselors with low self-efficacy about working with NSSI may tend to put less effort into an activity and experience greater anxiety about failure (Kozina et al., 2010). Accordingly, counselors' confidence or self-efficacy may influence their willingness to work with or seek training regarding NSSI clients. Self-efficacy is the belief in one's ability to perform specific tasks and counselor self-efficacy would be extremely important for working with NSSI clients. The components of self-efficacy include performance achievements, vicarious experience, verbal persuasion, and emotional arousal.

This study aims to determine whether self-efficacy, graduate level education, training in NSSI, and/or years of experience in the field that a counselor has predicts the willingness to work with NSSI clients. This is important because it ultimately could predict the effectiveness of the treatment that a client engaging in NSSI receives. A quote from a client on a message board illustrates why this is important. "To you, I need help for these injuries I put unto myself. The blade you see is covered in blood. That blade is my friend, old and true. What you don't see is that these injuries are my help, and you can never be my blade." –Kira, Tribe message board. It is our ethical responsibility as counselors to engage in nonmaleficence and beneficence, therefore we need to have the training and self-efficacy to provide effective help to Kira and everyone like Kira.

Definition of terms

While there have been a wide variety of definitions of self-injury, the operational definition has been sectioned into four different categories (Miller & Brock, 2010; Simeon & Hollander, 2001). The categories are major, stereotypic, compulsive and impulsive self-injury.

- Compulsive self-injury: behavior that includes ritualistic acts that happen multiple times a day. Examples of compulsive self-injury include trichotillomania (compulsive hair-pulling), chronic and extensive onychophagia (nail biting), and onychotillomania (compulsive skin picking and scratching) (Miller & Brock, 2010).

- Counselor anxiety: counselors feel discomfort and an innate negative reaction that occurs in response to a given trigger event (Dodge-Evans, 2020; Shamoon, Lappan, & Blow, 2016).
- Counselor willingness: the extent to which a counselor chooses to work with a client (Atkinson, 2011). Individuals that have a mastery goal orientation see achievement situations as opportunities for them to learn new skills or improve old ones. They see failures and mistakes as giving information on how to improve (Stoeber & Rennert, 2008).
- Impulsive self-injury: behavior that includes skin cutting, burning, carving, interfering with wound healing, bone breaking, self-hitting, and needle sticking (Miller & Brock, 2010; Simeon & Hollander, 2001; Favazza, 2011).
- Major self-injury: acts that have a significant amount of damage to body tissue (e.g. eye enucleation, castration, and limb amputation) (Miller & Brock, 2010; Walsh & Rosen, 1988).
- Self-efficacy: one's belief in their ability to perform specific tasks (Goreczny et al., 2015, Bandura, 1993; Bandura, 1977).
- Stereotypic self-injury: behavior that includes head-banging, biting, scratching, punching and other behavioral acts that are often rhythmic and repetitive in nature (Miller & Brock, 2010; duToit et al., 2001).

CHAPTER TWO

LITERATURE REVIEW

Overview

This chapter reviews literature regarding non-suicidal self-injury (NSSI), self-efficacy theory and how counselor preparedness impacts the level of counselor self-efficacy. First, the review begins by discussing the challenges that counselors face in working with NSSI clients. Next, there is a discussion of the training counselors receive in relation to working with NSSI clients. Then, prevalence of NSSI based on developmental levels is described. Albert Bandura's self-efficacy theory is explored by looking at the four core components of the theory: performance accomplishments, vicarious learning, verbal persuasion and emotional arousal as well as the theoretical outcomes. Next, the chapter explores literature concerning counselor self-efficacy, ethical considerations regarding working with NSSI clients and NSSI and counselor preparedness in working with this population. The rationale for the study is to highlight how self-efficacy may influence how counselors approach working with NSSI clients, how counselors' self-efficacy influences their desire to work with NSSI clients as well as counselors' desire to seek additional training in working with this population. Furthermore, this study will examine if self-efficacy predicts the level of anxiety counselors experience in working with NSSI. Finally, this study will examine if experience and training play a role in counselor self-efficacy in working with NSSI clients.

Therapeutic Relationship and Treatment Selection Challenges for Counselors

Researchers have found that most practitioners struggle with assessing and treating NSSI (Whitlock et al., 2009; Trepal & Wester, 2007). In a mixed methods study, Whitlock et al., (2009) surveyed 290 college and university counseling center directors across the United States via an online survey. Participants held a range of social service degrees, including bachelor's, master's and doctoral-level counselors, psychologists, and social workers. The participants were asked questions about detecting and treating self-injurious behavior. Whitlock et al. (2009) reported that more than half of their participants identified clients who self-injure as the most difficult to treat. Furthermore, less than one third (28.3%) of the sample indicated that they knew enough about self-injury to effectively work with these clients (Whitlock et al., 2009).

Trepal and Wester (2007) conducted a national study of 1000 counselors to see what treatment methods they were using with NSSI clients. This random sample was taken from the American Mental Health Counselor Association (AMHCA) membership database. The study was one of the first to examine the extent to which counselors were seeing NSSI clients in outpatient mental health settings, as well as what treatment approaches they were using. The results of the survey indicated that many of the respondents used behaviorally based treatments such as Cognitive Behavioral Therapy (40.5%) and Dialectical Behavior Therapy (17.6%). Respondents also reported using Behavioral Therapy (10.8%), Cognitive (6.8%), Psychoanalytic/Object Relations (6.8%), Gestalt (5.4%), Narrative Therapy (4.1%), Humanistic (2.7%), Solution-focused Therapy (2.7%), Eclectic approaches (2.7%), and Psychodrama (1.4%). However, information

regarding how or why a specific treatment method was used was not looked at in this study. The authors indicated that it "may be that counselors are selecting treatments based on the uniqueness or individual needs of their clients, along with selecting treatments that they feel wed to" (Trepal & Wester, 2007, p. 371). This appears to suggest that counselors were choosing treatments based on personal preference and not on training or research-based information.

Counselors-in-training also exhibited struggles with addressing NSSI in therapy sessions (De Stefano et al., 2012; Healey, Trepal, & Emelianchik-Key, 2010). DeStefano et al. (2012) conducted a qualitative study in Canada with 12 master's level trainees who had recently worked with at least one client who had self-injured. Trainees reported a number of personal struggles including their own emotional reactivity and resolving ethical and confidentiality issues. Interestingly, the heightened feelings of uncertainty were only partially alleviated by supervision (DeStefano et al., 2012). This appears to suggest that trainees need more than supervision; that it is possible they need more of an educational underpinning during their graduate program of how to work with NSSI clients to increase self-efficacy. Healey, Trepal, and Emelianchik-Key (2010) also conducted a qualitative study among 67 beginning counselors recruited from the counselor preparation programs at three universities in the southeastern region of the United States. This study focused on diagnosis, gender perception and bias when treating NSSI clients. One of the results of the study was that there was a general lack of certainty and knowledge of the conceptualization, diagnosis and treatment of NSSI. Four of the

respondents stated a specific concern about whether they were competent enough to work with a self-injuring client (Healey, Trepal, & Emelianchik-Key, 2010).

Although counselors are trained to nonjudgmentally join with their clients, counselors may have intense reactions to NSSI. A survey was conducted by Heath, Toste, and Beettam (2006) to study high school teachers' perceptions of adolescent NSSI, knowledge, self-perceived knowledge, and attitudes regarding self-injury. 50 teachers from six American high schools in a large urban area made up 40% of the sample, and the other 60% came from high school teachers recruited from graduate level classes at a university (Heath, Toste, & Beettam, 2006). The teachers completed the survey and while they indicated knowledge of some basic facts regarding self-injury, 78% underestimated prevalence of NSSI and only 20% felt that they were knowledgeable on the topic of NSSI. There were 48% of the participants that found the idea of NSSI "horrifying"; with 68% of the participants disagreeing that NSSI was "often manipulative" (Heath, Toste, & Beettam, 2006).

Fleet and Mintz (2013) conducted a qualitative study, on the unique experiences of five counselors who worked with NSSI clients. Semi-structured interviews were done using three broad questions to understand the subjective thoughts and feelings of the counselor in working with NSSI clients (Fleet & Mintz, 2013). Results of the Fleet and Mintz study (2013) yielded some important information. There were five major categories that the responses fell into: the impact on the counselor, the necessary requirements of a counselor working with a client engaging in self-harm, the counselor's focus on stopping the self-harm, the perception of the counselor regarding the client's

progression in therapy, and the perception of the counselor about why a client engages in self-harm (Fleet & Mintz, 2013). Shock, sadness, anger, anxiety, frustration and diminished professional self-confidence were found to be common responses to NSSI (Fleet & Mintz, 2013). Specifically, three of the five counselors verbalized that working with self-harm had affected their self-confidence negatively (Fleet & Mintz, 2013).

Regarding the requirements of a counselor working with self-harm, there were themes related to whether the counselor should focus on the self-harm or not focus on the self-harm; a requirement to educate clients about first aid of the wounds after self-harm; communicating the consequences of the scars left after self-harm and the responsibility of assessing for suicide risk and severe self-harm (Fleet & Mintz, 2013).

All five of the counselors wanted to stop the NSSI behavior, but three of the counselors communicated this goal implicitly and the other two were more directive with the clients that the NSSI behavior needed to stop (Fleet & Mintz, 2013). The next theme addressed client improvement in therapy. Counselors determined progression by a decrease in the physical damage to the skin (i.e., superficial cuts, cuts not as deep); client use of replacement strategies, client ability to regulate their affect in sessions and clients being able to gain insight and self-understanding to their NSSI behavior (Fleet & Mintz, 2013). Finally, four of the counselors spoke about the reasons why clients engage in self-harm and explained it as a reaction to overwhelming feelings triggered by personal experiences or a coping mechanism (Fleet & Mintz, 2013).

When a counselor begins to develop emotional reactions towards their NSSI clients, there is a negative influence on the therapeutic relationship. Data that was

collected from 117 mental health clinicians yielded that self-injury was the most distressing client behavior in therapy and furthermore, clinicians found self-injury to be the most traumatizing to encounter (Kress, 2003). Due to this risk, it is even more important to provide counselors with an understanding of self-injurious behavior so that they have expertise in awareness of countertransference reactions, expertise in conceptual and clinical formulation of treatment planning, and expertise in assessment when working with NSSI clients.

Self-injury has consistently been regarded as a highly stigmatized behavior (Rayner, Allen, & Johnson, 2005). Working with clients who self-injure can be challenging, even for seasoned practitioners. If working with a client who self-injures can produce these intense feelings in seasoned clinicians, it is likely that counselors-in-training may experience similarly intense, or even more intense, emotional reactions when they realize that their client self-injures. White, McCormick, & Kelly (2003) reported that countertransference related to client self-injury may interfere with clinicians' ability to make treatment decisions and interact with clients in a helpful manner. One of the most important aspects of working with clients engaging in NSSI is having a strong therapeutic alliance (Kress, 2003).

Despite research (Laye-Gindhu & Schonert-Reichl, 2005) highlighting acts of self-injury mostly occur in private, a common and long-standing belief suggests that the act of self-injury is an interpersonally manipulative and attention-seeking behavior. Counselors must be compassionate and communicate empathy and respect toward those who self-injure. According to Favazza and Conterio (1989), 75% of those who self-injure

identify themselves as being a burden to others. If counselors treat clients as manipulative and attention-seeking, they may inadvertently reinforce clients to continue the behavior.

Wieand (2016) researched clinicians who treat patients who self-injure and found that many clinicians seem to experience negative emotions when treating difficult populations, specifically those that self-injure. There were several patterns that showed up in the participants' responses. The first pattern explored the lived experiences of treating patients engaging in self-injury. For example, clinicians discussed the distressing images of wounds that were present in their memories and worry for client well-being when they discontinued therapy for NSSI (Wieand, 2016).

The second pattern entailed counselor descriptions of their feelings towards their clients and how they viewed their work. For instance, feeling unprepared for their work with NSSI clients, "a fear of patients becoming worse either by continuing to self-injure or because the type of self-injury escalated," feeling responsible for patients who had not worked through the concerns leading to self-injury and/or patients never stopping their NSSI behavior." While most of the list was negative, there were some feelings of hope and optimism (Wieand, 2016, p. 91).

The desire to change treatment populations was also discussed by the participants. Some of the participants discussed changing treatment populations and not working with self-injuring clients (Wieand, 2016). There was also concern for escalating NSSI behavior and lack of therapy progress. Participants had a difficult time with the sight of blood and wounds, while others were disgusted by the NSSI behavior (Wieand, 2016). All the counselors took responsibility, felt disappointment in themselves and blamed

themselves for their clients not making progress. The last area that was discussed by the participants was the need for coping mechanisms when working with the NSSI population and many discussed using stress-relieving activities to not only maintain their mental health but to be able to effectively treat their clients (Wieand, 2016).

Whisenhunt et al. (2014) noted in their research that "the limited scholarly resources available on understanding and treatment in self-injury can leave counselors feeling frustrated and apprehensive in their work with these clients, ultimately resulting in a lower quality of care" (p.388). A survey of 443 school counselors regarding their experiences with NSSI, found that while counselors felt they were the appropriate people to work with students who self-injure, they indicated a need for more training on the topic (Roberts-Dobie & Donatelle, 2007). The barriers that kept the school counselors from being more confident and successful in working with students who engage in NSSI were a lack of training, lack of school policy on the topic of NSSI, and the lack of cooperation with school personnel (Roberts-Dobie & Donatelle, 2007).

Reed (2010) looked at the perceptions of school counselors as it relates to NSSI. Out of the 73 school counselors that completed the survey, the majority (72.6%) of respondents indicated they felt confident in being able to recognize the signs of NSSI. However, over 70% of respondents indicated they were not confident at all, or only somewhat confident in their ability to actually work with someone who self-injures. Additionally, over 90% of respondents reported being "comfortable" or "very comfortable" with the thought of self-injury, and that thinking or talking about the topic does not cause distress or discomfort. However, more than 45% reported that they would

be only somewhat confident or not confident at all in just conducting an initial interview of a student who engages in self-injury.

In addition to the few studies above that looked specifically at the apprehension of counselors to work with NSSI, there was research done with teachers and their attitudes regarding self-injury. Overall, teachers reported negative emotional reactions toward NSSI, including shock, repulsion, alarm and panic, and being "freaked out". All the teachers agreed that additional training was necessary to raise awareness (Best 2005, 2006). Carlson et al. (2005) conducted a study with teachers in Chicago to examine their level of awareness and knowledge about NSSI as well as their confidence in responding to students engaging in NSSI. 87.4% understood NSSI as a maladaptive coping mechanism, 62.7% perceived NSSI as a form of attention-seeking and 56.7% felt that NSSI was not a serious concern. Interestingly, the number of years of teaching experience was not associated with the teachers' knowledge regarding NSSI or their confidence in their ability to respond to it (Heath et al, 2010).

Hadfield et al. (2009) interviewed five accident and emergency room doctors in the United Kingdom with an average of seven years' experience working with clients engaging in dxNSSI. According to Hadfield et al. (2009) "doctors expressed greater irritation, less personal optimism, less willingness to help and saw less of a need for training" (p.757).

The therapeutic relationship and treatment selection for clients engaging in NSSI can be challenging. According to the aforementioned studies, self-injury is seen as the most difficult concern to treat in therapy. Research shows that counselors struggle with

treating NSSI clients. While there was some evidence of hope and optimism, the data shows that counselors report feeling that they did not have enough knowledge to effectively treat NSSI clients. Counselors appeared to mostly utilize cognitive behavioral therapy and dialectical behavior therapy as treatment selections for self-injury. However, they did not seem to select treatment options because of training or research reasons, but rather for personal preference reasons. Counselors also appeared to be emotionally affected by working with NSSI clients. Uncertainty, horror, shock, sadness, anger, anxiety, and frustration were the common words used by counselors to describe their work with NSSI clients. The emotional reactions led to countertransference at times, which could affect treatment decisions made by the counselor. Professional self-confidence was also diminished. Counselors took responsibility for the clients' NSSI behavior and blamed themselves for the lack of progress. Due to the emotional toll, some counselors even decided to stop treating NSSI clients altogether.

This lack of certainty and knowledge can lead to questioning whether one is competent to treat NSSI clients. Therefore, counselors can experience an impact on their self-efficacy when working with NSSI clients. Self-efficacy is partially born of requisite skill and knowledge. Therefore, training and education would be important factors for counselors when learning how to treat clients engaging in NSSI.

Self-Efficacy Theory

Albert Bandura is known as being instrumental in developing self-efficacy theory, which is concerned with an individual's beliefs in their capabilities to demonstrate skills and/or behaviors. There are four core factors that impact a person's self-efficacy:

performance accomplishments (performing the skills), vicarious experience (observing the skills being performed), verbal persuasion (receiving encouragement and support) and physiological states (regulating emotions/arousal) (Bandura, 1977, 1993).

Performance accomplishments

Individuals increase their mastery expectations through having successes and conversely repeated failures lower mastery expectations. If strong efficacy expectations are developed, the impact of occasional failures is more likely to be reduced. The effects of failures on personal efficacy depends on the timing and the total pattern of experiences where the failures happen. For example, if a series of failures occur early in a situation and those mistakes are later overcome by sustained effort, efficacy can be increased. (Bandura, 1977, 1993).

When an individual begins to experience enhanced self-efficacy, this can generalize to other situations where performance may have been dampened by feelings of inadequacy. Generalization effects tend to occur most for situations that are similar to other tasks where self-efficacy was present. (Bandura, 1977, 1993). However, individuals can avoid situations where they have not experienced enough practice. People tend to avoid situations in which they do not feel competent.

Vicarious Experience

Self-efficacy is further impacted by seeing others perform feared activities without adverse consequences. This gives the observer the expectation that they too can improve if they intensify and persist in their efforts to use the techniques practiced by the skilled individual (Bandura, 1977). The more similarities the observer has to the model in

other characteristics, the stronger the relevance obtained in the observation has for the observer. Modeled behavior with clear outcomes communicates more efficacy information than if the modeled actions are vague. Diversified modeling, where tasks or activities that observers view as difficult are repeatedly shown to be achievable by a variety of models is more effective than exposure to a single model. Individuals begin to increase their own self-efficacy because they believe if people of differing abilities can succeed, they can as well (Bandura, 1977).

Verbal Persuasion

The third factor impacting self-efficacy is verbal persuasion. Individuals are verbally led through suggestion that they can deal with what has been a challenge for them in the past. While verbal persuasion alone is not likely to enhance personal efficacy, it is believed to contribute to the successes achieved through corrective performance. For example, individuals who are told that they possess the capabilities to master challenging situations and additionally are given provisional aids are far more likely to achieve greater outcomes than those who only receive the performance aids (Bandura, 1977). It is important however to arrange conditions to facilitate effective performance, otherwise the mentors will be perceived as dishonest and the recipient will not achieve the desired perceived self-efficacy (Bandura, 1977).

Emotional Arousal

Stressful situations elicit emotional arousal that informs the individual about their perceived personal competency. This perception can affect self-efficacy in coping with the situation at hand. Individuals rely on their physiological arousal to judge how anxious

and vulnerable to stress they are. High arousal tends to negatively impact performance, therefore individuals tend to expect success when they are not experiencing high levels of anxiety and tension (Bandura, 1977).

By anticipating fearful thoughts about their ability to achieve the task successfully, individuals can trigger levels of anxiety that exceed the stress experienced during the situation. Anxiety arousal is diminished by modeling and experienced mastery through participant modeling. These strategies teach effective coping mechanisms by demonstrating new ways to handle anxiety-provoking situations. This is especially important during situations where there are behavioral deficits (Bandura, 1977).

Behavioral control affects how the stressful situation is perceived, but the anticipation of anxiety is further reduced by knowing how to handle the stressful situation. As discussed above, people tend to avoid situations where they do not feel competent. If fears are reduced, the individual can overcome self-doubt and debilitating self-arousal to the point where they can perform the feared activity successfully. Actual performance success is going to enhance self-efficacy (Bandura, 1977).

Outcomes of Self-Efficacy

Self-efficacy expectations are believed to have three behavioral consequences: (1) approach versus avoidance behavior, (2) quality of performance of behaviors in the target domain, and (3) persistence in the face of difficulties. Low self-efficacy expectations regarding a behavior or situation tend to lead to avoidance of those behaviors, poorer performance, and a tendency to quit when faced with discouragement or failure. (Bandura, 1977).

Approach versus avoidance

The first theoretical outcome of self-efficacy theory is approach vs. avoidance. In a nutshell, "approach" behavior is when we decide to try a task and "avoidance" behavior is when we decide not to give that task a try (Betz, 2000). A cycle begins to be created because the more the individual avoids the stressful activity, the less opportunity there is to develop coping strategies. This lack of knowledge can inadvertently cause the person to have a realistic basis for their fear and avoidance of the situation (Bandura, 1977).

Performance

The second theoretical outcome of self-efficacy theory is performance or how the individual fares on a specific task. The participant modeling approach to eliminating avoidant behavior utilizes successful performance as the primary method of psychological change. An environment where the individual can perform successfully despite their inadequacies typically uses modeling of threatening activities, graduated tasks, behavior over graduated time intervals, completing the activity with a skilled person, support to reduce consequences and variation in threat severity (Bandura, 1977, 1993). Over time, these tools are withdrawn so that individuals can develop a sense of personal efficacy and ultimately reducing/eliminating fears of engaging in the behavior (Bandura, 1977).

Persistence

The third outcome of self-efficacy theory is persistence. Persistence is when an individual continues to pursue the goal despite obstacles, failures, or external negative messages (Betz, 2000). An important part of this outcome is that an individual begins to

believe that even when a task is difficult, it can be mastered when there is determined persistence (Bandura, 1977, 1993).

The aforementioned studies by Wieand (2016), Whisenhunt et al. (2014), Fleet & Mintz (2013) and Reed (2010) all highlighted how a counselor's lack of self-confidence in their ability to work with NSSI clients impacted their therapeutic relationship. The emotional reactions to NSSI identified in the studies appear to have impacted the efficacy and client outcomes. The lack of confidence results in frustration and apprehension which ultimately leads to a lower quality of care. Self-efficacy may be a crucial factor in understanding the challenges that counselors experience working with NSSI clients.

Implications of Counselor Self-Efficacy on Training and Treatment Engagement

Self-efficacy is generally defined as one's belief in their ability to perform specific tasks (Goreczny et al., 2015). Bandura (1993) described four ways that self-efficacy increases: performing the skills, observing the skills being performed (vicarious learning), receiving encouragement and support, and regulating emotions/arousal. For example, self-efficacy regarding skills and abilities in one's chosen profession is a critical component of one's own vocational identity (Armstrong & Vogel, 2009). Among school counselors, self-efficacy (both general self-efficacy and counselor-specific self-efficacy) is a major predictor of use of data in performance of one's job (Holcomb-McCoy, Gonzalez, & Johnston, 2009). Not surprisingly, self-efficacy is also important because mental health professionals are more likely to utilize strategies with their clients if counselors believe in their ability to adequately deliver those specific strategies (Akpanudo, Price, Jordan, Khuder, & Price, 2009).

Self-Efficacy and Training

Sipps, Sugden, and Faiver (1988) conducted a study to see what the relationship was between graduate training and counselor trainees' self-efficacy in the use of introductory counseling skills. Of the 97 participants, there were 21 undergraduate students enrolled in an undergraduate Abnormal Behavior course in a small liberal arts college housed within a small Midwestern university. The other participants included 76 graduate students taking courses in a master's-level graduate program in counseling psychology with training from faculty who represent diverse theoretical backgrounds. There were 31 students in a first-semester graduate-level course, 16 counseling psychology graduate students participating in their first field placement experience, and 29 counseling psychology graduate students in their second and final field placement experience (Sipps, Sugden & Faiver, 1988).

Results of this study indicate that rather than a linear pattern, counselor self-efficacy appears to follow a curvilinear pattern. Undergraduates appear to have a relatively high degree of counselor self-efficacy despite having no advanced training. Beginning-level graduate students have lower counselor self-efficacy compared to undergraduate students in the study and advanced-level graduate students have the highest level of counselor self-efficacy (Sipps, Sugden & Faiver, 1988).

This implies that before students have learned any skills, they are confident because they don't know what they don't know. The beginning level graduate students have had difficulties by this time in their curriculum so they are no longer as confident. Advanced level graduate students have had a great deal of training by the end of their

program so they can now evaluate their skills with an increasingly positive self-appraisal, which explains their increase in self-efficacy.

Trainers and supervisors generally agree that counselor self-efficacy is an important precursor of competent practice and should be a required focus of clinical education. Since efficacy expectations are clearly linked to the performance of various tasks, it follows that self-efficacy is essential to the acquisition and mastery of the complex set of component skills that make up the nature of counseling and therapy performance (Kozina et al., 2010). Thus, counselor self-efficacy is the beliefs and attitudes embodied by helping professionals or trainees that impact their capacity for the effective delivery of counseling or psychotherapy services (Larson & Daniels, 1998). In repeated studies involving a variety of tasks, it was shown that successful task performance is directly related to an individual's judgments or beliefs about his or her ability to achieve desirable outcomes. Simply put, when self-efficacy beliefs are low, individuals put less effort into an activity, do so for shorter periods of time, and experience greater anxiety about failure (Kozina et al., 2010). Self-efficacy has relevance in any context in which individuals are expected to demonstrate or perform a set of tasks to a high level of proficiency (e.g., the classroom, career and athletic success, mastery of feared situations) (Barling & Abel, 1983; Lee, 1983; Williams & Watson, 1985). The contribution of self-efficacy to successful performance has been established in many areas. For example, Lent and Hackett (1987) concluded that individual perceptions of career options are related to self-efficacy and people tend to explore options when they feel that they could be successful and rule out professions where they lack this self-

efficacy. In addition, its application to clinical training and supervision continues to grow. This is not unusual since activities for increasing self-efficacy beliefs (e.g., watching others live or on video, receiving credible feedback, reducing performance anxiety) are already the foundation of many training programs. Therefore, integrating aspects of this empirically supported model to the training curricula of mental health practitioners should facilitate the training of new counselors (Kozina et al., 2010).

Although the earliest attempts to measure self-efficacy date back to the 1940s (Irwin & Mintzer, 1942), it was only much later that applications specific to counseling were made (Larson et al., 1992; Lent, Hill, & Hoffman, 2003). In the domain of counseling and counselor training, self-efficacy research focused primarily on establishing the relationship between various levels or stages of training and self-efficacy beliefs (Johnson, Baker, Kopala, Kiselica, & Thompson, 1989). There have also been extensions of the self-efficacy concept to supervision (Cashwell & Dooley, 2001; Friedlander & Snyder, 1983) and competence in career counseling (Heppner et al., 1996). However, what is of particular interest to trainers and clinical supervisors is the extent to which self-efficacy beliefs impact clinical practice (Kozina et al., 2010). For example, Lent and colleagues (2006) found that trainees who were more confident in their basic skills and at handling challenging situations were also more likely to express confidence at managing the fundamental aspects of counseling.

Kozina et al. (2010) examined the changes in self-efficacy beliefs that occur during the training of novice practitioners. Two research questions were established to determine how counselor self-efficacy beliefs are affected by training. Specifically, the

first question asked: What is the general impact of training on novices' self-perceived skills? Training is here defined as ongoing weekly academic instruction and supervision in micro skills and case conceptualization. The second research question asked: How does perceived skill development in each of the five areas identified in the Counseling Self-Estimate Inventory (COSE) (i.e., micro skills, process, challenging client behaviors, cultural competence, and self-awareness of values) evolve with time and training?

In this study, an entire practicum cohort of first-year MA students in counseling psychology attending a large, urban, North American university was invited to participate in the study (N = 25). From this initial number, 20 agreed to participate (80% of the cohort). The ages of the counselors ranged from 23 to 45 but the majority were in their mid-twenties. All were of Caucasian background. Men and women were represented in the sample, although not equally (female N = 16 and male N = 4); the high preponderance of women in counseling psychology programs is a typical pattern. Participants were assessed twice in the winter semester with an interval of eight weeks between the two assessment periods. One of the unique features of this program is that students start to work with actual clients within six weeks of the start of their Master of Arts degree (i.e., within their first semester) and as such counselor self-efficacy beliefs should reflect real clinical experience and not simulated activities such as role-playing (Kozina et al., 2010). In the first semester and prior to the first assessment, the participants received instruction and training in the following areas: micro skills and interview techniques, theories of counseling and psychotherapy, case conceptualization, and ethics. At the time of the first assessment, participants had received an average of 39

hours of practicum instruction and 39 hours of group supervision and had had an average of 14 hours of direct client contact. At the second assessment, participants had received an additional 24 hours of both practicum instruction and group supervision, thereby totaling 63 hours for each. Their total client contact hours were approximately 30, reflecting a 16-hour increase between time periods (Kozina et al., 2010).

Following approval from the ethics review board of the university, all first-year master's students in counseling psychology were invited, via e-mail, to participate in the study. At the first assessment period, two graduate students informed the participants about the general purpose of the study and its voluntary nature and collected consent forms. Participants then completed a brief demographics form (number of client counseling hours, hours of supervision, and hours of practicum instruction) and the Counseling Self-Estimate Inventory (COSE) questionnaire. To ensure confidentiality, the questionnaires were pre-coded and separated from the demographics and consent forms. At the second assessment period, eight weeks later, a modified demographics form that incorporated changes in hours of training and counseling was collected along with the COSE questionnaire. Both assessments were conducted in the second semester of the first-year master's program (Kozina et al., 2010).

Despite significant increases in general self-efficacy beliefs, these findings need to be taken in context to the small sample size. Increases in overall counselor self-efficacy is certainly in line with the goals of a first-year practicum, which is generally to give a basic theoretical knowledge and practice in micro skills through role-playing, demonstrations, and clinical practice. This finding is of interest since it suggests that

increases in counselor self-efficacy beliefs can occur within a relatively short period of training (Kozina et al., 2010). Pertaining to the second research question that regarded novices' self-perceptions in the five areas identified by the COSE, the following was found: Trainees perceived increases in self-efficacy after the acquisition and use of their counseling micro skills. These findings are consistent with the primary task of many clinical programs where intense effort is given to discrete micro skills (e.g., Ivey, Bradford-Ivey, & Zalaquett, 2009) and other verbal responses within the first year (Kozina et al., 2010).

Counselors' self-perceptions in the area of four factors (global counselor self-efficacy, micro skills, cultural competence and awareness of values) did not show significant changes. However, two factors (process and handling difficult client behaviors) did show a decrease. It is likely that had participants been assessed at a later time (after accumulating additional experience and supervision) the researchers hypothesized that they might have seen increases in the areas tapped into by all of the factors identified (Kozina et al., 2010). Even though training routinely addresses issues related to session and client management, both objectives should be considered mid-level tasks which are mastered only with increased time and experience. The fact that no significant difference was found for cultural competence was not surprising because cultural competence is a slow and gradual process that requires training, exposure to a diverse clientele, and the willingness to examine one's own cultural values (Sue, 2001). Both cultural competence and the final factor, values, are more advanced skills which, in addition to training, require an exploration of personal biases, attitudes, and entrenched

racism, and these are not easily examined (Hays, 2016). It is not surprising then that the values factor showed a decrease in efficacy beliefs and may reflect the emerging awareness of trainees that working with real clients will fundamentally challenge all their pre-existing notions, biases, and stereotypes. These results support Larson and colleagues' (1992) findings that training is associated with an increase in one's counseling self-efficacy beliefs. The sample (N = 20 versus N = 10), albeit still small, allowed the researchers to further determine which of the five factors account for the change in self-efficacy beliefs (Kozina et al., 2010). An unanticipated finding was that the global scores of five counselors decreased during this time. A likely explanation is that these trainees were encountering unique personal distress, or preoccupation with effectiveness that was not being addressed in their training or supervision (Kozina et al., 2010; Skovholt & Ronnestad, 2003; Theriault & Gazzola, 2005).

Although it is not unusual to see small sample sizes in supervision research, this was clearly a major deficit of the study. The sample size severely limits the generalizability of the findings and the questions posed call for a more rigorous methodology before truly determining the impact of training on self-efficacy (Kozina et al., 2010). While it is reasonable to assume that training and especially supervision (Bradley & Olsen, 1980) have undeniable benefits on one's generalized sense of efficacy, it is still not known which components of training and supervision lead to competence (Kozina et al., 2010). More research using different training modules emphasizing discrete counselor competencies and assessing self-efficacy beliefs at each training milestone could shed additional light on this topic (Urbani et al., 2002). Another

drawback of the study concerns the measurement of efficacy specific to clinical competencies. Larson and colleagues (1992) developed the COSE to reflect the tasks with which novice practitioners would be familiar. However, this suggests a level of knowledge about counseling that exceeds that of most novice trainees and therefore actual items of the COSE may not reflect the unique, individual experience of the trainee (Lent, Hill & Hoffman, 2003).

Finally, with respect to scale format, there is unequal distribution and representation of items within the five factors (Kozina et al., 2010). For example, Urbani and colleagues (2002) found that counseling students tended to overestimate their skills prior to training. The COSE has been used primarily in training contexts with beginners and less with more advanced students or with licensed practitioners (Stoltenberg, 1998). Furthermore, most of these studies were conducted in the United States. There are, however, questions about whether self-efficacy is a universal principle that is not bounded by culture (Kozina et al., 2010).

Counselor Self-Efficacy and Treatment/Engagement with Clients

Research on the concept of counselor self-efficacy (CSE) has become an important part of the literature on counselor training and development over the past two decades (Mullen & Lambie, 2016; Douglas & Wachter Morris, 2015; Lent et al., 2006; Larson & Daniels, 1998). Counselor (or counseling) self-efficacy refers to counselors' beliefs about their ability to perform role-related behaviors. These beliefs have been operationalized in a variety of ways, especially as perceived capabilities to enact defined skills and routine session management tasks (which may be termed task or content self-

efficacy) or to negotiate more challenging clinical scenarios (coping efficacy). Adapted from Bandura's (1977, 1993) general social cognitive theory, CSE has been identified as playing an important role relative to trainees' clinical functioning, such as the nature of their cognitive, affective, and behavioral responses while interacting with clients (Larson & Daniels, 1998). For example, counselors who possess stronger versus weaker CSE beliefs (and at least adequate levels of counseling ability) may be likely to generate more helpful counseling responses, to persist longer and expend more effort when encountering clinical impasses, and to appear more poised during sessions (Lent et al., 2006). In addition to such clinical possibilities, CSE has also been seen as relevant to the process of trainees' own career development, for example, helping to determine their interest in, and desire to perform counseling as a central part of their work lives (Heppner, O'Brien, Hinkleman, & Flores, 1996).

CSE has also been found to relate to counselor affective states, such as anxiety, while engaged in the counseling role (Larson & Daniels, 1998). There has been limited study of CSE relative to in-session counselor behavior, with some findings indicating that CSE relates moderately to independent ratings of trainees' skill performance (e.g., Larson et al., 1992). There is a need for additional study of how, and under what conditions, CSE may be related to counseling-relevant process and outcome variables, such as counselors' behavior in, and clients' gains from, counseling. Another issue that deserves study is the relation between general and client-specific aspects of CSE (i.e., perceived ability to perform counseling behaviors with clients in general vs. with specific clients). It may also be useful to examine client-specific CSE in relation to general CSE and under conditions

that more closely approximate actual, ongoing counseling relationships (Lent et al., 2006). Lent et al. (2006) believes that counselors, both trainees and those with more experience, often see themselves as effective with clients, client types, or problem categories. Based partly on their past clinical experiences, many counselors gravitate toward a particular practice niche over time, focusing on the clientele with whom they believe they do their best work and perhaps avoiding certain client types or clinical issues with which they feel less efficacious (Lent et al, 2006). Even within their comfort zone of preferred client types and problems, counselors often feel differentially efficacious with the clients on their current caseload. Although trainees may have less clinical experience on which to base such beliefs, they may nevertheless derive them from impressions of their initial sessions with a given client, prior training experiences with similar clients, or generalizations from non-counseling experiences (Lent et al., 2006).

The Lent et al (2006) study consisted of 110 novice counselors and their clients. There were 96 master's-level trainees in counseling (e.g., school counseling, rehabilitation counseling) and 14 doctoral students in counseling psychology at a large mid-Atlantic university (Lent et al., 2006). All trainees were enrolled in pre-practicum courses in which they had first received didactic and experiential exposure to helping skills, followed by counseling of either a single client (masters trainees) or multiple clients (doctoral trainees) for up to five sessions. Of those that participated, 75% of the counselors were women, and 25% were men. Their mean age was 26.43 years (SD=5.70). In terms of race/ethnicity, 57% of the counselors were Caucasian, 21% were African American, five percent were Hispanic American, 13% were Asian or Asian American,

and four percent reported other racial/ethnic identifications. The clients were university students who had been offered the opportunity to participate in counseling through announcements in a variety of undergraduate courses (e.g., introductory psychology). Their average age was 21.27 years (SD =3.03) (Lent et. al., 2006). Recruitment procedures solicited those wishing to discuss academic, career, personal, or social concerns. Prospective clients were told that they would receive time-limited counseling from a counselor-in-training under supervised conditions. They were also informed that those experiencing relatively major life difficulties that required a longer period of counseling or help from a more experienced counselor would be referred instead to the university's counseling center (Lent et al., 2006). As for the counselors, 75% of them were women, and 25% were men. In terms of class standing, 6% were freshmen, 8% were sophomores, 29% were juniors, 55% were seniors, and 2% listed other statuses. For the clients, 70% were Caucasian, 11% were African American, four percent were Hispanic American, 12% were Asian American, and four percent reported other racial/ethnic identifications. Clients represented a variety of majors, with most reporting social science fields, particularly psychology (42%). The most common categories of presenting problems were emotional concerns, social relationships, and school or career issues (Lent et al., 2006).

In further examining the relationship of counselor and client session ratings, Lent et al. (2006) found that higher CSE was associated with greater congruence between clients' and counselors' perceptions of session quality. It is possible that the connection between counselors' and clients' ratings of session quality is due to a combination of

explicit and subtle actions. For instance, more self-efficacious counselors may be more likely to convey their view of how counseling is progressing (e.g., through strategic use of process comments and session summaries). Such actions, and their interpretation, may prompt a partially co-constructed evaluation of the proceedings. The significant correlation between counselor and client evaluations at each session supports the possibility that such a consensus-building process occurs, yet the modest size of these coefficients suggests that both parties also maintain somewhat idiosyncratic views of session quality (Lent et al., 2006).

Chandler, Balkin, & Perepiczka (2011) conducted one of the first studies to look at the self-efficacy beliefs of licensed counselors and their ability to provide substance abuse services. The researchers explored four questions: 1) What is the extent of the relationship between the number of graduate school courses taken by counselors and their perceived self-efficacy in providing substance abuse services?; 2) What is the extent of the relationship between the number of combined practicum and internship clock hours completed by counselors and their perceived self-efficacy in providing substance abuse services?; 3) What is the extent of the relationship between the percentages of clients with substance abuse as a primary diagnosis treated by licensed counselors and their perceived self-efficacy in relation to providing substance abuse services?; 4) What is the extent of the relationship between the number of continuing education clock hours completed in the area of substance abuse by licensed counselors and their perceived self-efficacy in relation to providing substance abuse services?

A questionnaire and the Substance Abuse Treatment Self-Efficacy Scale (SATSES) were emailed to 999 professional members of the American Counseling Association (ACA). Participants were randomly selected from throughout the United States. Ages ranged from 24 to 70 years and 69 participants were female and 33 were male (Chandler, Balkin & Perepiczka, 2011).

The results of this study determined that there was no statistically significant relationship between the number of graduate school substance abuse courses taken, combined practicum and internship hours completed in graduate school, amount of continuing education hours completed on the topic of substance abuse, percentage of clients treated with a primary substance abuse diagnosis and counselor self-efficacy. Counselors identified moderately high levels of confidence when treating clients with substance abuse issues no matter how much training they had received (Chandler, Balkin & Perepiczka, 2011). In this study, many of the participants (82%) had taken elective courses in substance abuse. This means that most participants had received information on substance abuse prior to providing substance abuse services to clients. There was no information collected on actual client outcomes (Chandler, Balkin, & Perepiczka, 2011). It is unclear as to the reason why counselors had high levels of confidence in their work in substance abuse.

Vaughn (2019) completed a dissertation focused on the self-efficacy of mental health counselors in central Appalachia with assessment and intervention for substance use. A sample of 65 counseling professionals responded to the SATSES and demographic questions. The counselors who participated in this research also demonstrated confidence

and self-efficacy in counseling domains and work with substance abuse and the hypothesis that mental health counselors in Central Appalachia will report low levels of self-efficacy in providing substance abuse services was not supported (Vaughn, 2019). A higher number of continuing education units was the best predictor for self-efficacy in counseling clients needing substance abuse services. The domains of assessment, treatment planning, individual counseling and group counseling also showed significant counselor self-efficacy (Vaughn, 2019).

Intuitively it would seem that the more understanding one has of any topic, the better the individual will be in effectively providing services in that area. There is also an ethical responsibility to make sure that awareness, education and training in a particular area provides the competence one needs to work with specific client populations. It is unclear why there was no statistical significance or predictive value for the years of experience, training, continuing education on counselor self-efficacy except for the Vaughn (2019) study that showed a higher number of continuing education units was the best predictor for self-efficacy in counseling clients needing substance abuse.

Another dissertation done by Schrotenboer (2019), looked at counselors and whether or not prior work experiences, age, academic course work, training, or self-efficacy influence whether or not a counselor chooses to counsel children aged three to six. This study recruited 119 participants that were pre-licensed clinicians in California. Of those recruited, 71 participants were determined to be eligible after removing those not meeting the criteria of the study. There was no statistically significant correlation between the Counseling Self-Estimate Inventory (COSE) score and professional

experience with children aged three to six. There also was no significant correlation between the COSE and counselor degree training programs. The results of this study indicated that counselor degree training programs and the years of professional experiences working with children aged three to six could not predict an effect on counselor self-efficacy (Schrotenboer, 2019).

Kozina et al. (2010), Chandler, Balkin, & Perepiczka, (2011), Vaughn (2019) and Schrotenboer (2019) all conducted studies that looked at the relationship between counselor self-efficacy and training, education, practicum, internship and/or continuing education. Interestingly, there was no significant correlation between counselor self-efficacy and training as it related to substance abuse or children aged three to six in two of the aforementioned studies. The Vaughn (2019) study however showed that a higher number of continuing education units was the best predictor for self-efficacy in counseling clients needing substance abuse services. The domains of assessment, treatment planning, individual counseling and group counseling also showed significant counselor self-efficacy (Vaughn, 2019). Kozina et al. (2010) also found that increases in counselor self-efficacy beliefs can occur within a relatively short period of training (Kozina et al., 2010). Therefore, counselor training/education appears to be another key factor as it relates to working with NSSI clients.

Significance of Non-suicidal Self-Injury Training for Counselors

Training and education are both cornerstones of understanding and to improve particular skills. Training in the components of clinical work with NSSI behavior was found to be lacking among health professionals (Warm, Murray, & Fox, 2003).

Counselors working with clients presenting with NSSI behavior have a unique and important obligation to enhance their training and education in this area because of the suicidal risk to their clients. The first method of education that many counselors receive is from the masters level curriculum in their college programs. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards are written with the intent to promote unity within the field of counseling.

The CACREP requirements ensure that students graduate with a strong professional identity and with specializations in one or more areas. Not only do students need to demonstrate knowledge in the curriculum but also demonstrate skill across the curriculum.

The 2009 CACREP Standards introduced a requirement for crisis response training in three of the eight curriculum areas and five of the specialty areas (Binkley & Leibert, 2015). National and state standards for professional counseling do identify the need to pay attention to crisis preparation but the standards do not delineate the type or level of education or training necessary to reduce the risk of crisis (McAdams & Keener, 2008). The vagueness of this requirement allows for graduate programs to include education in an inconsistent manner. Therefore, it is unclear how much training or education counselors receive regarding crisis response. Suicidal ideation, plan and/or intent would qualify as a crisis response event, however it is unclear if NSSI is considered as a crisis response event as it relates to CACREP standards.

The standards clearly identify the need to learn suicide prevention models and strategies as well as procedures for assessing risk of suicide. Individuals with a history of

NSSI are at an increased risk of suicide (Ward-Ciesielski,Schumacher, & Bagge, 2016; Toprak et al., 2010). When self-injury becomes a habitual behavior, the more the risk of suicide increases (Brain, Haines, & Williams, 2002). Therefore, it stands to reason that due to the relationship between NSSI behavior and the risk of suicide, counselors need to be prepared adequately to work with NSSI clients. The prevalence of NSSI behavior is high but the counseling profession does not have standards for training in the actual treatment of NSSI, either pre or post graduate level.

The second method of education that counselors receive is supervision. Hoffman & Kress (2008) studied supervision for clinical trainees working with self-injuring clients. The authors determined that supervisors played a critical role in giving accurate feedback to their supervisees as it relates to NSSI. For that reason, Hoffman & Kress (2008) recommended that supervisors without professional training in self-injury attend workshops, conferences, and read current literature on the area of self-injury. Furthermore, it was stressed that the supervision provided is direct and structured (Hoffman & Kress, 2008).

The third method of education that counselors receive would be workshops, seminars and webinars. While there was not a specific study that discussed workshops, seminars and webinars as it relates to NSSI, these forms of education are common ways that counselors obtain information throughout the course of their careers.

In summary, there should be systematic attention paid to the education and training for counselors in the area of self-injurious behavior for the following reasons: 1) The prevalence of individuals engaging in self-injurious behavior is high. The rates of

lifetime prevalence of NSSI for adolescents were 13.0% to 23.2% in 2007 (Jacobson & Gould, 2007). Just four years later, the prevalence rates were somewhere between 12-47% (Whitlock et al., 2011). Among college students, the lifetime prevalence rates in 2006 and 2007 averaged a little more than 15 percent (Whitlock et al., 2011). Four years later, lifetime prevalence rates were estimated to be 17-38% (Whitlock et al., 2011). 2) Research estimates indicate that 1 to 4% of the general population and 21% of clinical populations have engaged in an act of self-injury (Hoffman & Kress, 2008; Briere & Gil, 1998). The fact that almost a quarter of the clinical population has self-injured prior to counseling means that it is necessary for counselors to know how to address this issue with their clients. 3) The CDC estimates for "intentional self-harm by cutting with sharp or piercing instrument" is listed as a category on the National Hospital Ambulatory Medical Care Survey: 2017 Emergency Department Summary Table. However, it does not list a number and states that the estimate does not meet National Center for Health Statistics standards of reliability. There is another section of the same report that indicates the number of emergency room visits for self-harm as 479,000. Self-injury-related Internet sites, such as Healthy Place (Gluck, 2016) and Center for Discovery (Mahoney, 2018) estimates that one in five females and one in seven males engage in self-injury. These sites also report there are approximately two million cases reported each year. Known cases of NSSI jumped 250% from the 1980s to the late 1990s. The increase in these self-injury rates presents a major source of concern for families, service providers, and mental health professionals (Walsh, 2012). Having training in non-suicidal self-injury is not only important when working with this population, itis ethical to have an

understanding of the topic. The next section will highlight the specific ethical areas that relate to working with NSSI.

Ethics in Working with NSSI Clients

Ethical behavior is important in working with any client, but there are specific ethical areas of concern to be aware of as it relates to working with NSSI clients. The areas that will be discussed in this section are confidentiality, working with NSSI minors, safety planning and boundaries of competence.

Confidentiality

Confidentiality is an essential component of the therapeutic relationship (Moyer, Sullivan & Growcock, 2012). The issue of confidentiality can be complicated when working with clients who self-injure, especially if those clients are minors because self-injury is not considered suicidal behavior. Confidentiality and privacy should be explained clearly in the informed consent document in a community setting (Whisenhunt, Stargell, & Perjessy, 2016). In the school setting, counselors are ethically bound to keep information confidential unless the minor is in imminent danger or the student gives consent (Moyer, Sullivan & Growcock, 2012).

At intake, or when NSSI is disclosed, counselors should explain techniques and interventions that will be used specifically to address NSSI. Counselors should also be very clear about the duty to protect and how NSSI might lead to mandated reporting, such as if the client develops suicidal intentions or if NSSI results in a major health risk (e.g., large, infected wounds) (Whisenhunt, Stargell, & Perjessy, 2016).

Working with NSSI minors

If the client is a minor and caregivers are aware of the SI, an open discussion should occur to determine what types of information will be shared (e.g., types of interventions, progress toward goals) and how this will be shared with caregivers (e.g., privately over the phone, after session with the client present). If the caregivers of a minor are not aware that the client is using NSSI, counselors might need to disclose this information to parents because of the possibility of foreseeable harm. It is important for the client to feel empowered throughout the treatment process, especially when the counselor must notify parents or loved ones (Whisenhunt, Stargell, & Perjessy, 2016). School counselors are commonly told of risk-taking behaviors by students including self-injurious behavior (Moyer, Sullivan, & Growcock, 2012).

Safety planning

Regarding safety planning in a community setting, it is important to actively monitor and continually assess client suicide risk because of the possibility for NSSI behaviors to escalate. In the absence of developing other effective coping skills, it is not helpful to request that clients stop self-injuring. Instead, risk is diminished by simultaneously enhancing the client's other strengths and coping skills (Whisenhunt, Stargell, & Perjessy, 2016). In the school setting, school counselors believe that they need to break confidentiality and develop safety plans if risk-taking behavior occurs on school grounds (Moyer, Sullivan & Growcock, 2012).

Counselors should remember that risk assessments involve more than asking a quick close-ended question. Rather, it should involve use of a reliable and valid

instrument, such as the Inventory of Statements About Self-Injury (Glenn & Klonsky, 2011) or the Deliberate Self-Harm Inventory (Gratz, 2001) and should include dynamic, ongoing discussions about stress, coping and ideas about living (Whisenhunt, Stargell, & Perjessy, 2016).

Safety plans (as opposed to no-harm contracts) are an effective way to minimize client risk. At a minimum, safety plans need to include identification of warning signs, internal coping strategies, positive distractions, people to ask for help, professionals/agencies to ask for help and ways to make the environment safer (Whisenhunt, Stargell, & Perjessy, 2016).

Boundaries of competence

Ultimately, professional counselors, are only supposed to practice within the boundaries of competence based on education, training, supervised experience, state and national professional credentials, and appropriate professional experience. However, clients who self-injure usually present with multiple treatment issues that are complicated for both novice and seasoned clinicians to conceptualize (Whisenhunt, Stargell, & Perjessy, 2016). Therefore, it is advised that counselors take additional measures to ensure that they are able to competently deliver treatment to NSSI clients.

Counselors engaging in ongoing supervision and consultation can improve their clinical skills related to working with this population. Discussing clients who self-injure, in supervision or consultation contexts, provides counselors with new and different perspectives on their work, which can help them modify their treatment planning and

clinical interventions. Consultation and supervision also offer counselors opportunities to reflect on how they feel toward their clients (Whisenhunt, Stargell, & Perjessy, 2016).

It is also important for counselors who work with this population to read the existing literature on NSSI, seek continuing education on NSSI and remain current on emerging NSSI research. Competent counselors should practice treatment strategies that are evidence based and well-grounded in the literature, and access reputable resources (Whisenhunt, Stargell, & Perjessy, 2016).

In the event that a counselor does not see progress with a client, counselors have a responsibility to refer to another counselor who does have experience with NSSI clients and training on effective ways to work with this population (Whisenhunt, Stargell, & Perjessy, 2016). The ethical standards discussed would not be known without having training and for beginning counselors, their training comes from their graduate programs. Accreditation for university graduate programs in the counseling field comes from the Council for Accreditation of Counseling and Related Educational Programs (CACREP). The next section will focus on counselor preparedness as it pertains to NSSI.

NSSI and Counselor Preparedness

In a review of the literature, there appears to be only six studies that focus on the topic of counselors' preparedness in working with clients who self-injure. The study that is the most closely aligned with the goals of this writer's study is a dissertation completed by Taylor (2014). This study gathered data regarding school counselors' self-efficacy with NSSI, suicidal ideation and suicide with elementary, middle and high school students in the United States. The components of training, education and research were

explored by identifying the school counselor's education, number of years of experience, school level they worked in, amount of office referrals and number of sessions that specifically addressed NSSI or suicidal behavior (Taylor, 2014). There were 429 school counselors that completed the survey with a fairly even split between elementary (33.1%), middle school (30.8%) and high school level (36.1%). The Counseling Self-Estimate Inventory (COSE) was emailed to the entire American School Counselor Association email database (Taylor, 2014). The first research question was will education, in-service training, number of NSSI referrals, years of experience as a school counselor and school level significantly predict counseling self-efficacy when treating students with NSSI? The second research question was will education, in-service training, number of NSSI referrals, years of experience as a school counselor and school level significantly predict counseling self-efficacy when treating students with suicidal behavior (Taylor, 2014)? Results yielded that school counselors educated in information regarding treatment of NSSI felt more competent and able to effectively work with students struggling with NSSI (Taylor, 2014).

Furthermore, the study found that in-service training through staff development was predictive of greater counseling self-efficacy treating students engaging in NSSI. Elementary school counselors had greater self-efficacy as compared to high school counselors. There was no evidence indicating that middle school counselors had greater self-efficacy than high school counselors (Taylor, 2014). Similarly, school counselors had greater self-efficacy when they had more suicidal behavior cases treated. Again, elementary school counselors had more self-efficacy than high school counselors when it

came to suicidal behavior as well. Neither middle school or high schools were predictors for counselor self-efficacy when treating suicidal behavior (Taylor, 2014).

There were some limitations identified in the study including that the data did not yield why elementary school counselors had more self-efficacy than other levels of school counselors. Also, the demographic questionnaire was created by the researcher and so it was believed that some of the responses created were possibly limiting. The researcher also identified that the rationale behind the decisions to breach confidentiality, duty to warn or referring to a mental health assessment was not determined. Additionally, there was no delineation between counselors who trained themselves through on-the-job training or did self-training outside of work (Taylor, 2014).

A qualitative study by De Stefano et al., (2012) looked at the experiences of 12 second year masters level students in the counseling psychology program at a large Canadian university. The focus of the study was exploratory in nature and examined two major questions: 1) How do trainees describe and understand their experiences of working with these challenging clients (in this particular study, NSSI clients were the challenging clients) and 2) What can these experiences tell us about their evolving clinical development and learning? Participants for the study were gathered through a sample of convenience in a counseling psychology master's program. The students were in their second year and part of a cohort. The criterion for participation in the study was that the student had worked with one or more clients that had engaged in NSSI within the past nine months. All students were at the end of their internships and the internship sites were mostly made up of high schools (N=7). The other internship sites were university

counseling centers, a community college, a government funded addictions service and a small specialized high school for students with behavioral problems. The twelve trainees were all women, all Caucasian, and ages ranged from 23 to 37 years old (De Stefano et al., 2012).

The questions in the interviews with each of the trainees were in the following areas: a) their understanding of self-injury, b) their ideas about how prevalent it was in the population, c) their experiences working with clients who self-injure, d) the interventions they used and the outcomes of those interventions, e) their feelings in response to the clients, f) the supervision they received with regard to the clients and g) their ideas about how they would intervene with this clientele in the future (De Stefano et al., 2012).

Analysis of the results was done using consensual qualitative research (CQR) and specific domains were identified as a result of categorizing the responses of the participants. Those domains were a) understanding of NSSI, b) previous exposure to the literature on NSSI, c) reactions to NSSI disclosure, d) their feelings of efficacy, and e) their current understanding. The summary of the overall findings were that 1) the trainees had to construct their own working model of NSSI when faced with their lack of knowledge about NSSI; 2) the trainees described their experience with NSSI clients as causing strong emotions within them; and that they needed to monitor these emotions so as to not cause ethical concerns; and 3) their reflections about the learning gained from their clinical experiences suggested that their feelings of competence were not enhanced by their training or supervision (De Stefano et al., 2012).

The limitations of the study were that the participants were a sample of convenience from a master's level cohort and therefore the findings are not generalizable. Also, the findings were based on the participant reports so the manner in which the participants were interviewed may have impacted the outcomes. Most importantly, the methodology did not include triangulation of other sources of information which would have added some additional credibility. The participants were all Caucasian women which also would impact findings due to a limited cultural perspective (DeStefano et al., 2012).

Reed (2010) conducted a quantitative study that focused on 73 school counselors from Kentucky. This study focused on school counselors' perceptions and knowledge in regards to non-suicidal self-injury (NSSI), school prevention strategies and protocols, resources and training opportunities that were available, as well as training needs that were identified. The school counselors were given a knowledge measure based on Jeffrey and Warm's myths and accurate statements about NSSI. The results were that school counselors performed no differently than psychologists but showed greater knowledge than teachers. Despite school counselors having knowledge in some areas related to NSSI, qualitative analysis on some individual survey items showed several inaccuracies in other areas. Specifically, there were inaccuracies present regarding the association of NSSI to psychopathology, environmental risk factors, and functions of the behavior. Respondents indicated lack of training specific to NSSI, limited presence of school response plans regarding NSSI, and an expressed need by the respondents for more training and resources on the topic of NSSI (Reed, 2010).

Some of the limitations to this study were the low response rate, the years of experience reported by the respondents and the survey demographic questions did not ask about the counselors' gender, so there was no way to obtain information regarding differences in knowledge or experience as related to gender (Reed, 2010).

A third study focused on self-injury training, exposure and self-efficacy but was specific to special educators and teacher education (Jasper & Morris, 2012). The purpose of this study was to understand the training that special educators receive regarding self-injury. The results of the study found that 78% of the educators encountered students who self-injured, but only 37% had received any training on NSSI. This is a staggering outcome because it means that although these special educators are working with students who engage in NSSI, they lack the knowledge of how to best address the challenges of this behavior (Jasper & Morris, 2012). This study highlighted that the ability to identify students who self-injure is a positive step, however increased focus is needed in the area of training special educators to intervene with students who self-injure (Jasper & Morris, 2012).

The limitations to this study were that all of the respondents were in one state which means that the training may have all been by similar programs. The participants were recruited indirectly via an email addressed to school administrators. There was an inability to determine how many within the target population of special educators received the link to the online survey, therefore it is impossible to determine an accurate response rate (Jasper & Morris, 2012). The Training Adequacy and Self-Efficacy subscale portion of the survey used a 3 point Likert-type scale which limited the choices

respondents could give and more choices could provide more layers to the responses (Jasper & Morris, 2012).

There have been two additional studies that have looked at the impact of training on assessment and intervention for counselors working with NSSI clients. For example, Kool et al. (2014) conducted a study without a control group on the impact of a training intervention for working with self-harming clients. In this case, self-harm was defined as any deliberate damage to bodily tissue that did not lead to client death; the issue of intent underlying self-harm (i.e., suicidal or non-suicidal) was not cited, as specified by Criterion A in the DSM-5 classification for NSSI (APA, 2013). Participants in the study consisted of mental health professionals (primarily mental health nurses and social workers; N = 178). The training intervention, which lasted 1.5 days, included discussions about motivations for self-harm, instruction in the use of therapeutic strategies (e.g., familiarity with warning signs of self-harm), and stories from lay experts about personal self-harm experiences. The results indicated that, compared with pretest scores, participants' posttest scores were statistically significantly higher on several outcomes after training. These outcomes included empathic understanding toward self-harming clients, confidence in assessing the behavior, self-efficacy in working with self-harming clients, and feelings of closeness to self-harming clients.

Similarly, an investigation by Ougrin, et al. (2013) focused on training in a cognitive analytic-based approach for self-harm assessment and treatment. The sample included doctors, psychologists, social workers, and mental health nurses (N = 24). The training—delivered during five half-day training sessions held over the span of 5

weeks—included instruction on assessing self-harm and a variety of interventions aimed at dismantling the issues underlying acts of self-harm (e.g., cognitive behavior therapy and solution-focused brief therapy approaches). According to the results, the training intervention was associated with improvements in the quality of self-harm assessments, as determined by a combination of observer ratings and self-report measures.

In summary, three of the six studies have focused on samples of mental health nurses, psychologists, social workers, special educators and doctors. One study focused on masters level counseling psychology students that were still in training and looked at how they experienced NSSI clients and how those experiences were shaped by what they learned over time about NSSI. The one study that did include fully licensed counselors looked at school counselors' perceptions and knowledge in regards to non-suicidal self-injury (NSSI). The one study by Taylor (2014) that did focus on self-efficacy of counselors and NSSI clients only looked at school counselors. There are no studies to date that look at fully licensed school and community counselors and self-efficacy about NSSI and how that self-efficacy in working with NSSI clients may predict willingness to work with NSSI clients, counselor anxiety about working with NSSI clients and willingness to obtain NSSI training. To this writer's knowledge, no research has been conducted to investigate the connections between general counselor self-efficacy for school and community counselors and the delivery of treatment specifically designed for NSSI, yet there is an identified need for specialized knowledge in this area (White Kress, 2003). The gap in the literature emphasizes the need for this current study.

Conclusion

Self-injury is a significant problem as evidenced by the statistics above. The purpose of this dissertation is to highlight how self-efficacy may influence how counselors approach working with NSSI clients. There are some individuals that may counter this argument by stating that counselors can be prepared to address NSSI by receiving general therapy/counselor training and that there is no need for special training or understanding of the relationship to counselor self-efficacy. Self-injury can be seen by counselors and other mental health professionals as a symptomatic expression of someone with limited ways of dealing with painful affect and emotional experience and therefore it may seem that graduate level courses or other types of training on NSSI in general should be sufficient. However, self-injury has a complicated relationship with suicide. While individuals who engage in NSSI do not intend to complete suicide, they may accidentally cause more harm than intended, which could result in death. This connection between NSSI and suicide makes counselors have a heightened level of anxiety regarding treatment and an overall impact to their self-efficacy when working with the NSSI population.

Purpose of the Study

The current body of literature provides a great deal of information regarding prevalence of self-injury in specific populations, the purpose and functions of self-injury, and treatment of self-injury. However, none of the research focuses on the relevance of counselor self-efficacy and how it may influence how counselors approach working with

NSSI clients. The level of counselor self-efficacy may play a key role in the counselor response to clients engaging in NSSI.

During times of distress, individuals tend to reach out to others for comfort and validation. However, self-injurers do not reach out; rather they turn inward. Self-injurers exhibit significant difficulty in emotion regulation which impacts their ability to practice more healthy coping mechanisms. This presents a significant challenge for counselors in working with this population. This study will examine whether counselor self-efficacy for working with NSSI clients predicts counselors' willingness to work with NSSI clients, their anxiety in working with this population and their willingness to seek out training. The study will also examine whether the amount of education, training and/or years of experience is predictive of the level of counselor self-efficacy.

This study will include beginning counselors, experienced counselors as well as counselors who are supervisors. My study will be quantitative in nature. I will be utilizing Qualtrics, which is a confidential, electronic survey tool and SPSS to compile the results and analyze any trends in the data.

Research Hypotheses and Questions

The research hypotheses and questions for this study will be detailed below and will form the description of the study in the following chapter.

Hypotheses

1. Counselor self-efficacy predicts counselor willingness of counselors to work with clients engaging in self-injury

2. Counselor self-efficacy for working with NSSI clients predicts counselor anxiety in working with this population.

3. Counselor self-efficacy predicts counselor willingness to learn about NSSI treatments

Questions

1. Does the amount of counselor experience (years) predict counselor self-efficacy in working with clients engaging in self-injury?
2. Of those that have received training, does the most recent type of NSSI training (e.g. didactic, observation, role play/practice, multiple types, etc.) affect the level of counselor self-efficacy in working with NSSI clients?
3. Does the number of NSSI training hours predict counselor self-efficacy in working with NSSI clients?

CHAPTER THREE

METHODOLOGY

This chapter will introduce the methodology and design that was used in the analysis of counselor self-efficacy in working with NSSI clients and whether it is predictive of counselor willingness to work with this population. Also, this study will examine whether counselor self-efficacy in working with NSSI clients predicts counselor anxiety in working with this population. Furthermore, the study will examine whether or not counselor self-efficacy influences counselor willingness to learn about how to work with NSSI clients. Additional other factors that contribute to counselor engagement in training and working with NSSI clients will also be examined. This chapter will begin by identifying the purpose statement for the study, followed by the research questions and hypotheses. Next, there will be an explanation of the design for this study, which will include the participant inclusion criteria, specific procedures and the instruments used to measure each variable. The chapter will end with a description of the data analysis.

Purpose Statement

The purpose of this dissertation is to examine how self-efficacy may influence how counselors approach working with NSSI clients. The study will examine whether counselor self-efficacy (CSE) predicts willingness to work with NSSI clients and to seek out education regarding NSSI. Conversely, this study will examine whether counselor anxiety predicts willingness to work with NSSI clients. Non-suicidal self-injury is a challenging clinical behavior that is often seen during a counselor's career. It is also a

clinical behavior that can trigger emotionally intense reactions in counselors. Furthermore, it is a clinical behavior for which counselors can receive training to understand how to effectively work with clients. However, despite the opportunity to gain understanding, there appears to still be a hesitancy to work with NSSI clients. It was proposed that the amount of education in NSSI, specific training regarding NSSI and years of experience in the counseling field that a counselor has, would predict the level of counselor self-efficacy. Counselor self-efficacy is an important factor in how counselors perform role-related behaviors. Counselors who possess higher CSE would seem to perceive their capabilities in a positive light which would lead to willingness to work with NSSI clients.

Research Hypotheses and Questions

Hypotheses

1. Counselor self-efficacy predicts counselor willingness of counselors to work with clients engaging in self-injury.
2. Counselor self-efficacy for working with NSSI clients predicts counselor anxiety in working with this population.
3. Counselor self-efficacy predicts counselor willingness to learn about NSSI treatments.

Questions

1. Does the amount of counselor experience (years) predict counselor self-efficacy in working with clients engaging in self-injury?

2. Of those that have received training, does the most recent type of NSSI training (e.g. didactic, observation, role play/practice, multiple types, etc.) affect the level of counselor self-efficacy in working with NSSI clients?
3. Does the number of NSSI training hours predict counselor self-efficacy in working with NSSI clients?

Research Design

The present study utilized a quantitative methodology with a non-experimental survey design. The independent variables counselor self-efficacy, years of counseling experience, type of training for working with NSSI clients, number of hours of NSSI training, and CACREP accreditation status of graduate program attended were not able to be manipulated. The dependent variables were counselor willingness to work with NSSI clients and counselor anxiety about working with NSSI clients as well as counselor willingness to engage in training. Also, participants were not randomly assigned to treatment conditions. Therefore, a non-experimental design was chosen for this study. Survey design was used because the goal for this study was to explain the features of a large sample of a population. The instruments that were used assess the relationships among the design variables. Practicing counselors were recruited to participate in an online survey. The online survey collected data regarding counselors' self-efficacy for working with NSSI clients as well as their willingness to work with and seek training for addressing issues related to this population. Participants were also asked about their degree of anxiety working with NSSI clients. Additional data that was gathered by utilizing a demographic questionnaire included the following: gender, age, race, level of

graduate education, ability to practice under a license, location of where the counselor practices, whether the counselor graduated from a CACREP-accredited program, and years of experience in the counseling field. The demographic questionnaire also asked questions about the primary practice setting of the counselor, what was the most recent type of training the counselor completed on the topic of NSSI, and how many total hours of education/training the counselor had completed in the topic of NSSI.

Participants and Procedures

After receiving institutional review board approval, data was collected from 142 counselors, with an adjusted sample size of 121 counselors, practicing in the United States. To participate in the study, individuals were required to 1) be over the age of 18, 2) have at least a master's degree in counseling, and 3) be working as a counselor in a school, agency, residential or inpatient facility, private practice or other clinical setting. The rationale for having these criteria was to encompass the variety of experiences that counselors have. Individuals were excluded from the study if they did not practice counseling in the United States, if they did not have at least a master's degree in counseling and were not at least 18 years of age. A detailed summary of participants in this study was reviewed in chapter four.

The online survey consisted of 40 items. Of these, 15-items collected demographic information about gender, age, race, level of graduate education, ability to practice under a license, location of where the counselor practices, whether the counselor graduated from a CACREP-accredited program, and years of experience in the counseling field. The demographic questionnaire also asked questions about the primary

practice setting of the counselor, what the most recent type of training the counselor completed in the topic of NSSI (option to respond no training), if there was training, was the most recent type of training didactic (i.e. lecture classes, lecture seminars, lecture webinars, reading journal articles or books, etc.) in nature, did the most recent type of training include role playing (i.e. practicing skills learned), did the most recent type of training include observation (i.e. watching experienced counselors practice skills being taught), did the most recent type of training include multiple types (didactic, role play, observation) and how many total hours of education/training the counselor had completed in the topic of NSSI.

The survey section included the 16-item modified version of the original 25-item Counselor Suicide Assessment Efficacy Survey (CSAES) (Douglas & Morris, 2015) renamed the Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale. The survey also included 3 items on willingness to work with clients engaging in non-suicidal self-injury named the Willingness to Work with Clients That Self-Injure Survey, 3-items on willingness to seek training for working with NSSI clients named the Willingness to Obtain Training to Understand Self-Injury Survey and 3 questions on counselor anxiety about working with clients engaging in non-suicidal self-injury named the Counselor Anxiety Regarding NSSI Survey. The survey data was gathered using Qualtrics, web-based software. Each participant received an informed consent at the beginning of the survey. At the end of the survey, participants were given instructions for how to enter a prize drawing to win one of two $50 Visa gift cards. Recruitment of participants occurred through invitation through the American Counseling Association database called ACA

Connect. This is a listserv available only for individuals who are counselors. Recruitment was also done through invitation on the CES-NET listserv and Diversity Listserv. There were also invitations posted on several Facebook groups for counselors including Michigan LPCs Advocacy and Action, Oakland University MA Counseling Alumni, Licensed Professional Clinicians Network, and The Organized Therapist as a convenience sample. These Facebook groups were moderated and the only members accepted into the groups were those identifying as counselors. These recruitment sources were utilized specifically to attempt to control for individuals who are not counselors answering the survey.

Online Data Collection

Online research has become an approach that has given researchers the potential to reach a vast amount of people in an efficient and cost-effective manner. Specifically, web surveys provide the option for a shorter time frame for collecting responses from participants, partially due to the internet being able to reach a large, diverse population (LeFever, Dal, & Matthiasdottir, 2007).

Other advantages of online data collection are that it protects data from being lost and it streamlines transfer of data to a database so that it can be analyzed. It is also a practical and less time-consuming alternative to gathering information from participants in person (LeFever, Dal, & Matthiasdottir, 2007). There has been research showing that participant responses in email and online surveys tend to be more complete than paper-and-pencil surveys (LeFever, Dal, & Matthiasdottir, 2007; Truell, 2003).

Confidentiality and security are important factors to consider when it comes to online research. With email surveys, anonymity is limited because of the researcher being able to see the identifying information in their email address (Truell, 2003). However, with web surveys there are ways to protect confidentiality of the responses by hiding identifying information including their IP address. Security concerns arise when respondents are concerned about breaches occurring and their information being accessed (Truell, 2003). Researchers must make sure to protect information by installing anti-virus software, installing firewalls on their computers, updating operating systems, ensuring data encryption and restricting permission to any data through the use of strong passwords (Kraut et al., 2004).

The convenience of sending responses through the computer is a great advantage to respondents because they can complete the survey on their own time. However, this same convenience can be a disadvantage to researchers because the respondents may also postpone filling out the survey because they get busy with other things in their lives (LeFever, Dal, & Matthiasdottir, 2007). Non-respondent follow-ups has been studied in the literature and it has been suggested that researchers have shorter timing between follow-ups. In fact, one study yielded 89% of email and web survey respondents completed their surveys in five days (Truell, 2003). Truell (2003) also examined the number and timing of follow-ups and had different suggestions, in one case, first and second reminders on days two and four and in another case, one reminder from four to seven days after the original invitation, In any event, multiple contacts to non-respondents have been shown to almost double the response rates (Truell, 2003).

Furthermore, there are disadvantages related to the technical problems that may arise from the internet connections or the computer technology itself. There also may be a difficulty for the respondent because of their skill level in using computer technology. In addition, respondents may have a hesitancy to respond to online surveys because they do not trust how the information will be handled. Even in the recruitment stage, email invitations for participation may be deleted or interpreted as junk mail or spam (LeFever, Dal, & Matthiasdottir, 2007).

Other challenges with online data collection relate to the population samples. Specifically, there are concerns regarding fraudulent respondents and individuals completing the surveys as other people or not being truthful in their responses. Determining truthfulness is a challenge regardless of using online research or in person research. (LeFever, Dal, & Matthiasdottir, 2007). Because online data collection is based on volunteer sampling and not probability sampling, researchers do not have the ability to specifically identify which individuals are going to fill out the web survey from the sample invited to participate (LeFever, Dal, & Matthiasdottir, 2007).

Additional factors that can impact online research include whether or not to include progress indicators on surveys. More people tended to complete the survey without a progress indicator (Truell, 2003). It has also been suggested through research that providing respondents more than one response option such as fax or postal mail increases likelihood of response (Truell, 2003). While studies of response rates for online research yielded mixed results, response speed was shown to be significantly faster than mail surveys (Truell, 2003).

Restriction of access either through requiring the respondent to enter a password on the main screen or providing a unique identifier into the URL will assist in making sure that individuals who were not invited to participate or are trying to participate more than once are curbed (Truell, 2003).

Qualtrics allows researchers to send the survey out to only individuals who receive an invitation, an option to prevent multiple submissions by a single respondent and an option for anonymous responses. Anonymous responses do not record the respondents' IP addresses, location data or contact info. These choices create the opportunity for data integrity in the research (Retrieved from https://www.qualtrics.com/support/survey-platform/survey-module/survey-options/survey-protection/ on August 15, 2021). These options are selected by the researcher.

The Qualtrics security statement of April 23, 2021 states the following:

> "Servers are protected by high-end firewall systems and scans are performed regularly to ensure that any vulnerabilities are quickly found and patched. Application penetration tests are performed annually by an independent third-party. All services have quick failover points and redundant hardware, with backups performed daily. Access to systems is restricted to specific individuals who have a need-to-know such information and who are bound by confidentiality obligations. Access is monitored and audited for compliance. Qualtrics uses Transport Layer Security (TLS) encryption (also known as HTTPS) for all transmitted data. Surveys may be protected with passwords. Our services are hosted by trusted data centers that are independently audited using the industry standard SSAE-18 method (Retrieved from Qualtrics.com/security-statement/ on August 15, 2021)."

Data Protection

The data in this study was protected in a number of ways and this section will review how this researcher ensured confidentiality and integrity to the security of the survey. First, this researcher used the Qualtrics survey platform to collect data. This researcher used an invitation only option for the survey by creating a personal link that was provided in the post invitation to the American Counseling Association database called ACA Connect, to the CES-NET listserv and Diversity listserv and invitation posts on several Facebook groups for counselors including Michigan LPCs Advocacy and Action, Oakland University MA Counseling Alumni, Licensed Professional Clinicians Network, and The Organized Therapist. These Facebook groups are groups that can be joined by counselors only. Members must answer a series of questions and then be accepted by a moderator to join. In addition, this researcher required that if a respondent attempted to access the survey with an anonymous or multiple completes link, they received a message that said, “This survey can only be taken by invitation”.

The researcher chose the option for preventing multiple submissions. Because there was a monetary prize drawing incentive as part of the survey, it was extremely important to prevent respondents from taking the survey more than once. This also protected the integrity of the data so that there were not individuals responding to the survey more than once resulting in inaccurate data. To prevent the possibility of an individual clearing their browser cookies, using a different browser or even a different device to take the survey again, the researcher also used an SSO authenticator for the respondents from any of the Facebook pages. This ensured that individuals responding to

the survey were members of only the invited Facebook groups. The researcher used a contact authenticator for the respondents receiving the invitation through the American Counseling Association database. This ensured that only individuals receiving the invitation through the American Counseling Association database were able to respond to the survey.

The researcher chose to prevent indexing to prevent search engines from finding the survey and identifying it in search results on the internet. In addition, the researcher required permission to view uploaded files to prevent anyone other than the researcher to view responses. Responses were anonymized which removed the IP addresses and location data. It also disconnected the response from the respondent who provided it.

Lastly, the researcher ensured safeguards on the personal computer where the data was analyzed. The researcher's computer updated antivirus protection through Avast Antivirus, the network firewall was on for the domain, private and public network. The screen shut down within 5 minutes of inactivity and needed a password to log in again. The Windows operating system updated automatically. The researcher also had McAfee LiveSafe for VPN data encryption on the computer where the data was analyzed. Qualtrics also had layers of data encryption to protect the survey data as well.

Recruitment

Participants were provided with a link to the online version of the demographic questionnaire, the counselor willingness questions, counselor anxiety questions and the modified version of the CSAES. Participants were garnered through social media databases where counselors engage in networking and collaboration. There was only one

recruitment technique used in this study. This researcher sent out six notifications including the original invitation. The follow up requests were sent out every four days based on the Kittleson (1997) study. These requests were notifications that were directed to the Qualtrics software.

As stated above, non-respondent follow-ups has been studied in the literature and it has been suggested that researchers have shorter timing between follow-ups. One study by Jones and Pitt (1999) yielded 89% of email and web survey respondents completed their surveys in five days (Truell, 2003). Truell (2003) also examined the number and timing of follow-ups and had different suggestions, in one case, first and second reminders on days two and four (Crawford, Couper and Lamias, 2001) and in another case, one reminder from four to seven days after the original invitation (Kittleson, 1997).

Determining Participant Sample Size

The participant sample size was determined by using the formula recommended by Green (1991) which is a minimum of $N > 104 + m$ for a partial correlation. The largest of the two minimum N's was used to determine how many cases were needed for the study. The number of subjects or sample size is N and the number of predictors or independent variables is m (Wilson VanVoorhis & Morgan, 2007; Green, 1991). Based on the aforementioned formula, this study utilized a simple regression for hypothesis 1 through 3 as well as question 1 and 3. Therefore, the targeted participant sample size was at least 105 participants because $N > 104 + 1$ (independent variable=counselor self-efficacy).

The participant sample size for ANOVA was determined using the rule of thumb from Cohen (1988). Cohen stated that given a medium to large effect size, at least 30 participants per cell should lead to about 80% power, which is the minimum suggested power for an ordinary study (Wilson VanVoorhis & Morgan, 2007). Based on the aforementioned rule of thumb, question 2 utilized an ANOVA. Therefore, the targeted participant sample size was at least 120 for the ANOVA (30 X 4 (didactic, observation, role play, multiple). Overall, the goal was to obtain at least 120 participants in the sample size for this study. This ensured the appropriate number of individuals for the study as a whole.

Online Recruitment Method

Recruitment posts were created for several Facebook groups including Michigan LPCs Advocacy and Action, Oakland University MA Counseling Alumni, Licensed Professional Clinicians Network, The Organized Therapist, listservs for CES-NET and Diversity and ACA Connect through the American Counseling Association website. The link to the survey was provided and the first page of the survey included the informed consent. Potential participants were offered the opportunity to include their email addresses in a second disconnected survey if they wanted to enter a drawing for one of two $50 Visa gift cards at the conclusion of the survey. A recruitment statement and information sheet/informed consent statement were prepared by the researcher. These statements were provided to dissertation committee members and to the IRB.

Instruments

Demographic Questionnaire

Demographic information from the participants was collected. The 15 items asked questions regarding gender, age, race, level of graduate education, ability to practice under a license, location of where the counselor practices, whether or not the counselor graduated from a CACREP-accredited program, and years of experience in the counseling field. The demographic questionnaire also asked questions about the primary practice setting of the counselor, what the most recent type of training the counselor completed in the topic of NSSI, (option to respond no training), if there was training, was the most recent type of training didactic (i.e. lecture classes, lecture seminars, lecture webinars, reading journal articles or books, etc.) in nature, did the most recent type of training include role playing (i.e. practicing skills learned), did the most recent type of training include observation (i.e. watching experienced counselors practice skills being taught), did the most recent type of training include multiple types (didactic, role play, observation) and how many total hours of education/training the counselor has completed in the topic of NSSI.

Willingness Measures

No applicable measures were found in the literature for willingness of counselors to work with specific clients or willingness to seek additional training. Therefore, scales were created to measure the constructs of willingness to work with NSSI clients and willingness to seek out training. The items created for each of the respective scales were based on the following definitions. A general operational definition of willingness to

work with clients was stated as the extent to which a counselor chooses to work with a client (Atkinson, 2011). There was also an operational research definition focused on approach/avoidance behavior/motivation that relates to willingness to obtain training to work with NSSI clients. The operational definition of willingness to obtain training to work with NSSI clients was stated as individuals that have a mastery goal orientation see achievement situations as opportunities for them to learn new skills or improve old ones. They see failures and mistakes as giving information on how to improve (Stoeber et al., 2008).

Willingness to Work with Clients that Self-Injure

This measure was created to determine how willing counselors were to work with clients engaging in NSSI. These three items highlighted the component of self-efficacy theory regarding approach/avoidance. A Likert sca1e of 1=Strongly disagree to 5=Strongly agree and 0=prefer not to answer was utilized for this measure. The first item explored if a counselor was assigned a client that was engaging in self-injury, would the counselor be willing to treat them. The second survey item that explored whether the counselor would refer clients that self-injure to another clinician was reverse scored: 5= Strongly disagree to 1=Strongly agree and 0=prefer not to answer. This item was reverse scored because the decision for the response had different directionality than the other statements. The last item explored if the counselor would be willing to work with clients engaging in NSSI whenever they had the opportunity. The possible score range of the 3-item instrument was between 3 and 15. The internal consistency of this measurement was found to be good with an α=.87.

Willingness to Obtain Training to Work with NSSI Clients

This measure was created to determine how willing counselors were to obtain training of any kind regarding NSSI. For the purposes of this study, training included: didactic information, role plays, observation or multiple types. These three items highlighted the component of self-efficacy theory that spoke to the components of approach/avoidance and performance. A Likert sca1e of 1=Strongly disagree to 5=Strongly agree and 0=prefer not to answer was utilized for this measure. The first item explored if a counselor is willing to seek training to improve their work with clients that self-injure. The next item explored whether the counselor would do their own studying on how to improve their work with clients that self-injure. The last item explored if the counselor would be willing to seek out supervision or consultation to improve their work with clients that self-injure. The possible score range of the 3-item instrument was between 3 and 15. The internal consistency of this measurement was found to be acceptable with an α=.75.

Counselor Anxiety in Working with NSSI Clients Scale

The definition of counselor anxiety was not specifically found in the literature. However, the operational definition of counselor anxiety that was used in this study was "the discomfort and innate reaction that occurs in response to a given stimulus" (Dodge-Evans, 2020; Shamoon, Lappan, Blow, 2016).

Despite searching for applicable surveys that measure counselor anxiety in working with certain client populations/clients that self-injure, there were none found in the research. Therefore, the counselor anxiety survey items were designed by the

researcher for this study. There were 3 Likert-scale items regarding counselor anxiety when working with clients engaging in NSSI. The Likert-scale response options for participants are as follows: 1= Strongly disagree to 5=Strongly agree and 0=prefer not to answer. The first item focused on feeling apprehensive about working with self-injuring clients. The second item focused on the counselor being afraid they may be providing the wrong standard of care to clients that self-injure. The third item focused on the counselor feeling anxious when working with clients that self-injure more so than when working with other clients. The possible score range of the 3-item instrument was between 3 and 15. The internal consistency of this measurement was found to be good with an α=.83.

Counselor Suicide Assessment Efficacy Survey (CSAES)

The CSAES (Douglas & Morris, 2015) scale is a 25-item self-report measure designed to determine level of counselor self-efficacy in suicide assessment and intervention. Items 1–7 belong to the factor General Suicide Assessment, Items 8–17 belong to Assessment of Personal Characteristics, Items 18–20 belong to Assessment of Suicide History, and Items 21–25 belong to Suicide Intervention (Douglas & Morris, 2015). For the purposes of this study, questions that were specific to suicide assessment and intervention were changed to non-suicidal self-injury assessment and intervention. Those changes were detailed later in this section. In this modified version of the CSAES, this study used a 16-item instrument modeling the framework of the CSAES without the subscales. An exploratory factor analysis was completed for this modified version of the CSAES. The participant sample size for the factor analysis was determined using the rule

identified by Tabachnick & Fidell (1996) stating 50 as very poor; 100 as poor, 200 as fair, 300 as good, 500 as very good and 1000 as excellent.

The original CSAES focused on both the general suicide assessment questions (e.g., asking about suicidal thoughts) and assessment questions that invoke varying degrees of personal information that may be related to suicide risk (e.g., asking about acceptance of sexuality) and family history of suicide. Based on the guidelines from Bandura (1993), respondents were asked to rate each item on a scale of 0 to 100; 0 means cannot do at all and 100 means highly certain that they can do (Douglas & Morris, 2015). Item responses were ultimately changed to a 5-point Likert scale where 1= not confident to 5=highly confident and 0=prefer not to answer.

The original CSAES had four subscales: General Suicide Assessment, Assessment of Personal Characteristics, Assessment of Suicide History, and Suicide Intervention. The scale reliability and internal consistency was reported as high (α=.95) (Douglas & Morris, 2015). The validity of the original CSAES was investigated using an exploratory factor analysis and was found to have strong structural aspects of validity (Douglas & Morris, 2015).

The internal reliability was calculated using Cronbach's alpha for each of the four scales: General Suicide Assessment α=.88 (7 items), Assessment of Personal Characteristics α= .88 (10 items), Assessment of Suicide History α= .81 (3 items), Suicide Intervention α = .83 (5 items); and the second-order factor Suicide Assessment α=.93 (20 items). All of these reliability coefficients were deemed to be high (Douglas & Morris, 2015). An analysis of the internal consistency reliability was conducted on the

modified version of the measure for this study as well. The internal consistency of this modified measurement was also found to be excellent with an α=.95.

There were items that were deleted from the original CSAES because they were not related to the constructs being researched in this study. The following statements were deleted: I can effectively assess hopelessness, I can effectively inquire whether a student has withdrawn from relationships, I can effectively assess a student's acceptance of sexuality, I can effectively talk with a student about his or her hygiene, I can effectively discuss with a student his or her writings about death, I can appropriately inquire whether a student has been a victim of abuse, I can effectively ask a student about his or her family history of suicide, I am able to appropriately intervene if a student reports suicidal thoughts, but I do not believe him or her, and I am able to intervene appropriately if a student denies suicidal thoughts, but I do not believe him or her.

The language was changed to say client instead of student and non-suicidal self-injury instead of suicide for the following statements: I can effectively inquire if a student has had thoughts of killing oneself, I can effectively assess whether a student has means to carry out a suicide plan, I can effectively inquire whether a student has a suicide plan, I can effectively counsel a student who has had a history of making suicidal threats, but has had no attempts, I can effectively counsel a student who has previously attempted suicide, I am able to assess a student's level of risk for a suicide attempt, I know the point at which I need to break confidentiality, I can appropriately take action if I determine a student is moderately at risk for suicide, and I can appropriately intervene if a student is at imminent risk for suicide.

The following statements remained in the assessment as they were created in the original CSAES: I can effectively ask a student about his or her drug abuse, I can effectively ask a student about his or her history of sexual abuse, and I can effectively ask a student about his or her history of mental illness.

The following four statements were added by this writer: I can effectively counsel a client who is currently engaging in non-suicidal self-injury, I am aware of tools and strategies to help prevent non-suicidal self-injury, I can effectively ask a client about whether he or she has low self-esteem (changed to low self-worth), and I actively use strategies to treat non-suicidal self-injury with clients.

The total score will be used for the analysis of this modified version of the CSAES. Therefore the possible score range of the 16-item instrument can be anywhere from 16 to 80.

Data Analysis

There were three hypotheses and three research questions that were statistically tested using the Statistical Package for the Social Sciences (SPSS) software, version 28.0. Linear regression was used to test the research hypotheses.

To test hypothesis 1- counselor self-efficacy (independent variable) predicted counselor willingness of counselors to work with clients engaging in self-injury (dependent variable), linear regression was used. To test hypothesis 2- counselor self-efficacy (independent variable) for working with NSSI clients predicted counselor anxiety in working with this population (dependent variable), linear regression was used. To test hypothesis 3- counselor self-efficacy (independent variable) predicted counselor

willingness to learn about NSSI treatments (dependent variable), linear regression was used. The alpha level was set at .05. Before completing the linear regression test, steps for data preparation and testing assumptions were followed.

The years of work experience in the counseling field, and amount of counselor training in NSSI and whether these factors predict counselor self-efficacy were examined using linear regression. To examine whether there were differences in types of NSSI training and its impact on counselor self-efficacy ANOVA was used. ANOVA was used because it is a statistical method that is designed to determine if there are statistical differences between the means of more than two groups.

CHAPTER FOUR

RESULTS

This chapter includes the results of the data analyses. First, the data preparation procedures are reviewed. Next, a detailed description of the survey participants and demographic information are described. The chapter goes on to discuss the preliminary analysis including the independent and dependent variables and the descriptive statistics of the measures used in the study. Last, hypotheses testing and additional analyses are presented.

Data Preparation

The data was prepared for analysis by taking several steps to clean and organize the data. All surveys were exported from Qualtrics.com into IBM Statistical Package for the Social Sciences (SPSS) software, version 28.0. Survey responses from 142 participants were imported into SPSS. The review of data for missing values happened in two phases. For the first phase, the data was examined to determine which cases did not respond at all to the four main assessments used in this study. To identify how many usable data sets there were, the rule of thumb suggested by Tabachnick and Fidell (2007) stating that a completed data set is when participants complete at least 85% of the survey. Twelve cases were removed from the data analyses using listwise deletion by selecting cases that had less than 85% progress on the total survey and 2 cases were just manually removed because the progress showed 100% complete but the respondents skipped through and did not respond to either the training questions or the four primary

assessments. These 14 participants skipped all the training questions (questions 11-15) and all the four primary assessments (questions 18, 19, 20, and 21). To address the data sets that included missing data, listwise deletion was used for these 14 cases. Listwise deletion eliminates each unit that contains a missing value. For example, if a dataset contains an infinite number of columns but only has missing data in one column, listwise deletion still deletes the entire unit from further analyses (Lodder, 2013; Meyers, Gamst, & Guarino, 2006). The listwise option was used because these 14 respondents that had missing data skipped the training questions and all the four primary assessments being studied. (Lodder, 2013; Meyers et al., 2006). It would have distorted the data if a mean imputation was done, which would have replaced all the missing values with the mean of non-missing values of the item. It also would have distorted the data if a regression imputation was done, which would have predicted missing values from the other values that were present. Regression imputation would have been difficult because there were no other values in the assessment section that could have been used for prediction. At this point of the review of missing data, the adjusted sample size was 128.

For the second phase, data was reviewed to see if there were any cases that reached the 85% completion mark but were missing large portions of any one of the four main assessments. There were nine cases that had missing data for the Counselor Self-Efficacy (CSE) variable, seven cases that missed all the CSE data and two that only missed some CSE data. The 7 cases that missed all the CSE data were manually removed from the data set. A multiple imputation was completed on the 2 cases that were missing only some CSE data. The imputation method used in SPSS was the fully conditional

specification method since this method generally yields value estimates that are unbiased. This method also allows for flexibility because regression models are used on a variable by variable basis (Liu & De, 2015). After both phases of reviewing the data was complete, the adjusted sample size was 121.

The next step in the data analysis was to test the normality of the data through the skewness, which measures how symmetrical the distribution was, and kurtosis, which provides information about how concentrated values are around the mean (Pallant, 2016; Meyers et al., 2006). Normally distributed variables have skewness and kurtosis values close to 0, with an acceptable range between +1 to -1 (Meyers et al., 2006). The variables for each assessment were analyzed for skewness and kurtosis and yielded the following: Counselor Self-Efficacy (skewness = -.94; kurtosis = .18); Willingness to Work with NSSI Clients (skewness = -1.34; kurtosis = 1.94); Willingness to Seek NSSI Training (skewness = -1.21; kurtosis = .55); and Counselor Anxiety Regarding NSSI (skewness = .34; kurtosis = -.74). Outliers were examined and elimination was considered, however, there were no outliers that needed to be removed for the aforementioned variables.

Parametric tests assume that samples come from a normal distribution, but the central limit theorem means that this assumption is not necessary if the sample is large enough, typically more than 100 is considered large (Mishra et al., 2019). This study operated with an adjusted sample size of 121.

The next step in the data analysis was to test the linearity of the data. Linearity tests determine whether the independent variables and dependent variables are linear or not (Pallant, 2016; Meyers et al., 2006). When the significance value is greater than 0.05,

then the relationship between the variables is linearly dependent. There was a linear relationship between the variables of counselor self-efficacy and willingness to work with NSSI clients with a (p =.35), between the variables of counselor self-efficacy and willingness to obtain training in NSSI (p =.82) and between the variables of counselor self-efficacy and counselor anxiety (p =.08). Additionally, there was linearity between the variables of counselor years of experience and counselor self-efficacy (p =.96) and the variables of training in NSSI and counselor self-efficacy (p =.59).

The next assumption of homoscedasticity was tested to determine whether the variance was equivalent across levels of the dependent variables. To check for homoscedasticity, a plot of the standardized residuals by the regression standardized predicted value was assessed. Homoscedasticity is shown when the residuals are scattered randomly around the horizontal line of 0 (Osborne & Waters, 2002). In this study, the residuals were scattered randomly around the horizontal line of 0, indicating homoscedasticity.

Summary of Sample Respondents

This study aimed to recruit a diverse group of licensed professional counselors in order to understand the perspectives of a variety of counselors who worked in several types of clinical settings, both community and school. Table 1 describes the demographic characteristics of the individuals participating in the study including gender, race, degree, practice setting and whether or not they graduated from a CACREP-accredited program. Most of the participants were female and Caucasian. All the participants were licensed

professional counselors and the majority of them had master's degrees and worked in private practice. Most of the respondents graduated from a CACREP-accredited program.

The ages of respondents ranged from 25-75 (M = 40.3; SD = 11.0) years. Years of clinical experience ranged from less than a year to 35 (M = 8.3; SD = 6.9) years. The question of whether there was a difference between CACREP and non-CACREP programs and their impact on counselor self-efficacy in working with NSSI clients was explored using an independent samples t-test. There was no significant difference found between counselors completing CACREP programs or not and counselor self-efficacy (t = -.33; df = 118; p= .75).

Table 2 shows the frequency of types of training for NSSI received by participants. The majority of participants had completed training on the topic of NSSI (61.2%, n= 74) with 38% reporting they had not completed any training on NSSI (n=46). Didactic training was defined as lecture classes, lecture seminars, lecture webinars, reading journal articles or books, etc. Role playing training was defined as practicing the skills learned in the training. Observation training was defined as watching experienced counselors practice skills being taught. Multiple types of training were defined as a combination of didactic, role playing, and/or observation. Of those participants who reported that they had engaged in NSSI training, most of them engaged in didactic NSSI training, with the least amount engaging in both role play and observation NSSI training.

Participants were asked what the most recent type of NSSI training they engaged in was, not every NSSI training they had ever taken in their clinical experience. They

Table 1. Summary of Demographic Characteristics of Research Participants

Characteristic	N	%
Gender		
Female	107	88.4%
Male	9	7.4%
Other	5	4.1%
Race		
Caucasian	89	73.6%
African-American	15	12.4%
Hispanic	7	5.8%
Multiracial	7	5.8%
Asian	2	1.7%
Turkish	1	.8%
Degree		
Masters	102	84.3%
Doctorate	19	15.7%
Practice Setting		
Private Practice	58	47.9%
School	18	14.9%
Community Mental Health Clinic	18	14.9%
Outpatient	14	11.6%
Other	4	3.3%
College/University	4	3.3%
Residential Treatment	2	1.7%
Partial Hospitalization/IOP	2	1.7%
Inpatient	1	.8%
CACREP Program		
Yes	102	84.3%
No	18	14.9%

Note: N=121 CACREP Program N=120

Table 2. Summary of NSSI Training Completed by Research Participants

Type of Training	N	%
Didactic only	46	62.2%
Didactic and Role Play	9	12.2%
Didactic and Observation	8	10.8%
Role Play and Observation	1	1.4%
Didactic, Role Play & Observation	10	13.5%

Note: *n*=74

were asked about the most recent so that the reporting of type of training was easier to recall.

Preliminary Analysis

The purpose of this dissertation is to examine how self-efficacy may influence how counselors approach working with non-suicidal self-injury (NSSI) clients. The study examined whether counselor self-efficacy (CSE) predicted willingness to work with NSSI clients and willingness to seek out education regarding NSSI. Conversely, this study examined whether counselor anxiety predicted willingness to work with NSSI clients. The independent variables in this study were: counselor self-efficacy (CSE), years of counseling experience, type of training for working with NSSI clients, number of hours of NSSI training and CACREP accreditation status of graduate program. The dependent variables were counselor willingness to work with NSSI clients, counselor

anxiety about working with NSSI clients and counselor willingness to seek out education/training regarding NSSI.

Participants in the study were asked to rate themselves on a Likert scale on four different assessments including the Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale, Willingness to Work with NSSI Clients Survey, Willingness to Obtain Training in NSSI and the Counselor Anxiety Regarding NSSI Survey. Table 3 shows the descriptive statistics of the assessment variables in the study including the mean, standard deviation, the actual reported median scores of the assessments, the actual reported minimum scores and the actual reported maximum scores of the assessments. Respondents tended to rank themselves highly confident as it related to counselor self-efficacy, and very willing as it related to willingness to work with NSSI clients and willingness to obtain NSSI training. Respondents reported lower scores on the counselor anxiety scale meaning that they tended to not experience anxiety about working with NSSI clients.

Table 3. Descriptive Statistics for Study Variables

Instrument	Mean	SD	Median	Minimum	Maximum
CSE	67.95	10.75	70.00	36	80
WW	12.28	2.44	13.00	3	15
WT	13.86	1.52	15.00	9	15
CA	7.65	3.02	7.00	3	15

Note: N=121 CSE=Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale, WW=Willingness to Work with NSSI Clients Survey, WT=Willingness to Obtain Training in NSSI, CA=Counselor Anxiety Regarding NSSI Survey

The instrument used to measure the independent variable, counselor self-efficacy, was the Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale (CNSAES) which was modified from the Counselor Suicide Assessment Efficacy Survey (CSAES) (Douglas & Morris, 2015). The scores on this instrument ranged from 36 to 80. The actual reported score range was 44.00.

The instrument used to measure the dependent variable, counselor willingness to work with NSSI clients was the Willingness to Work with Clients That Self-Injure Survey. The scores on this instrument ranged from 3 to 15. The actual reported score range was 12.00. The instrument used to measure the dependent variable, counselor willingness to obtain NSSI training was the Willingness to Obtain Training to Understand Self-Injury Survey. The scores on this instrument ranged from 9 to 15. The actual reported score range was 6.00. The instrument used to measure the dependent variable, counselor anxiety about working with NSSI clients was the Counselor Anxiety Regarding NSSI Survey. The scores on this instrument ranged from 3 to 15. The actual reported score range was 12.00.

The remaining independent variables including years of counseling experience and number of hours of NSSI training were measured using the demographic portion of the survey. The reported mean on the variable for years of counseling experience was 8.29 years (SD = 6.90) with a median of 6. The range was 35, the skewness was 1.78, and the kurtosis was 3.11.

The reported mean on the variable for number of hours of NSSI training was 6.98 hours (SD = 14.48) with a median of 3. The range was 100, the skewness was 3.86, and

the kurtosis was 17.50. The outliers in this set were a respondent with 40 hours of NSSI training, three respondents with 60 hours of NSSI training and one respondent with 100 hours of NSSI training. In this case, there will be no elimination of the outliers because the individual responses are actual responses to the question, not random responses.

Table 4 reflects the correlation test that was run using the total score variables for all of the assessments, total years of clinical experience and total number of NSSI training hours to determine if there was a relationship between any of the variables. As shown in Table 4, Counselor Self-Efficacy in Non-suicidal Self-Injury Assessment had a significant relationship with every variable except the survey on Willingness to Obtain Training in NSSI.

Table 4. Correlations Among Study Variables

	1.	2	3	4	5	6
1. CSE	-					
2. WW	.37**	-				
3. WT	.07	.37**	-			
4. CA	-.59**	-.57**	-.08	-		
5. Years of Experience	.31**	.11	-.19*	-.23**	-	
6. Hours of Training	.26**	1.0	-.13	-.08	.25**	-

Note: N=121 **p < .01. *p <.05 CSE=Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale, WW=Willingness to Work with NSSI Clients Survey, WT=Willingness to Obtain Training in NSSI, CA=Counselor Anxiety Regarding NSSI Survey

Years of counseling experience had a significant relationship with every variable except the Willingness to Work With NSSI Clients survey. The strongest relationship appeared to be between the Counselor Anxiety Regarding NSSI survey and the Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale (r = -.59). This relationship makes sense because of the connection between how anxiety impacts the core components of efficacy theory.

Hypothesis Testing and Additional Analyses

This study tested three hypotheses designed to explain the influence of counselor self-efficacy on working with clients engaging in non-suicidal self-injury. The study examined whether counselor self-efficacy (CSE) predicted willingness to work with NSSI clients and willingness to seek out education regarding NSSI. Conversely, this study examined whether counselor anxiety predicted willingness to work with NSSI clients. The alpha level was set at .05.

To test hypothesis 1- Counselor self-efficacy predicts counselor willingness to work with clients engaging in self-injury, with counselor self-efficacy as independent variable and counselor willingness to work with clients engaging in self-injury as dependent variable, linear regression was used. Table 5 introduces the results of the regression of counselor self-efficacy in working with NSSI clients on the willingness to work with NSSI clients by stating the unstandardized beta, the lower limit and upper limit of the confidence interval, the standardized beta, the t test statistic, and the probability value. The hypothesis was that more counselor self-efficacy in working with non-suicidal self-injury clients yields higher willingness to work with clients engaging in self-injury.

The data showed that for every unit change in willingness to work with NSSI clients, there was a .08 unit change in counselor self-efficacy (B = .08; $p < .001$). The adjusted r^2 was .130, which means that 13% of the variance was explained by counselor self-efficacy in working with NSSI clients. The results in Table 5 indicated counselor self-efficacy did significantly predict willingness to work with NSSI clients. Therefore, hypothesis 1 was supported by the data.

Table 5. Regression of CSE on Willingness to Work with NSSI Clients

Variable	B	95% CI		ß	*t*	*p*
		LL	UL			
(Constant)	6.57	[3.94	9.20]		4.95	<.001
CSE	.08	[.05	.12]	.37	4.36	<.001

Note: N=121 CSE=Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale

To test hypothesis 2- Counselor self-efficacy for working with NSSI clients predicts counselor anxiety in working with this population., with counselor self-efficacy as independent variable and counselor anxiety in working with clients engaging in self-injury as dependent variable, linear regression was used. Table 6 discusses the results of the regression of counselor self-efficacy in working with NSSI clients on counselor anxiety regarding NSSI by stating the unstandardized beta, the lower limit and upper limit of the confidence interval, the standardized beta, the t test statistic, and the probability value. The hypothesis was that greater counselor self-efficacy in working with

non-suicidal self-injury clients would yield lower anxiety of counselors in working with clients engaging in self-injury. The data showed a statistically significant relation such that for every unit increase in counselor anxiety regarding NSSI, there was a -.17 unit decrease in counselor self-efficacy (B = -.17; $p < .001$). The adjusted r^2 was .342, which means that 34% of the variance was explained by counselor self-efficacy in working with NSSI clients. The results in Table 6 indicated counselor self-efficacy did significantly predict counselor anxiety regarding NSSI. Therefore, hypothesis 2 was supported by the data.

Table 6. Regression of CSE on Counselor Anxiety Regarding NSSI

Variable	B	95% CI		ß	*t*	*p*
		LL	UL			
(Constant)	18.92	[16.09	21.76]		13.21	<.001
CSE	-.17	[-.21	-.13]	-.59	-7.96	<.001

Note: N=121 CSE=Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale

To test hypothesis 3- Counselor self-efficacy predicts counselor willingness to learn about NSSI treatments, with counselor self-efficacy as independent variable and counselor willingness to learn about NSSI treatments as dependent variable, linear regression was used. Table 7 states the results of the regression of counselor self-efficacy in working with NSSI clients on willingness to obtain NSSI training by stating the unstandardized beta, the lower limit and upper limit of the confidence interval, the

standardized beta, the t test statistic, and the probability value. The hypothesis was that more counselor self-efficacy in working with non-suicidal self-injury clients would yield higher willingness to learn about NSSI treatments. As depicted in Table 7, the data showed a non-significant slope. For every unit change in willingness to obtain NSSI training, there was a .01 unit change in counselor self-efficacy (B = .01; p = .43). The adjusted r^2 was -.003, which means that 0% of the variance was explained by counselor self-efficacy in working with NSSI clients. These results indicated counselor self-efficacy did not significantly predict counselor willingness to obtain NSSI training. Therefore, hypothesis 3 was not supported by the data.

Table 7. Regression of CSE on Willingness to Obtain NSSI Training

Variable	B	95% CI		ß	*t*	*p*
		LL	UL			
(Constant)	13.17	[11.40	14.93]		14.77	<.001
CSE	.01	[-.02	.04]	.07	.79	.43

Note: N=121 CSE=Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale

The next areas to test were the questions including question 1- does the amount of counselor experience (years) predict counselor self-efficacy in working with clients engaging in self-injury? The years of work experience in the counseling field as independent variable and counselor self-efficacy as dependent variable were examined using linear regression. Table 8 explains the results of the regression of years of

counseling experience on counselor self-efficacy in working with NSSI clients by stating the unstandardized beta, the lower limit and upper limit of the confidence interval, the standardized beta, the t test statistic, and the probability value. The data revealed that for every unit change in counselor self-efficacy, there was a .49 unit change in years of counselor experience, which was statistically significant (B = .49; $p < .001$). The adjusted r^2 was .089, which means that 9% of the variance was explained by counselor self-efficacy in working with NSSI clients. The results in Table 8 indicated years of counseling experience did significantly predict counselor self-efficacy in working with clients engaging in self-injury. Therefore, the results indicate, that the more years of counseling experience a person has predicts the amount of counselor self-efficacy in working with NSSI clients.

Table 8. Regression of Years of Counseling Experience on CSE

Variable	B	95% CI		ß	*t*	*p*
		LL	UL			
(Constant)	63.93	[61.04	66.82]		43.73	<.001
Experience	.49	[.22	.75]	.31	3.57	<.001

Note: N=121 CSE=Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale

Question 2 focused on those who have received training, and asked whether the most recent type of NSSI training (e.g. didactic, observation, role play/practice,

multiple types, etc.) affected the level of counselor self-efficacy in working with NSSI clients? To examine whether there were differences in types of NSSI training and its impact on counselor self-efficacy, initially it was proposed that an ANOVA would be used in the data analysis. ANOVA was proposed because it is a statistical method that is designed to determine if there are statistical differences between the means of more than two groups. A variable was created for type of training and identified as the independent variables and counselor self-efficacy as the dependent variable. However, there ended up only being 2 groups instead of 4 groups, didactic and multiple. There were no respondents that only chose role play or only chose observation. They only chose didactic or multiple types of training. Therefore, the data was collapsed into two groups, didactic and multiple, and an independent samples t-test rather than ANOVA was used. Multiple types of training was defined as more than one training type, i.e. didactic and role play, didactic and observation, role play and observation or all three didactic, role play and observation.

Table 9. Independent Samples T-Test Results Comparing Types of Training on CSE

Variable	*t*	*df*	*p*
Equal variances assumed	-.98	72	.33

Note: $n = 74$ CSE= Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale Types of training were Didactic only ($n = 46$) and Multiple ($n = 28$) = more than one training type, i.e. didactic and role play, didactic and observation, role play and observation or all three didactic, role play and observation.

The results in Table 9 indicated that the type of NSSI training did not yield a significant difference with counselor self-efficacy (t = -.98; p = .33; Didactic-M = 71.02; SD = 9.12; Multiple-M = 73.00; SD = 7.14). Therefore, results indicate no impact of type of training on counselor self-efficacy.

An exploratory analysis was conducted on whether any NSSI training vs. no training demonstrated a significant difference on counselor self-efficacy in NSSI, using an independent samples t test. As shown in Table 10, this analysis revealed that there was a significant difference in counselor self-efficacy based on whether there was any NSSI training. Specifically, participants who reported training had higher self-efficacy (M = 71.77; SD = 8.43) than those who had not reported training (M = 61.78; SD = 11.40). Therefore, the data suggests that it does not matter what type of NSSI training the counselor engages in, as long as they engage in training it will increase their self-efficacy.

Table 10. Independent Samples T-Test for whether NSSI training predicts CSE

Variable	*t*	*df*	*p*
Equal variances assumed	5.5	118	<.001

Note: n=120 CSE= Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale Variables were Training or No Training

To test question 3- does the number of NSSI training hours predict counselor self-efficacy in working with NSSI clients with number of NSSI training hours as independent variable and counselor self-efficacy in working with NSSI clients as dependent variable, linear regression was used. Table 11 states the results of the regression of the number of NSSI training hours on counselor self-efficacy in working

with NSSI clients by stating the unstandardized beta, the lower limit and upper limit of the confidence interval, the standardized beta, the t test statistic, and the probability value. The hypothesis was that the more NSSI training hours the counselor completed, the higher the counselor self-efficacy in working with NSSI clients. The analysis showed that for every unit change in number of hours of NSSI training, there was a .20 change in counselor self-efficacy (B = .20; p = .004). The adjusted r^2 was .061, which means that 6% of the variance was explained by the number of hours of NSSI training. The results in Table 11 indicated that number of NSSI training hours completed did significantly predict self-efficacy. Therefore, results indicate there was an impact of hours of NSSI training on counselor self-efficacy in working with NSSI clients.

Table 11. Regression of number of hours of NSSI training on CSE

Variable	B	95% CI LL	95% CI UL	ß	*t*	*p*
(Constant)	66.60	[64.51	68.67]		63.30	<.001
Hours of Training	.20	[.07	.33]	.26	2.97	.004

Note: n=120 CSE= Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale

Summary of Findings

In conclusion, the results indicated that counselor self-efficacy for working with NSSI clients significantly predicted willingness to work with NSSI clients. The results indicated that counselor self-efficacy in working with NSSI clients significantly predicted

counselor anxiety regarding NSSI. The results also indicated that counselor self-efficacy did not significantly predict counselor willingness to obtain NSSI training. The results indicated that years of counseling experience did significantly predict self-efficacy in working with NSSI clients. The results indicated the type of NSSI training (didactic, role play, observation, and multiple) did not yield a significant difference with counselor self-efficacy in working with NSSI clients. However, there was a significant difference between whether there was any NSSI training at all and counselor self-efficacy in working with NSSI clients. Therefore, the data suggests that if counselors do engage in NSSI training to learn more about the topic, that it does not matter what type of training as long as they participate in something, they feel more counselor self-efficacy in working with NSSI clients. The results indicated that the amount of NSSI training hours did significantly predict counselor self-efficacy in working with NSSI clients. Therefore, hypotheses 1 and 2 were supported in this study. Examination of the research questions indicated that years of clinical experience and amount of NSSI training hours significantly predicted counselor self-efficacy in working with NSSI clients. The answer to the third research question indicated that the type of NSSI training did not yield a difference with counselor self-efficacy in working with NSSI. However, additional analysis did indicate that having any kind of NSSI training showed a significant difference with counselor self-efficacy.

CHAPTER FIVE

DISCUSSION

This chapter presents a discussion of the findings from the data analyses. First, an overview of results from the current study. Next is a discussion of the results in relation to previous research. Third, implications for practice are described. Last, the limitations of the study and the recommendations for future research are presented.

Overview of Results

The purpose of this dissertation was to examine how self-efficacy may influence how counselors approach working with non-suicidal self-injury (NSSI) clients. The study examined whether counselor self-efficacy (CSE) predicted willingness to work with NSSI clients and willingness to seek out education regarding NSSI. Conversely, this study examined whether counselor self-efficacy (CSE) predicted counselor anxiety about working with NSSI clients. Participants included 142 licensed masters and doctoral level counselors who worked in a variety of organizational settings (e.g., school, community mental health, private practice), with an adjusted sample size of 121. Their responses to the survey statements provide an understanding of how counselor self-efficacy impacts the treatment of NSSI clients. The results of the study are described below.

The results indicated that counselor self-efficacy in working with NSSI clients did significantly predict willingness to work with NSSI clients. As discussed previously, there are many emotions that are unearthed when working with this population such as shock, sadness, anger, anxiety, frustration and diminished professional self-confidence

(Fleet & Mintz, 2013). These emotions may undermine counselor self-efficacy. However, the data suggests that if counselors engage in NSSI training to learn more about the topic, they feel more self-efficacy when working with NSSI clients regardless of the type of training. In other words, the process of learning is the key, not the format in which the training is presented. Furthermore, when counselors experience opportunities in line with self-efficacy theory such as performance accomplishments (performing the skills), vicarious experience (observing the skills being performed), verbal persuasion (receiving encouragement and support) and physiological states (regulating emotions/arousal), they feel confident in the situations that they find themselves. The respondents in this study tended towards feeling increased efficacy with this population and therefore they reported little hesitation in their willingness to work with NSSI clients. The results support one of Bandura's (1977) theorized outcomes of self-efficacy in which people with higher levels of confidence are more likely to engage in those pursuits rather than avoid. Self-efficacy is also theoretically linked to persistence suggesting that counselors with higher confidence levels may be more resilient in the face of setbacks and disappointments in working with NSSI clients.

The results indicated that greater counselor self-efficacy significantly predicted reduced counselor anxiety regarding NSSI. In the gathered participant responses, it appeared that many of the counselors in this study indicated that they felt generally confident in terms of self-efficacy which in turn predicted a decrease in anxiety in working with non-suicidal self-injury clients. Specifically, counselor self-efficacy predicted lower anxiety in working with NSSI clients despite NSSI behavior being one of

the most challenging clinical behaviors. This was also evidenced by the strongest correlational relationship being between the Counselor Anxiety Regarding NSSI survey and the Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale. Because people tend to avoid situations where they do not feel competent, there is an argument to be made that counselor self-efficacy reduces the anxiety about working with NSSI clients.

The results indicated that counselor self-efficacy did not significantly predict counselor willingness to obtain NSSI training. Despite many respondents indicating that they would seek out training or supervision/consultation, there did not appear to be support in the data that one variable predicted the other. Contrary to self-efficacy theory (Bandura, 1977), confidence does not seem to be a prerequisite for counselors to seek out training in that there does not appear to be any approach or avoidance to NSSI training based on levels of self-efficacy. It is possible that those counselors that received training did so because they were interested in the topic of NSSI or had a perceived a need to seek out training opportunities. It is also possible that the training was compulsory in nature, either required through their workplaces or required through continuing education.

The results indicated that years of counseling experience did significantly predict self-efficacy. The more time counselors spent in clinical work with clients in general, the more likely they were to have counselor self-efficacy in working with NSSI clients. Each year that counselors spend in the field affords them more opportunities for performance and persistence, two of the outcomes of efficacy theory. The results appeared to show these efficacy components leading to counselors developing self-efficacy. The more time

a counselor spends in the field, the more types of clients that they will see. Efficacy can be generalized from one situation to other situations (Bandura, 1977, 1993). Therefore, the time spent in the field feeling confident with other clients may help counselors feel comfortable with NSSI clients.

The results indicated the type of NSSI training (didactic, role play, observation, and multiple types of training) did not yield a significant difference with counselor self-efficacy. However, there was a significant difference between whether there was any NSSI training at all and counselor self-efficacy regarding NSSI. The data suggests that if counselors do engage in NSSI training to learn more about the topic, then the type of training does not matter. As long as counselors participate in some kind of NSSI training, they feel more counselor self-efficacy in working with NSSI clients. The process of learning is the key, so it does not matter the format in which the training is presented.

The results indicated that the amount of NSSI training hours did significantly predict counselor self-efficacy. This appears to relate to the results in the previous question that indicate that the more performance and persistence opportunities there are, the more improvement there will be in counselor self-efficacy in working with NSSI clients. Also, the more time counselors spend learning about the subject, the more efficacious they feel.

Therefore, two of the hypotheses were supported in this study (CSE predicting willingness to work with NSSI clients and CSE predicting counselor anxiety regarding NSSI). Examination of two of the research questions indicated that years of clinical experience and amount of NSSI training hours significantly predicted counselor self-

efficacy in working with this population. Examination of a third research question indicated that there were no significant differences in the type of NSSI training received on counselor self-efficacy with NSSI clients. A follow up analysis did indicate that having any kind of NSSI training vs. no training at all yielded significant difference in counselor self-efficacy was supported. The strongest predictors among all the variables appeared to be CSE and counselor years of experience.

Results in Relation to Previous Studies

Clinicians who treat patients who self-injure have verbalized experiencing negative emotions when treating non-suicidal self-injuring populations. Counselors have reported being emotionally affected by working with NSSI clients. Uncertainty, horror, shock, sadness, anger, anxiety, and frustration were the common words used by counselors to describe their work with NSSI clients (Wieand, 2016). This lack of certainty and emotional upheaval can lead to questioning whether one is competent to treat NSSI clients. Therefore, counselors can experience feelings of reduced self-efficacy when working with NSSI clients. Self-efficacy is partially born out of necessary skill and knowledge. Therefore, training and education would be important factors for counselors when learning how to treat clients engaging in NSSI.

There have been six studies done previously on the topic of counselors' work with NSSI clients and their self-efficacy in working with these clients (Jasper & Morris, 2012, Kool et al., 2014, Ougrin et al., 2013, De Stefano et al., 2012, Taylor, 2014, Reed, 2010). A study by Jasper and Morris (2012) examined self-injury training, exposure and self-efficacy reported that many (78%) of the special educators worked with NSSI students,

but very few received any NSSI training (37%) (Jasper & Morris, 2012). In contrast, the current study by this writer found that the majority of counselors had received NSSI training (61.2%). This suggests that helping professionals are engaging in varying amounts of NSSI training. It does provide a positive sign that counselors are taking advantage of opportunities to gain more understanding in the treatment of NSSI so that they understand how to work with this population.

A study by Kool et al. (2014) with mental health nurses and social workers found that posttest scores were significantly higher than pretest scores on several outcomes including confidence in assessing NSSI and self-efficacy in working with NSSI after a day and a half of training. Similarly, a study by Ougrin et al. (2013) found that after five half-days of training in self-harm assessment and treatment, the doctors, psychologists, social workers and mental health nurses showed improvements in the quality of their self-harm assessments. While the current study did not find that counselor self-efficacy in working with NSSI clients predicted willingness to seek training, the study did find that receiving training in general and the number of hours of training did impact self-efficacy. This suggests that there may be other reasons besides self-efficacy that motivate counselors to obtain training, such as ethical obligations or continuing education requirements. The De Stefano et al. (2012) study found that counseling psychology students had to construct their own working model of NSSI to deal with their lack of NSSI knowledge. The study also found that students reported experiencing strong emotions that needed to be monitored and that their feelings of competence were not improved by their training or supervision (De Stefano et al., 2012). As previously stated,

this current study found the amount of NSSI training hours did predict counselor self-efficacy in working with NSSI clients, but additionally this study found that counselor self-efficacy predicted counselor willingness to work with the NSSI population. Counselors reported feeling like not only did the amount of training impact their self-efficacy, but also the years of counseling experience they had predicted their self-efficacy in working with NSSI clients. This suggests that the more opportunities for training and experience that counselors receive, the more competent they feel when working with this challenging population.

A study by Reed (2010) examined school counselors' perceptions and knowledge in regards to non-suicidal self-injury found that respondents reported a lack of training in NSSI, limited school response plans regarding NSSI and verbalized an expressed desire for more training on NSSI. The current study looked at different forms of training based on self-efficacy theory (didactic, role play, observation or multiple types of training) and found that type of training did not make a difference counselor self-efficacy, but rather whether or not there was NSSI training at all did influence levels of counselor self-efficacy. This suggests that the counselors responding to this study did in fact report higher levels of self-efficacy in relation to having some type of training and affirms the necessity of training for working with this population (Reed, 2010). In a similar vein, the Taylor (2014) study found that school counselors who were trained in treatment of NSSI felt more competent in working with NSSI students, and that in-service training was predictive of greater counseling self-efficacy in treating students with NSSI. Further, it was reported that school counselors had greater self-efficacy when they treated more

NSSI cases. Comparatively, even with both community and school counselors included in this writer's study, the outcomes are similar. More NSSI training hours and more counseling experience predicts counselor self-efficacy in working with NSSI clients, counselor self-efficacy in working with NSSI clients predicts the amount of counselor anxiety in working with NSSI, and counselor self-efficacy in working with NSSI clients predicts willingness to work with NSSI clients. The only difference is that Taylor (2014) found that there was a type of training (in-service) that was predictive of greater self-efficacy, whereas in this current study there was no type of training that demonstrated significant differences. The consistency of these results confirms how important counselor self-efficacy, training, experience and education are in making counselors more comfortable in working with the NSSI population.

There are no studies to date that look at fully licensed school and community counselors and self-efficacy about NSSI and how that self-efficacy in working with NSSI clients may predict willingness to work with NSSI clients, counselor anxiety about working with NSSI clients and willingness to obtain NSSI training. To this writer's knowledge, no research has been conducted to investigate the connections between general counselor self-efficacy for school and community counselors and the delivery of treatment specifically designed for NSSI, yet there is an identified need for specialized knowledge in this area (White Kress, 2003). The gap in the literature emphasizes the need for this current study.

Implications for Practice

There are clinical implications for continued work in this area. The four sources of self-efficacy developed by Bandura (1977), included performance accomplishments, vicarious experience, verbal persuasion and emotional arousal. These core factors provide a roadmap for how to increase counselor self-efficacy when working with NSSI clients. Performance accomplishments allow for counselors to place themselves in situations where they can be successful, and each successive successful experience yields more efficacy. Even when the counselor experiences a failure, if they work towards overcoming that failure through sustained effort in their work with NSSI clients, efficacy can be increased. Once efficacy in one area is increased, counselors can feel efficacy in other areas where they also have felt inadequate. Although in the current study, no single core factor promoting self-efficacy emerged as more influential than any other, training that included any of these factors led to improved self-efficacy in working with NSSI clients. NSSI trainings that include didactic, role-play, or observation experiences may be involved in building counselor confidence in working with this population.

One example of how performance accomplishments could be important for counselors in training would be to have supervised role-playing experiences of working with NSSI clients in an effort to start building confidence in working with this population.

Vicarious experience allows counselors to observe other experienced counselors engage in the feared situation. Once counselors can see that the feared situation can be managed successfully, they see that if they utilize the techniques practiced by the

experienced counselors, they will also be able to be successful. Efficacy is increased, especially when the counselor can see similarities between themselves and the experienced counselor and when counselors are able to see a variety of models working with NSSI clients. Therefore, an example of how vicarious experience could be beneficial for counselors would be for them to observe an experienced counselor working with a client struggling with NSSI behavior either through live demonstration or video.

Verbal persuasion provides situations for counselors to receive positive affirmations from other counselors along with the tools to be able to be effective with NSSI clients. When counselors only receive verbal praise without having an opportunity to work with NSSI clients or the tools to work with them, verbal persuasion will not work to increase self-efficacy, because it will be perceived as disingenuous. Accordingly, an example of how verbal persuasion would be important for counselors could be utilized in supervision where the supervisor acknowledges and reinforces when a counselor makes progress with a NSSI client or properly implements an intervention.

Emotional arousal is identified when counselors experience distress and when the arousal is high, it can trigger a negative impact to performance. If counselors experience anxiety in working with NSSI clients, this emotional arousal could cause continued tension in working with or avoidance of NSSI clients. An example of how emotional arousal would be beneficial could be for the supervisor to help identify anxiety or any other negative feelings about working with NSSI clients. Openly discussing feelings about working with NSSI clients may provide a chance to identify any self-doubt or perceived capacity in working with this population.

Based on the previous research regarding counselors who have expressed frustration, self-blame, worry and anxiety about working with the NSSI population (Fleet & Mintz, 2013), the result of this study is promising. The data shows a willingness to work with NSSI clients when there is elevated counselor self-efficacy. This data shows a reduction in anxiety in working with NSSI clients when counselor self-efficacy was high. The data shows that counselors are availing themselves of training on NSSI and therefore understanding the condition more and ultimately being able to experience more self-efficacy in working with NSSI clients. This is encouraging and stresses the importance of continuing to provide the four factors of self-efficacy in not only curriculums in graduate school, but in webinars and seminars for counselors. This will allow for growth and knowledge and ultimately quality care for NSSI clients who desperately need this help.

Study Limitations

Several limitations should be considered when interpreting the results of this study. Specifically, several of the instruments are self-report surveys and may not be reflective of actual practice or behaviors. The Counselor Non-suicidal Self-Injury Assessment and Efficacy Scale (CNSAES) was modified from the Counselor Suicide Assessment Efficacy Survey (CSAES) (Douglas & Morris, 2015). Due to utilizing a modified version of an existing measure, it is not known to what degree the modifications impacted the original validity evidence. Additionally, the study relied on recollection of the nature of previous training as well the amount of training received. Therefore, no direct assessment on the nature or duration of training was directly assessed. Another limitation for consideration is that participants were primarily female and Caucasian

ethnicity, which limits the generalizability of the results. There were only 121 participants as well, so a limitation would also include that the study could have more participants to make the results even more generalizable. A structural limitation of the surveys is that they all included an option on the Likert scale that allowed the respondent to prefer not to answer.

Recommendations for Future Research

The results of this study provided some insight about the gap that exists in the literature regarding counselor self-efficacy in working with NSSI clients, counselor anxiety and the willingness to treat NSSI clients. As the research suggests, CSE, NSSI training and longevity in the field in terms of years of experience are the best strategies to prepare counselors to work with NSSI clients. Since years of experience play a role in self-efficacy in working with NSSI clients, future studies may want to conduct longitudinal studies with counselors to examine the rate at which self-efficacy in working with NSSI clients increases over time. Additionally, future studies may examine what specific types of interventions counselors are utilizing with NSSI clients that gives them self-efficacy and which approaches may be working better with this population. Such studies might also include the nature of practice, types of clients seen, and theoretical orientations of experienced counselors to see if there are any contextual factors that have influenced their levels of confidence.

Another option for future study would be a pre and post-test of specific types of NSSI training on counselor self-efficacy at the time of the training instead of respondents relying on recall. Additionally, comparative studies on different types of NSSI training

would also provide an ability to find out what counselors experience in the moment instead of reflecting upon past training. Given that Taylor (2014) found a difference in training types, this warrants further investigation in terms of whether how training is delivered influences counselor self-efficacy. Further, expanding the recruitment pool to include psychologists, social workers and other mental health professionals to do a comparison study on the use of the Treatment for Self-Injurious Behaviors (T-SIB), a brief, nine session behavioral intervention specifically developed to treat NSSI among young adults. (Andover et al., 2020; Andover et. al., 2015). This study could determine if counselors, psychologists, social workers and other mental health professionals feel more efficacious using a structured approach to treatment with NSSI clients. Additionally, studies exploring counselor reactions to tapping into pain with their NSSI clients would be fertile ground to conduct future work.

Conclusion

In conclusion, this study tested several hypotheses designed to provide a better understanding of the influence of counselor self-efficacy on counselor anxiety regarding working with NSSI clients, willingness to work with NSSI clients, and willingness to seek out training/education to understand NSSI. There was support for the hypothesis that more counselor self-efficacy predicts more counselor willingness to work with NSSI clients. Counselor self-efficacy in working with NSSI clients did prove to be a statistically significant predictor of counselor anxiety in working with NSSI clients. There was not significant support for the hypothesis that counselor self-efficacy predicts willingness to seek out training in NSSI. Outcomes suggested that the four types of

training based in self-efficacy theory (didactic, role-playing, observational and multiple types) did not predict more counselor self-efficacy in working with NSSI clients. However, just having any kind of NSSI training was a significant predictor of counselor self-efficacy. Additionally, amount of clinical experience and amount of NSSI training hours showed a significant difference with counselor self-efficacy in working with NSSI clients as well.

Self-injury is a significant and concerning phenomenon that counselors in community and school settings encounter in clinical settings (Kerr, Muehlenkamp, & Turner, 2010). The Diagnostic and Statistical Manual of Mental Disorders Text Revision (DSM-V-TR) that was released in March 2022 added a symptom code for non-suicidal self-injury, so making sure that counselors feel confident in their work with this population is important.

This study demonstrates support for the hypotheses that counselor self-efficacy predicts willingness to work with NSSI clients; and predicts whether a counselor will or will not be anxious when working with a NSSI client, which confirms the importance of emphasizing these factors during graduate program curriculums and trainings. Additional studies are needed to gain a broader understanding of counselor self-efficacy in working with NSSI clients and the factors that may improve the quality of treatment and treatment relationships for NSSI clients.

APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

OAKLAND UNIVERSITY

Institutional Review Board

Date: January 7, 2022
Study #: IRB-FY2022-79

Study Title: Counselor self-efficacy, work experience, and educational background as predictors in willingness to treat and seek additional training to work with non-suicidal self-injury clients

Submission Type: Initial
IRB Decision: Exempt

Research Team:
Tobi Russell
Brian Taber

Based on applicable federal regulations, the above referenced study has been determined to be Exempt, with the following categories:
Category 2. (i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording).
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.

Letter and Consent Document:
This letter along with the IRB approved (date-stamped) consent document can be found in Cayuse in the Submission Details page under Letters and Attachments, respectively.
The IRB date stamped consent document must be downloaded and used in consenting participants.
Permission from Research Sites: Please note the following:

- This IRB exemption determination letter means that this research has met one or more of the federal criteria for exemption per 45 CFR 46.104- Exempt Research.
- Before the research is initiated, permission to conduct research at a given site must be obtained from all research locations listed in the IRB submission. You must keep copies of all such permission letters for your files.

- It is the responsibility of each researcher to follow all applicable policies and procedures of any outside institution where the research will be conducted.

Modifications:

Any changes to this exempt project must be reviewed by the IRB prior to initiation by submitting a MODIFICATION request. Do not collect data while the changes are being reviewed. Data collected during this time cannot be used in research.

Record Retention:

Exempt projects will be retained by the IRB office for three years after the last action on the project.

You are approved to start the research. Please retain a copy of this notification for your records.

If you have any questions, please contact the IRB office.

Thank you.
The Oakland University IRB

APPENDIX B

PERMISSION TO MODIFY COUNSELOR SUICIDE ASSESSMENT EFFICACY SURVEY (CSAES)

from: **Tobi Russell** <tyrussel@oakland.edu>
to: douglask@purdue.edu
date: Aug 23, 2019, 8:31 PM
subject: Request for permission to utilize Counselor Suicide Assessment Efficacy Survey in research

Hello,

My name is Tobi Russell and I am a doctoral student in counseling at Oakland University in Rochester Hills, Michigan. I am in the process of reviewing potential measures for my research on counselors to determine if the amount and/or type of education received in non-suicidal self-injury (NSSI) predicts counselor self-efficacy in working with clients engaging in NSSI behavior. I am interested in adapting the survey items from your Counselor Suicide Assessment Efficacy Survey (CSAES) to focus on the topic of NSSI and wondered if you would be willing to share the survey.

Thank you for your consideration,

Tobi Russell LPC
Doctoral Candidate

from: **Douglas, Kerrie** <douglask@purdue.edu>

to: Tobi Russell <tyrussel@oakland.edu>

cc: Carrie Wachter Morris <carrie.wachter@gmail.com>

date: Aug 26, 2019, 10:02 AM

subject: Re: Request for permission to utilize Counselor Suicide Assessment Efficacy Survey in research

Hi Tobi,

Thanks for reaching out. You have our permission to use the CSAES. The items are included in the published article.

https://www.tandfonline.com/doi/full/10.1177/2150137814567471

Best of luck on your dissertation studies!
Kerrie

from: **Tobi Russell** <tyrussel@oakland.edu>

to: "Douglas, Kerrie" <douglask@purdue.edu>

cc: Carrie Wachter Morris <carrie.wachter@gmail.com>

date: Aug 26, 2019, 11:30 PM

subject: Re: Request for permission to utilize Counselor Suicide Assessment Efficacy Survey in research

Thank you so much!

Tobi Russell LPC
Doctoral Candidate

from: **Tobi Russell** <tyrussel@oakland.edu>

to: cawmorris@uncg.edu

date: Aug 23, 2019, 8:33 PM

subject: Request for permission to utilize Counselor Suicide Assessment Efficacy Survey in research

Hello,

My name is Tobi Russell and I am a doctoral student in counseling at Oakland University in Rochester Hills, Michigan. I am in the process of reviewing potential measures for my research on counselors to determine if the amount and/or type of education received in non-suicidal self-injury (NSSI) predicts counselor self-efficacy in working with clients engaging in NSSI behavior. I am interested in adapting the survey items from your Counselor Suicide Assessment Efficacy Survey (CSAES) to focus on the topic of NSSI and wondered if you would be willing to share the survey.

Thank you for your consideration,

Tobi Russell LPC
Doctoral Candidate

from: **Carrie Morris** <cawachte@uncg.edu>

to: Tobi Russell <tyrussel@oakland.edu>

date: Aug 24, 2019, 8:15 AM

subject: Re: Request for permission to utilize Counselor Suicide Assessment Efficacy Survey in research

Yes, you may use it.

Best of luck!
Carrie

from: **Tobi Russell** <tyrussel@oakland.edu>

to: Carrie Morris <cawachte@uncg.edu>

date: Aug 24, 2019, 4:26 PM

subject: Re: Request for permission to utilize Counselor Suicide Assessment Efficacy Survey in research

Thank you so much!

Tobi Russell LPC
Doctoral Candidate

APPENDIX C

SURVEY INSTRUMENTS

DEMOGRAPHIC QUESTIONNAIRE

1. What is your gender?

    - Female
    - Male
    - Transgender
    - Other

2. What is your age?

3. How would you describe your identity?
    - African American/Black
    - Asian American
    - European American/White Caucasian
    - Hispanic/Latino/a
    - Middle Eastern American
    - Mixed/Multiracial/Multiethnic
    - Native American/Alaska Native
    - Native Hawaiian/Other Pacific Islander
    - Other (Please Specify)_____

4. What is your highest level of education?
    - Doctoral Degree
    - Master's Degree

5. Are you licensed to practice in your discipline?
    - Yes
    - No
6. Do you practice counseling in the United States?
    - Yes, if so, please specify what is the primary state you practice in?
    - No
7. Did you graduate from a CACREP-accredited program?
    - Yes
    - No

8. How many years of clinical experience do you have?

9. What is your primary practice setting?
    - Outpatient Clinic
    - Inpatient Clinic
    - Hospital
    - Community Mental Health Clinic
    - Court
    - Partial Hospitalization/Intensive Outpatient Program
    - School
    - Residential Treatment Center
    - College/University Counseling Center
    - VA Medical Center/Outpatient Center
    - Private Practice
    - Other: Please specify_____

10. Have you completed any training on the topic of non-suicidal self-injury?

    - Yes
    - No

11. If you answered yes to question #10, was the most recent type of training you have completed on the topic of non-suicidal self-injury didactic in nature? (i.e. lecture class, lecture seminar, lecture webinar, reading journal articles or books, etc.)

    - Yes
    - No

12. If you answered yes to question #10, was the most recent type of training you have completed on the topic of non-suicidal self-injury role playing in nature? (i.e. practicing the skills learned in the training)

    - Yes
    - No

13. If you answered yes to question #10, was the most recent type of training you have completed on the topic of non-suicidal self-injury observation in nature? (i.e. watching experienced counselors practice skills being taught)

    - Yes
    - No

14. If you answered yes to question #10, did the most recent training you have completed on the topic of non-suicidal self-injury include multiple types of training? (i.e. combination of didactic, role playing, and/or observation)

    - Yes
    - No

15. Approximately how many hours of education/training have you completed on the topic of non-suicidal self-injury?

Modified Counselor Suicide Assessment Efficacy Scale (CSAES)

Counselor Non-suicidal Self-Injury Assessment Efficacy Scale (CNSAES)

0	1	2	3	4	5
Prefer not to answer	Not confident	Slightly confident	Moderately confident	Generally confident	Highly confident

1. I can effectively inquire if a client has had thoughts of non-suicidal self-injury.
2. I can effectively assess whether a client has the means to carry out non-suicidal self-injury.
3. I can effectively inquire whether a client has a non-suicidal self-injury plan.
4. I can effectively counsel a client who has had a history of making non-suicidal self-injury threats, but has not acted on it.
5. I can effectively counsel a client who has previously engaged in non-suicidal self-injury.
6. I can effectively counsel a client who is currently engaging in non-suicidal self-injury.
7. I am able to assess a client's level of risk for non-suicidal self-injury.
8. I am aware of tools and strategies to help prevent non-suicidal self-injury.
9. I can effectively ask a client about his or her drug or alcohol abuse.
10. I can effectively ask a client about his or her history of sexual abuse.
11. I can effectively ask a client about his or her history of mental illness.
12. I can effectively ask a client about whether he or she has low self-worth.
13. I know the point at which I need to break confidentiality when it comes to non-suicidal self-injury.
14. I can appropriately take action if I determine that a client is moderately at risk for non-suicidal self-injury.
15. I actively use strategies to treat non-suicidal self-injury with clients.
16. I can appropriately intervene if a client is at severe, imminent risk for non-suicidal self-injury.

Willingness Survey
NSSI-refers to non-suicidal self-injury

0	1	2	3	4	5
Prefer not to answer	Strongly disagree	Disagree	Unsure	Agree	Strongly agree

Willingness to work with clients that self-injure

1. If I was assigned a client that was engaging in self-injury, I would be willing to treat them

2. I typically refer clients that self-injure to another clinician.
   *REVERSE SCORE THIS ITEM.

3. I would be willing to work with clients engaging in NSSI whenever I had the opportunity

Willingness to obtain training to understand self-injury

1. I am willing to seek training to improve my work with clients that self-injure

2. I am willing to do my own studying on how to improve my work with clients that self-injure

3. I am willing to seek out supervision or consultation in order to improve my work with clients that self-injure.

Counselor Anxiety Regarding NSSI
NSSI-refers to non-suicidal self-injury

0	1	2	3	4	5
Prefer not to answer	Strongly disagree	Disagree	Unsure	Agree	Strongly agree

1. I am willing to seek out supervision or consultation in order to improve my work with clients that self-injure.

2. I am afraid that I may be providing the wrong standard of care to clients that self-injure.

3. I feel anxious when working with clients that self-injure more so than when working with other clients.

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