

A School Counseling Program's Accountable Response to Adolescent Self-Mutilation

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Abstract

Self-mutilation is a prevalent concern, particularly for adolescents. School counseling programs can play an important role in the recognition, prevention, and intervention of self-mutilation. This study reviews current literature on adolescent self-mutilation, prevention, and treatment suggestions offered school counseling program personnel. Also included is a brief review of school counseling program accountability literature followed by suggestions for school counseling program implementation of prevention and intervention strategies which incorporate accountability components in order to further the research on school counseling programmatic best practices for adolescent self-mutilation.

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Self-mutilation is a prevalent problem among adolescents (Alderman, 2004; Froeschle & Moyer, 2004; Kress, Gibson, & Reynolds, 2004; Nock & Prinstein, 2004; Ross & Heath, 2002; Zila & Kiselica, 2001), and school counselors are in a unique position to be among the first professionals to see a student engaged in self-mutilation (Froeschle & Moyer). However, there is a paucity of research, particularly in the school counseling literature that addresses the growing problem of adolescent self-mutilation. Although anywhere from 14% (Ross & Heath) to almost 40% (Lloyd, 1997, as cited in Froeschle & Moyer) of high school students sampled have engaged in self-mutilation at least once, the American School Counselor Association (ASCA) has yet to issue a position statement regarding the role of the school counselor in responding to the needs of students engaged in self-mutilation. Some researchers (Froeschle & Moyer; Kress et al.) performed literature reviews from non-school counseling sources in order to surmise prevention and intervention ideas for school counseling programs. However, because there is such a lack of direct research from school counseling programs, it is yet unclear whether or not these suggested interventions are the most potent. It seems critical for school counseling programs, particularly in the context of the great push for school counselor program accountability measures (Campbell & Robinson, 1990; Dahir & Stone, 2003; Fairchild & Seeley, 1995; Gysbers, 2004; Isaacs, 2003; Myrick, 2003), to perform direct research in order to illuminate best practices.

The purpose of this article is three-fold. First, a brief overview of the literature on self-mutilation and the postulated suggestions for the school counseling programs gleaned from existing literature reviews will be outlined. Second, a brief overview of the

call for school counseling program research-based accountability will be described. Finally, the self-mutilation literature and the accountability literature will be synthesized into suggestion for school counseling program intervention and prevention strategies and specific methods for school counseling programs to document the effectiveness of such interventions.

Overview of Self-Mutilation Literature

Favazza and Rosenthal (1998) described three types of self-mutilation including stereotypic, which is most often observed in institutionalized patients with mental retardation; major, which generally involves psychotic patients who destroy a major body part; and the most common form, moderate. This article addresses moderate self-mutilation, which is repetitive, intermittent, non life-threatening, and appears in many forms. The majority engaged in moderate self-mutilation cut their wrists and forearms, yet others reported cuts to other areas of the body (e.g., legs, abdomen, breasts, and genitals), while still others burn their skin, impede the healing of wounds, or constrict air passages (Zila & Kiselica, 2001).

Nock and Prinstein (2004) cited prevalence figures of self-mutilation in adolescence as 14%-39% in the community and 40%-61% in psychiatric inpatient settings. Zila and Kiselica (2001) cited many authors in reporting the typical self-mutilation as “female, adolescent or young adult, single, usually from a middle- to upper-middle class family, and intelligent” (p.46). There appears to be no singular definition of moderate self-mutilation. Indeed, Zila and Kiselica reported that over 30 different terms have been used to describe self-mutilation along with multiple definitions for each term. Froeschle and Moyer (2004) offered the following: “self-mutilation...refers

to those who seek out pain and blood in order to relieve emotional pain” (p. 231). One of the definitions relayed by Zila and Kiselica was “an act that is done to oneself, performed by oneself, physically violent, not suicidal, and intentional and purposeful” (p. 47).

Froeschle and Moyer (2004) debunked a list of common myths about self-mutilation. These include that self-mutilation is used to manipulate others, self-mutilation is synonymous with suicide, those who engage in self-mutilation are dangerous and will harm others, and those who engage in self-mutilation do so for the attention. Froeschle and Moyer pointed toward research revealing that those who perform self-mutilation are actually attempting to mask emotional pain and do not wish to die. Instead, those performing self-mutilation are engaged in a ritual most often acted out in isolation which is designed to find some empowerment. Additionally, they go to great lengths to conceal their injuries and scars and present themselves as uninjured. There remains a paucity of research on moderate self-mutilation because much of the past research focused on hospital samples, thus neglecting those never hospitalized. Furthermore, those hospitalized for self-harm were often admitted for suicide attempts, and many researchers intermingled those engaged in ritualistic self-mutilation with suicidal patients in their data.

Nock and Prinstein (2004) asserted most previous investigations focused on the psychosocial constructs related to self-mutilation. They cited such constructs including “depression, anxiety, post-traumatic stress, anger, aggressiveness, impulsiveness, loneliness, social isolation, and hopelessness” (p. 885). Indeed, Hawton, Kingsbury, Steinhardt, James, and Fagg (1999) specifically investigated the role of psychological

factors in the repetition of self-mutilation in adolescents. They revealed significant depression and hopelessness, low self-concept, and high trait anger; yet depression was an “overwhelming factor” (p. 375).

Webb (2002) likewise investigated psychological factors associated with self-mutilation and found that after controlling for depression, impulsivity, lack of problem-solving skills, family dysfunction, and an internal locus of control were prevalent in self-mutilation. Webb also investigated psychosocial factors that included family conflict in combination with external pressures. The nature of school stresses was psychosocial, including bullying, rather than academic. Furthermore, Webb reported personal identity difficulties including sexuality and personal violation, family illness and conflict, and pressure to achieve were also contributing factors. In addition, Hawton, Rodham, Evans, and Weatherall (2002) found that self harm by friends and family members contributed to adolescent self-mutilation. However, both the Hawton et al. and the Webb study did not distinguish suicidal adolescents from those performing ritualistic self-mutilation.

Nock and Prinstein (2004) were interested in a functional approach that could reveal more of the causes and conditions of self-mutilation rather than utilizing the syndromal approach. After administering the Functional Assessment of Self-Mutilation to 108 adolescents in a New England adolescent psychiatric inpatient unit, the researchers confirmed that self-mutilation was pervasive; onset begins during early adolescence, and occurs via multiple methods. Further, Nock and Prinstein revealed that the primary purpose of most adolescent self-mutilation is the “regulation (i.e., both decrease and increase) of emotional or physiological experience” and “social

reinforcement was endorsed by a significant portion of adolescent self-mutilators and is considered a significant factor in influencing the occurrence” (p. 889). This challenges one of Froeschle and Moyer’s (2004) conclusions of masking pain, but like many studies, Nock and Prinstein utilized a hospital sample in their investigation, so results should be reviewed with caution. Very few studies with non-hospital samples are represented in the literature. This is problematic because most cases may not be represented in hospital reporting.

Rodham, Hawton, and Evans (2004) reported the majority of self-mutilation takes place in the community that does not result in hospitalization; as a result they surveyed students in 41 schools in England. Of the 5,737 participants, 6.9% reported self-mutilation that met the study criteria. Rodham et al. found that self-cutting was by far the most prevalent form of self-mutilation with self-poisoning following. Girls engaged in self-mutilation, including self-cutting, much more than boys. The most common reasons for self-mutilation included “to get relief from a terrible state of mind, to die, to punish themselves, and to show how desperate they were feeling” (p. 4). Clearly, Rodham et al. findings did not distinguish suicidal adolescents from ritualistic self-mutilation. In fact, less than 1% of self-cutters reported wanting to die, while the self-poisoners were significantly more likely to report so. Rodham et al. further revealed the impulsivity related to self-mutilation with the majority of adolescents reporting less than an hour of premeditation prior to self-mutilation.

Ross and Heath (2002) likewise studied the frequency of self-mutilation in a community sample of adolescents. They found that almost 14% of the 440 high school students they studied reported engaging in self-mutilation at some time. Again, self-

cutting was the method most frequently used, and self-mutilation was highly correlated with symptoms of depression and anxiety. They confirmed the already well-documented fact that girls engaged in self-mutilation significantly more than boys (Zila & Kiselica, 2001) and found no significant differences in the rates of self-mutilation between those living in urban and suburban environments.

Goddard, Subotsky, and Fombonne (1996) investigated demographics in relation to adolescent self-mutilation. Researchers utilized a hospital sample of 100 adolescents in England. They discovered the referral rate for Black adolescents was proportionate to the community composition. However, Black participants reported more social stress than other adolescents. Finally, both Black and White adolescents were comparable for all the following characteristics: background socio-demographic variables, circumstances of self-mutilation and outcome, and psychiatric symptoms. Nevertheless, Goddard et al. did not distinguish adolescents hospitalized for suicide attempts from those engaged in self-mutilation. Again, researchers caution against relying on data from hospital samples as the majority have been admitted for suicide attempts (Rodham, Hawton, & Evans, 2004).

Froeschle and Moyer (2004) performed a literature review that offered various self-mutilation definitions, gender differences, a profile, and suggestions specifically for school counselors in more accurate assessment, prevention, and confidentiality. Froeschle and Moyers found that self-mutilation was co-morbid with previous abuse, eating disorders, drug and alcohol abuse, and above-average intelligence. They compiled many risk factors including loss of a parent, conflicts with peers, sexual abuse, another self-mutilating family member, witnessing family violence, recent loss, inability

to form intimate relationships, and impulse disorders. Froeschle and Moyers reported research indicating self-mutilation as a means to alleviate unexpressed rage, stress, depression, rejection, alienation, and numbness.

Another literature review, which contained 20 studies attempted to compare interventions for adolescent self-mutilation, revealed “insufficient evidence on which to make firm recommendations about the most effective forms of treatment for patients who have recently deliberately harmed themselves” (Hawton et al., 1998, p. 5). One of the challenges these researchers faced was, again, the amalgamation of patients having suicide attempts with those engaged in ritualistic self-mutilation. Throughout this literature review, including the previous literature reviews contained within, researchers have attempted to propose some explanation of self-mutilation along with possible implications or suggestions for practice. Some of these suggestions follow.

Overview of School Counselor Accountability Literature

School counselors perform a myriad of roles (Erford, 2003) and are in a unique position to be the first professionals to intervene with students engaged in self-mutilation (Kress et al., 2004). Yet there is no research revealing the current best practices for school counselors responding to students engaged in self-mutilation. Even ASCA remains silent with regard to the role of the school counselor in working with students engaged in self-mutilation. Nevertheless school counselors have an ethical responsibility to utilize best practices in all counseling domains (ASCA, 2004a) and to “demonstrate the effectiveness of the school counseling program in measurable terms” (ASCA, 2004b, p. 4). School counseling researchers have reported that school counselors have not been held to the same high standards of accountability as others in

the education profession (Dahir & Stone, 2003), yet cite good reasons for such accountability (Campbell & Robinson, 1990; Dahir & Stone; Fairchild & Seeley, 1995; Gysbers, 2004; Isaacs, 2003; Myrick, 2003). In fact, Gysbers documented the ongoing call for school counseling accountability since the inception of the profession in 1920.

Investigators cited several arguments for performing research in school counseling including improving overall services, offering evidence of effectiveness, and enhancing the professional image (Fairchild & Seeley, 1995). Isaacs (2003) discussed the necessity of school counselor accountability as a profession-saving action as it relates to the No Child Left Behind legislation and the current high-stakes testing environment. Erford (2003) addressed one of the main reasons accountability is a key issue for school counselors today when he wrote about the profession overall,

...much more evidence is needed to document effectiveness and establish school counseling as an accountable profession. The transformed professional school counselors understands the vital nature of this mission and establishes collaborative partnerships to conduct field-based action research and outcomes evaluation to benefit students and the profession” (p. 435).

Several authors have discussed some of the main barriers of research including deficiency in research methods and strategies (Fairchild & Seeley, 1995), and lack of time, knowledge, and skills (Myrick, 2003). Counselors may also label such work as nonessential, preferring to rely on their own instincts as a gauge for effectiveness (Myrick, 2003). Myrick also discussed counselor-reported fears, including the fear of being judged overall and the fear of being found incompetent. Moreover, many

researchers have attempted to overcome some barriers to research by proposing methods designed to aid school counselors in designing and implementing research. Such suggestions begin with counselor training (Campbell & Robinson, 1990) and others address those school counselors already in the field (Dahir & Stone, 2003; Fairchild & Seeley; Isaacs, 2003; Myrick).

Isaacs (2003) asserted to become a research-based program does not necessarily entail measuring everything a counselor does in a given day. Rather, accountability research begins with defining and articulating a measurable goal, naming stakeholders, outlining actions to reach that goal, and listing specific measurements to gauge growth (Dahir & Stone, 2003). As previously mentioned, school counselors were offered suggestions for best practices with regard to self-mutilation gleaned from other professionals (Froeschle & Moyer, 2004; Kress et al., 2004). As a general practice, school counselors may have heeded this advice solely on faith that they were serving students engaged in self-mutilation. This is no longer acceptable. Now more than ever, school counselors have an obligation to heed those suggestions while documenting the impact interventions have on those they serve. Suggestions and examples for accountability when providing services for students engaged in self-mutilation follows.

Self-Mutilation Prevention and Intervention

School counseling programs have been offered many suggestions for preventing, treating, and referring students engaged in self-mutilation. School counseling program leaders may first wish to perform a needs assessment to illuminate those issues most prevalent for students and faculty (Fairchild & Seeley, 1995). Programs may decide to specifically look for those risk factors associated with self-mutilation in designing

psychoeducational small group interventions. Froeschle and Moyer (2004) and Kress et al. (2004) suggested the use of small groups, as these allow for clear, measurable goals that school counselors may use for accountability. For example, a group focusing on self esteem may list learning objectives such as “Students will:

1. Describe the self-images and thoughts of depressed moods.
2. Explain the link between self-esteem and moods.
3. Identify techniques to improve self-esteem and control depression and emotional spirals” (Eggert, Nicholas, & Owen, 1995, p. 212).

School counseling programs that identify and provide assessments for each group will be able to quantify the effectiveness of each group session. Moreover, group leaders may consider giving pre- and post-group screenings for depression and anxiety in order to learn whether or not groups were effective overall in addressing the deeper emotional needs of those prone to self-mutilation.

Another recommendation of Froeschle and Moyer (2004) and Kress et al. (2004) was to dispel myths regarding self-mutilation. Accountability for this action may simply involve a pre- and post-test for a teacher in-service training, a health class, or a PTA meeting. Pre-tests could offer faculty, students, and parents a simple true or false checklist outlining some of the common facts and myths of self-mutilation. Once completed, the checklist could be used as the teaching tool itself. Then pre- and post-test figures should be recorded and maintained for the school counseling program records and reported to administration.

A final suggestion for research accountability comes from Milia’s (1996) account. Milia documented her individual work with an adolescent engaged in self-mutilation.

Milia practiced art therapy and created a case study from her experience. Indeed, many advocate the use of personal case notes (Baker, 2000; Erford, 2004; Fairchild & Seeley, 1995). School counseling programs interested in advancing the research on treating students engaged in self-mutilation may wish to compile case notes into actual case conceptualizations or case studies for publication. Of course, any distinguishable information about the student must be altered.

A qualitative case study will not be transferable to the general population, but as professionals often on the first line of identification of self-mutilation, school counseling programs must engage in the professional dialogue regarding treatment experiences. No longer should school counseling programs borrow from other professional literature in lieu of its own. Ethically, school counseling programs should create a base of literature from which to design further study and replication.

Recommendations

In their research, Rodham et al. (2004) revealed that there is often little time for intervention in self-mutilation and as such suggested that prevention focus on relieving stresses and difficulties that led to self-mutilation. Additionally, adolescents should be aided in learning alternative problem-solving strategies and identifying sources of help through school-based programs (Rodham et al.). Hawton, Rodham et al. (2002) likewise endorsed school-based “mental health initiatives” (p. 1207), including psychoeducation and screening services to address adolescent self-mutilation.

In addition, some researchers endorsed utilizing behavioral approaches when treating self-mutilation. For example, Hawton, Kingsbury et al. (1999) specified a cognitive behavioral approach including the adoption of problem-solving skills. Nock and

Prinstein (2004) suggested that clinicians further identify the specific function of self-mutilation and provide diverse treatment approaches designed to replace self-mutilation with functionally comparable behaviors.

Webb (2002) reported that few studies have focused on protective factors, but that family cohesiveness and intactness have been identified as protection against self-mutilation. Implications for practice included the development of a profile from which to identify adolescents in the pre-act stage (Webb). Another well-endorsed intervention is to simply address questions directly to an adolescent engaged in self-mutilation, thus demonstrating a willingness to offer empathy and help the person find alternative actions (Alderman, 2004; Froeschle & Moyer, 2004).

Malia (1996) offered a rationale behind utilizing art therapy to treat self-mutilation. Malia included a case study that documented the therapeutic actions apparent in the process. Malia reported that the client was able to create representations of her physical body to mutilate, including paintings and clay figures, and through this medium found expression for unarticulated feelings of aggression and anger. Malia reported witnessing a clear release of client tension after sessions and proposed this form of therapy useful for processing traumatic memories. As previously reported, trauma such as sexual abuse, is a common characteristic in self-mutilation. Of course, professionals must practice within the bounds of competence (American Counseling Association, 1995; ASCA, 2004a) and should not practice art therapy without appropriate training. Yet many of the recommendations above may be utilized in a school counseling programmatic setting.

Recommendations for School Counselors

Froeschle and Moyer (2004) encouraged school counselors to first bring awareness and recognition to this problem of self-mutilation. By dispelling erroneous myths, parents and other professionals will be more knowledgeable if and when they encounter self-mutilation. Kress et al.(2004) specifically suggested providing information to faculty during in-services, parents during parent group meetings, and students in health classes. Teachers should be well informed about how to identify a student who may be engaged in self-mutilation and know some appropriate ways to communicate with such a student (Kress et al.).

Further suggestions offered by Froeschle and Moyer (2004) included gaining knowledge of and collaboration with professionals and community resources that specialize in self-mutilation. They also advocate a systemic approach to addressing self-mutilation through increased overall access to school counseling professionals and established individual and group counseling strategies that assist with self-mutilation along with parallel issues of loss, anger, grief, self-esteem, divorce, and assertiveness training. Another important aspect of prevention and intervention is dispelling the myths for all school professionals through verbalizing the act of self-mutilation. Additionally, as required by law, suspected child abuse must be appropriately reported and care should be taken with parent notification.

Confidentiality is a particularly challenging aspect of counseling a student engaged in self-mutilation (Froeschle & Moyer, 2004). Because those who engage in self-mutilation are already alienated from others, it seems critical to maintain that client's confidence. However, the California Tarasoff ruling created liability for professionals

who are aware of potential physical harm yet do not report such danger. Parents may feel entitled to more knowledge of the counseling process than the school counselor or client may feel comfortable disclosing. Ultimately, Froeschle and Moyer recommended that school counselors be familiar with state laws, clarify confidentiality policies, maintain objective and accurate records, consult with colleagues, keep liability coverage, and always practice within the boundaries of competence.

Kress et al. (2004) also offered strategies to address self-mutilation specifically for the school counselor. With regard to intervention, Kress et al. encouraged school counselors to build a strong relationship with a student engaged in self-mutilation, which includes addressing the act of self-mutilation in a non-threatening way; creating a safety plan outlining triggers, cues, and safe alternatives; increasing alternative coping skills; and fostering the ability to identify and express emotions. School counselors should also stress the importance of not bringing self-mutilation instruments to school, lest they be viewed as weapons. School counselors must act as referral agents so that adolescents engaged in self-mutilation will have appropriate care and counseling in the community (Kress et al.). School counseling programs should address prevention and intervention, not diagnosis and treatment (Baker, 2000). School counselors must be knowledgeable of referral sources, including treatment options and availability (Kress et al.).

Kress et al. (2004) also discussed a school counseling programmatic approach to prevention. Because of their knowledge of co-morbid conditions and precursors to self-mutilation, school counselors may identify students at risk and provide individual or group counseling to enable healthy expression of stress and emotions. Psychoeducational groups designed to address issues such as impulse control, anger

management, self-efficacy, and potent communication could help prevent self-mutilation. Finally, Kress et al. strongly suggest that any school counselor working with students engaged in self-mutilation constantly monitor their own personal reactions to the students. They advise that “ongoing consultation and supervision can help in ensuring that counselors maintain an objective perspective when working with this population” (Kress et al., 2004, p. 200).

Conclusion

Self-mutilation is a prevailing challenge among adolescents. As the age of onset primarily occurs during early adolescence, school counseling programs can have a dramatic impact in educating school personnel, students, and families as well as providing critical prevention and intervention services for those most at-risk for self-mutilation. Many researchers offered suggestions for successful treatment of adolescent self-mutilation; however no primary research has been performed involving school counseling programs. Furthermore, there exists a great push toward overall increased accountability in the school counseling profession. Therefore, school counseling programs must take the lead in designing accountability measures in conjunction with adolescent self-mutilation. It seems critical for school counseling programs to contribute to the direct research on adolescent self-mutilation rather than continue to borrow from other fields and hope these borrowed methods are effective. For it is only through direct research that school counseling programs can begin to feel confident that they indeed provide valuable and potent services.

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