

Clinical Work With Clients Who Self-Injure: A Descriptive Study



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Nonsuicidal self-injury (NSSI) is a common clinical concern. We surveyed a national sample of 94 licensed clinicians to better understand their work with clients who self-injure. Our data revealed that over the past year, 95.7% ($n = 90$) of the sample reported working with at least one client who self-injured. Thirty-six clinicians (38%) reported that most or all of their clients who self-injured were adolescents, 61 (64.9%) reported that most or all clients who self-injured were female, and 43 (45.7%) reported that most or all clients who self-injured engaged in cutting as the primary NSSI method. About 35% ($n = 33$) of the clinicians in our sample indicated they have never asked clients who self-injured about their online activity related to NSSI. The majority of our participants ($n = 78$; 83%) supported the notion that NSSI could be an addictive behavior for some clients and less than half ($n = 42$; 44.7%) received NSSI training in their graduate coursework.

Keywords: nonsuicidal self-injury, NSSI, licensed clinicians, training, behavioral addiction

Nonsuicidal self-injury (NSSI) is a complex phenomenon. Favazza (1998) defined NSSI as “the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent” (p. 260). The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association [APA], 2013) noted that NSSI is intentional and self-inflicted body damage that is not socially sanctioned (e.g., piercings or tattoos) and lacks suicidal intent. The fact that NSSI is intentional and direct distinguishes it from unplanned or indirect forms of self-harm such as disordered eating or substance abuse (Favazza, 1998; Walsh, 2012). Furthermore, although a relationship exists, NSSI is distinct from suicide attempts in that it is a means of seeking relief and coping, thereby sustaining rather than ending one’s life (Walsh, 2012; Wester & Trepal, 2017). NSSI has been conceptualized as a behavioral addiction (Buser & Buser, 2013) given that some clients demonstrate a loss of control over NSSI, continued engagement despite negative consequences, craving to engage in NSSI, and compulsivity, which are hallmarks of addiction. Also, researchers have found evidence for NSSI contagion, in which the behavior is imitated by others in a specific community (Walsh, 2012; Walsh & Rosen, 1985). Given these complexities, it is imperative that clinicians are adequately trained to assess and treat NSSI.

In light of previously published prevalence rates, it is likely that most clinicians will work with clients who self-injure at some point in their careers. Indeed, 21%–80% of inpatient clients and 22%–40% of outpatient clients have reported engagement in self-injurious behavior (Wester & Trepal, 2017). Moreover, in a national sample of 74 clinical practitioners, 60 (81%) reported working with clients who self-injured (Trepal & Wester, 2007), and among 443 school counselors, 357 (81%) reported working with at least one student engaged in self-injury (Roberts-Dobie & Donatelle, 2007). Much has changed, however, in the social landscape related to self-injury, including the popularity of sharing NSSI images online; television shows, movies, and songs depicting NSSI; and celebrities disclosing NSSI behavior. Thus, we sought to investigate licensed clinicians’ experiences working with clients who self-injure to provide updated information and better inform the profession of counseling.

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Terminology and Prevalence of NSSI

NSSI is not a new abnormal behavior. Indeed, it was documented in the gospel account of Mark written between A.D. 55 and 65, in which the author described a man cutting himself with stones (Mark 5:5; *NIV Life Application Study Bible*, 1984). Self-injurious behavior has been labeled *self-mutilation*, *self-harm*, *deliberate self-harm*, *parasuicide*, *cutting*, and *non-suicidal self-directed violence* (Wester & Trepal, 2017). In this paper, we use the term *nonsuicidal self-injury* (NSSI) as it is currently listed as the proposed diagnosis in the *DSM-5* (Section III, Conditions for Further Study; APA, 2013).

Current prevalence rates indicate that NSSI affects a substantial portion of the population, particularly female adolescents (Nock, 2009; Wester & Trepal, 2017). For example, in a study of 665 adolescents, researchers determined that 8% engaged in NSSI at some point in their lives, which included 9% of the females in the sample and 6.7% of the males (Barrocas et al., 2012). Furthermore, Doyle and colleagues (2017) surveyed adolescents in Ireland and found that 12% had engaged in NSSI, the majority (72.8%) of which were female. Moreover, the examination of data from emergency room visits among youth in the United States (10–24 years of age) indicated a rise in non-fatal self-inflicted injury among females (with and without suicidal intent) from 2001 to 2015 (Mercado et al., 2017). Specifically, self-inflicted injuries with a sharp object rose from 261 incidents in 2001 to 1,021 incidents in 2015 (Mercado et al., 2017). Along with adolescent populations, NSSI is a growing concern among young adults. Wester et al. (2018) examined NSSI among three cohorts of freshman college students and found that lifetime NSSI increased from 16% in the 2008 cohort to 45% in the 2015 cohort. Additionally, current NSSI increased from 2.6% in the 2008 cohort to 19.4% in the 2015 cohort (Wester et al., 2018).

Motives for NSSI

The function of NSSI can be challenging to comprehend among those who do not engage in the behavior. Criterion B in the proposed criteria for NSSI Disorder in the *DSM-5* (APA, 2013) highlighted three potential functions: (a) to relieve negative feelings and cognitions, (b) to address relational difficulties, and (c) to stimulate positive feelings. Indeed, emotion regulation is a primary motivation for NSSI (Nock, 2009). Among 108 adolescents in inpatient treatment who engaged in self-injurious thoughts or behaviors, Nock and Prinstein (2004) found 52.9% engaged in NSSI to relieve negative emotions, 34.1% engaged to feel something, and 30.6% engaged as a form of self-punishment. Doyle et al. (2017) found 79% of adolescents who engaged in NSSI did so to find relief from negative emotions or cognitions, 38% engaged to punish themselves, and 35% sought to communicate the extent of their distress. In light of the many means of emotion regulation that exist, Nock (2009) identified three reasons why some individuals choose NSSI: (a) as a result of social learning from the media, friends, and family; (b) as a form of punishment via self-directed abuse; and (c) as a means of social signaling, or communicating with others (particularly when other forms of communication were ineffective). Engaging in NSSI may be a more accessible, affordable, and easy-to-hide method of emotion regulation compared to other strategies such as substance abuse (Nock, 2009).

NSSI Social Contagion

One important consideration related to NSSI is *social contagion*, or the engagement in a behavior by at least two people in a group within 24 hours (Jarvi et al., 2013; Walsh, 2012; Walsh & Rosen, 1985; Wester & Trepal, 2017). Individuals can become exposed to NSSI through peers, family members, media, and song lyrics, which contribute to social learning (Jarvi et al., 2013; Nock, 2009) and potentially sensationalize the behavior (Walsh, 2012). In a review of the literature, researchers found 16 studies supporting the association between social contagion and NSSI (Jarvi et al., 2013). In a seminal work, Walsh and Rosen (1985) studied the behavior of 25 adolescents in treatment for

various mental health diagnoses for one year. The researchers analyzed the frequency and timing of particular behaviors, including NSSI, and found significant clustering of self-injurious incidents, supporting contagion for NSSI among the group. Furthermore, researchers have found that a small portion of those who engage in NSSI do so to influence others (e.g., get the attention of a particular person, manipulate others, or elicit care; Doyle et al., 2017; Nock, 2008).

In light of the ubiquitous nature of the internet, NSSI social contagion may occur among online groups, as well as those that exist offline. Walsh (2012) noted that factors contributing to social contagion offline can also occur online within the context of social networking sites, message boards, chat rooms, and YouTube. Researchers have confirmed the prevalence of NSSI images and videos online. Lewis and colleagues (2011) investigated NSSI videos on YouTube and found that the top 100 NSSI videos were viewed over 2 million times. Miguel et al. (2017) found 770 NSSI-related images on three social media platforms in a 6-month period using one search term (#cutting). The researchers classified 59.5% of the images as graphic in nature (Miguel et al., 2017). Although there are potential benefits of online communication about NSSI, such as encouraging help-seeking and support, online NSSI-related images and videos pose risks as well. Lewis et al. (2012) noted that online mediums may provide reinforcement for NSSI, provide tips and strategies (such as first aid considerations), and trigger urges among users to engage in NSSI.

NSSI as a Behavioral Addiction

Given its seemingly compulsive nature, some authors have proposed the conceptualization of NSSI as a behavioral addiction (Buser & Buser, 2013; Davis & Lewis, 2019). Indeed, Buser and Buser (2013) posited that for some individuals, NSSI reflects the commonly used criteria for addiction, including compulsivity, loss of control, continuation despite negative consequences, relief from negative emotions, and tolerance. Specifically, tolerance to NSSI can develop as a result of frequent activation of the endogenous opioid system, to which the individual becomes less sensitive (Buser & Buser, 2013; Walsh, 2012). Tolerance among those who self-injure may manifest as increased frequency of NSSI, increased severity of skin tissue damage, or the use of additional NSSI methods (Wester & Trepal, 2017). In the content analysis of 500 posts on NSSI online message boards, Davis and Lewis (2019) determined six themes that underscored the addictive nature of NSSI: urge/obsession, relapse, can't/don't want to stop, coping mechanism, hiding shame, and getting worse/not enough. These themes indicate that some individuals who engage in NSSI experience cravings, a loss of control, urges, and relapse—all common features of addictive behaviors (American Society of Addiction Medicine, 2019). Given the growing acceptance of behavioral addictions, as evidenced by recent changes and additions to both the *DSM-5* (APA, 2013) and the *International Classification of Diseases (ICD-11)* (World Health Organization, 2018), it is important to assess whether clinicians working with clients who self-injure conceptualize the behavior as addictive.

Purpose of the Study

Although some researchers have investigated the experience of clinicians addressing clients who self-injure (Roberts-Dobie & Donatelle, 2007; Trepal & Wester, 2007), the growing prevalence of NSSI (Mercado et al., 2017; Wester et al., 2018) warrants updated information. Therefore, we designed the current study to explore licensed clinicians' experiences with clients who engage in self-injurious behaviors. Specifically, we sought to examine the frequency of addressing NSSI in clinical work, characteristics of clients who self-injure, NSSI assessment practices, the role of the internet in NSSI, clinicians' beliefs pertaining to NSSI, and clinical training and competence.

Method

Sample

Our sample consisted of 94 licensed clinicians in the United States. Participants ranged in age from 26 to 70 years old with a mean age of 45 ($SD = 11.06$). Eighty (85.1%) participants identified as White, six (6.4%) as Black/African American, three (3.2%) as biracial/multiracial, three (3.2%) as other, and two (2.1%) as Latino(a)/Hispanic. With regard to gender, 79 (84%) participants identified as female, 13 (13.8%) as male, one (1.1%) as transgender, and one (1.1%) as other. Of the 94 participants, 82 (87.2%) identified as heterosexual, five (5.3%) as bisexual, three (3.2%) as queer, two (2.1%) as lesbian, and one (1.1%) each as gay and other.

In relation to professional background, the clinicians represented varying degree levels and educational fields of study. Most of the participants' highest degree was a master's ($n = 86$; 91.5%), while seven (7.4%) earned a doctoral degree, and one (1.1%) participant earned a specialist degree. Fifty-six (59.6%) of the participants reported that their highest degree was from a CACREP-accredited program, while 26 (27.7%) of the participants came from a non-CACREP-accredited program, and 12 (12.8%) did not answer the question. Some diversity existed among participants' programs of study and licensure: 51 (54.3%) participants studied professional counseling or counselor education, 27 (28.7%) studied counseling psychology, seven (7.4%) studied clinical psychology, six (6.4%) studied other areas not listed, and three (3.2%) studied rehabilitation counseling. In terms of licensure, 47 (50%) participants were licensed professional counselors (LPCs), 19 (20.2%) were licensed mental health counselors (LMHCs), 15 (16%) were licensed professional clinical counselors (LPCCs), 11 (11.7%) held licensures not listed in our questionnaire, 11 (11.7%) were licensed clinical professional counselors (LCPCs), seven (7.4%) were licensed clinical mental health counselors (LCMHs), four (4.3%) were licensed professional counselors of mental health (LPCMHs), three (3.2%) were licensed marriage and family therapists (LMFTs), and one (1.1%) was a licensed chemical dependency counselor (LCDC).

The participants had varying years of clinical experience. Eighteen (19.1%) participants had been counseling clients for 1–5 years, 43 (45.7%) for 6–10 years, 17 (18.1%) for 11–15 years, six (6.4%) for 16–20 years, three (3.2%) for 21–25 years, five (5.3%) for 26–30 years, and two (2.1%) for more than 30 years. All participants stated they were currently seeing clients. We asked participants to describe their typical client base by selecting all applicable responses: 84 (89.4%) of the participants counseled adults, 37 (39.4%) counseled adolescents, 37 (39.4%) counseled college students, 27 (28.7%) counseled couples, 19 (20.2%) counseled children, and 12 (12.8%) counseled families.

Instrument

Similar to the approach employed by Trepal and Wester (2007), our questionnaire consisted of two sections: participants' demographics and clinical experiences with NSSI. In the demographics section, we assessed participants' age, race, ethnicity, gender, sexual orientation, education, clinical license, and typical client base. Next, to better understand clinical work with clients who self-injure, we compiled a series of descriptive, Likert-type assessment items. Specifically, the questionnaire items explored how often clinicians addressed issues of NSSI in counseling, characteristics of clients who self-injured, methods of assessing NSSI, clients' internet and social networking activity pertaining to self-injury, the extent to which clinicians conceptualized NSSI as an addiction and whether NSSI should be a formal diagnosis included in the *DSM* proper (rather than as an appendix), extent of clinical training pertaining to NSSI, and perceived clinical competence when working with issues of NSSI among clients. In sum, the questionnaire contained 22 items related to clinical work with NSSI.

Design

We acquired our national sample of licensed clinical participants using the clinician database on the *Psychology Today* website. Specifically, we conducted a search of clinicians with experience addressing a general clinical issue (i.e., anxiety) within each of the 50 states. We identified the names of the first 13 licensed clinicians from each state and searched the internet for their email addresses. If an email address could not be found, we replaced this clinician with the next licensed clinician listed on the *Psychology Today* website for that particular state. We continued this process until we had names and email addresses for 13 licensed clinicians from each state, yielding 650 potential participants.

We calculated a desired sample of 650 given that researchers purported an average response rate of 15.7% for online research surveys sent to professional counselors in the “other” category (members of state-level associations), which most closely reflected our sample (Poynton et al., 2019). After receiving approval from the Institutional Review Board, we emailed the questionnaire link utilizing the Qualtrics software program to the 650 potential participants. Fifty-two emails were undeliverable, resulting in 598 emails sent. We sent participants three reminder emails over the course of three weeks. We received 102 questionnaires (17.1% response rate) from our national sample of licensed clinicians. After removing eight unfinished questionnaires, our final sample consisted of 94 participants (adjusted response rate = 15.7%).

Results

To answer our research questions regarding licensed clinicians’ experiences with client NSSI, we assessed descriptive data resulting from responses to our questionnaire. The data fell into six broad categories: (a) frequency of NSSI in clinical work, (b) descriptions of clients who self-injure, (c) assessment of NSSI, (d) role of the internet, (e) clinicians’ beliefs about NSSI as an addiction and formal diagnosis, and (f) NSSI-related training and perceived competence.

Frequency of NSSI in Clinical Work

We first sought to examine how frequently licensed clinicians worked with clients who self-injured. Specifically, we asked our sample how often in the totality of their clinical work they addressed client NSSI. Results indicated that only two (2.1%) clinicians had never worked with a client reporting NSSI, 37 (39.4%) addressed NSSI rarely (about 10% of the time), 33 (35.1%) addressed NSSI occasionally (about 30% of the time), 13 (13.8%) addressed NSSI a moderate amount (about 50% of the time), five (5.3%) addressed NSSI frequently (about 70% of the time), and four (4.3%) addressed NSSI almost always (about 90% of the time). Thus, among a national sample of 94 licensed clinicians, 92 (97.9%) reported working with NSSI at some point in their careers, with 55 (58.5%) reporting that they addressed NSSI 30% of the time or more.

We also assessed frequency of NSSI among clients in the past year. Only one (1.1%) clinician reported not having self-injuring clients in the previous 12 months. Fifty-one (54.3%) clinicians worked with 1–5 clients who self-injured, 24 (25.5%) worked with 6–10 clients who self-injured, six (6.4%) worked with 11–15 clients who self-injured, and nine (9.6%) worked with more than 15 clients who self-injured. Three (3.2%) participants did not respond to this item.

Descriptions of Clients Who Self-Injure

We then examined clinicians’ descriptions of clients who reported NSSI. Specifically, we inquired about age, gender, race, and method of self-harm by asking clinicians what portion of their clients who self-injured fell into various categories (Table 1). Sixty-one (64.9%) clinicians reported that

most or all of their clients who self-injured were female, five (5.3%) reported that most or all of their clients who self-injured were transgender, and one (1.1%) reported that most or all clients who self-injured were male. With regard to race, 63 (67.0%) clinicians reported that most or all of their clients who self-injured were White and nine (9.6%) clinicians reported that most or all of their clients who self-injured were members of a marginalized racial group. With regard to age, 36 (38.3%) clinicians reported that most or all of their clients who self-injured were adolescents, 31 (33.0%) reported that most or all of their clients who self-injured were adults, and one (1.1%) reported that most or all of their clients who self-injured were children. In terms of method of self-injury, 43 (45.7%) clinicians reported that most or all of their clients who self-injured engaged in cutting and seven (7.4%) clinicians reported that most or all of their clients who self-injured engaged in self-injurious behavior other than cutting (e.g., burning, hitting, scratching, punching). Therefore, the experience of NSSI is diverse. Although a substantial portion of clinicians reported that the majority of clients presenting with NSSI were White female adolescents who engaged in cutting, numerous clinicians indicated some clients (up to 50%) were male or transgender, children or adults, clients of color, and engaged in methods other than cutting.

Table 1

Number of Clinicians Endorsing Each Response

Item: Among your clients who self-injure, what portion are:	None (0%)	Some (<50%)	About half (50%)	Most (>50%)	All (100%)
Female	1 (1.1%)	17 (18.1%)	12 (12.8%)	43 (45.7%)	18 (19.1%)
Male	21 (22.3%)	57 (60.6%)	11 (11.7%)	1 (1.1%)	0
Transgender	39 (41.5%)	37 (39.4%)	9 (9.6%)	3 (3.2%)	2 (2.1%)
White	2 (2.1%)	20 (21.3%)	6 (6.4%)	45 (47.9%)	18 (19.1%)
Person of Color	25 (26.6%)	51 (54.3%)	7 (7.4%)	6 (6.4%)	3 (3.2%)
Children	64 (68.1%)	24 (25.5%)	0	0	1 (1.1%)
Adolescents	19 (20.2%)	22 (23.4%)	15 (16.0%)	31 (33.0%)	5 (5.3%)
Adults	7 (7.4%)	39 (41.5%)	13 (13.8%)	22 (23.4%)	9 (9.6%)
Engaged primarily in cutting	2 (2.1%)	32 (34.0%)	14 (14.9%)	35 (37.2%)	8 (8.5%)
Engaged primarily in self-injurious behavior other than cutting	19 (20.2%)	52 (55.3%)	14 (14.9%)	6 (6.4%)	1 (1.1%)

Note. Numerical values refer to number of clinicians endorsing that response, followed by percent of clinicians out of the total ($N = 94$); percentages do not equate to 100 because of missing items: female (missing 3), male (missing 4), transgender (missing 4), White (missing 3), person of color (missing 2), children (missing 5), adolescents (missing 2), adults (missing 4), primarily cutting (missing 3), primarily other behavior (missing 2).

Assessment of NSSI

We also examined data related to the clinical assessment of NSSI. The most commonly endorsed form of assessing NSSI among clinicians was informal assessment through dialogue ($n = 83$, 88.3%), followed by the use of formal NSSI assessment instruments ($n = 21$, 22.3%). One (1.1%) clinician reported never assessing NSSI in their clinical work. We also inquired as to whether or not clinicians' intake forms contained items related to NSSI. Forty-six (48.9%) reported yes, the NSSI item was separate from suicide items; 22 (23.4%) reported yes, the NSSI item was in conjunction with suicide attempts; 16 (17.0%) clinicians reported no, their intake form did not have an item related to NSSI; and 10 (10.6%) did not know or did not answer this question.

Role of the Internet in Client Self-Injurious Behavior

We investigated participants' responses to items related to clients' internet use related to NSSI. Specifically, we asked clinicians what portion of their clients engaging in NSSI utilized the internet or social networking sites (SNS) to share pictures of self-injury. Forty-two (44.7%) clinicians reported they did not know because they never discussed the issue with their clients who self-injured. Twenty-six (27.7%) clinicians reported that some (up to 50%) of their clients who self-injured shared NSSI pictures online, 20 (21.3%) reported none of their clients who self-injured shared NSSI pictures online, and three (3.2%) reported that half to all of their clients who self-injured shared NSSI pictures online. In response to the item assessing the frequency in which clinicians asked clients who self-injured about their internet and SNS use related to self-injury, 33 (35.1%) clinicians reported they never asked about this topic, 27 (28.7%) asked sometimes (less than 50% of the time), seven (7.4%) asked about half the time, 17 (18.1%) asked most of the time (more than 50%), and eight (8.5%) always asked. Therefore, it appears that clinicians do not consistently inquire about clients' internet and SNS use as it relates to NSSI, but those who do find that some of their clients share pictures of self-injury online.

Clinicians' Beliefs About NSSI

In light of the current status of NSSI Disorder as a condition for further study in the *DSM-5* (APA, 2013) and debate about the addictive nature of NSSI, we asked clinicians to share their beliefs on these two topics. With regard to diagnostic status, 32 (34%) clinicians believed NSSI Disorder should be a formal diagnosis in the next edition of the *DSM*, 24 (25.5%) did not have a preference, and 13 (13.8%) did not believe it should be a diagnosis. Twenty-five (26.6%) participants did not respond to this item. Pertaining to the conceptualization of NSSI as an addiction, 78 (83.0%) clinicians believed that for some individuals, NSSI can be an addiction; eight (8.5%) did not believe NSSI could be an addiction; six (6.4%) stated they did not know; and two (2.1%) did not answer this item. Thus, it appears that one third of the sample supported a formal diagnosis of NSSI Disorder in the *DSM* proper and a large majority of the sample agreed that NSSI could be an addictive behavior.

NSSI-Related Training and Competence

Finally, participants reported settings in which they received training to address NSSI in clinical work (participants could select all modalities that applied). The most common training modality was continuing education (e.g., conference presentations, workshops, seminars), which was endorsed by 55 (58.5%) clinicians. On-the-job training was the second most common modality, endorsed by 47 (50.0%) clinicians, followed by graduate school coursework, endorsed by 42 (44.7%) clinicians; self-study, endorsed by 38 (40.4%) clinicians; and graduate school internships, endorsed by 28 (29.8%) clinicians. Three (3.2%) clinicians reported that they had never received NSSI training. Clinicians further reported the extent to which they felt competent addressing NSSI in counseling. Four (4.3%) clinicians felt extremely incompetent, eight (8.5%) felt somewhat incompetent, 10 (10.6%) felt neither

competent nor 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. About half of our sample felt somewhat competent to address NSSI, indicating opportunities to improve NSSI training and competence among clinicians.

Discussion

Given the rising prevalence of NSSI (Mercado et al., 2017; Wester et al., 2018) and new considerations such as social contagion (Walsh, 2012; Walsh & Rosen, 1985) and sharing NSSI images online (Lewis et al., 2011; Miguel et al., 2017), continued research is needed related to clinical work with self-injury. We disseminated a questionnaire among a national sample of licensed clinicians to examine the prevalence of NSSI, descriptions of clients who engage in NSSI, means of assessing NSSI, role of the internet in NSSI behaviors, clinicians' beliefs about NSSI, and NSSI training and perceived competence. Our results indicated that most clinicians surveyed ($n = 92$, 97.9%) have worked with at least one client who engaged in NSSI. This prevalence rate suggests a potential increase in the presenting concern since Trepal and Wester's (2007) study, in which 81% of practicing counselors reported working with a client who self-injured during their careers. Furthermore, our results revealed that 95.7% ($n = 90$) of clinicians treated at least one client participating in NSSI within the past year. Although researchers have determined that 8% of adolescents (Barrocas et al., 2012) and 45% of college freshman (Wester et al., 2018) in naturalistic samples engaged in NSSI at some point in their lifetimes, it appears the frequency might be higher among clients seeking counseling services.

Previous researchers have established that NSSI is more prevalent among females than males (Barrocas et al., 2012; Doyle et al., 2017; Mercado et al., 2017). Our results confirmed these findings as 61 (64.9%) of the clinicians in our sample indicated that most or all of their clients who self-injured were female, as compared to only one (1.1%) who said most or all were male. It is important to note, however, the prevalence of clinicians who reported working with male clients who self-injured. Specifically, 57 (60.6%) noted that some of their clients who self-injured were male and 11 (11.7%) reported that about half of their clients who self-injured were male. Thus, these results indicate that although NSSI is more prevalent among females, it also occurs among male populations. Additionally, although NSSI typically begins in adolescence (Nock & Prinstein, 2004; Wester & Trepal, 2017), 31 (33%) of the clinicians in our sample reported that most or all of their clients who engaged in NSSI were adults. It is imperative, therefore, that clinicians who work with both adolescents and adults are prepared to effectively screen for and treat NSSI.

Regarding the assessment of self-injurious behaviors, our results revealed that only 21 (22.3%) clinicians utilized formal NSSI assessments. Although informal assessment measures often are effective, clinicians could benefit from reviewing psychometrically sound NSSI assessment instruments such as the Deliberate Self-Harm Inventory (Gratz, 2001), the Alexian Brothers Urge to Self-Injure Scale (ABUSI; Washburn et al., 2010), or the Non-Suicidal Self-Injury-Assessment Tool (Whitlock et al., 2014; see Wester & Trepal, 2017, for an extensive description of multiple NSSI assessments). White Kress (2003) summarized that clinicians should assess the function, severity, and dynamics of NSSI, including age of onset, emotions while engaging in NSSI, antecedents to NSSI, desire and efforts to stop or control NSSI, use of substances while self-injuring, medical complications, and changes over time.

We also sought to understand the role of the internet and SNS in NSSI behaviors. Specifically, we inquired of licensed clinicians the extent to which their clients utilized the internet or SNS to share NSSI

images and the frequency in which they asked clients who self-injured about their internet behavior. According to the results of our survey, almost half of clinicians surveyed ($n = 42$; 44.7%) did not know about the role of the internet or SNS among clients who self-injured because they did not ask. Twenty-nine (30.9%) clinicians reported that at least some of their clients used the internet to share pictures. Furthermore, 33 (35.1%) of the clinicians in our study disclosed they had never asked about SNS or the internet when assessing and treating clients engaging in NSSI, and 27 (28.7%) reported asking less than 50% of the time. These numbers indicate a need for clinicians to have access to current research related to the prevalence of viewing and sharing NSSI images online (Lewis et al., 2011; Miguel et al., 2017). For example, Lewis and Seko (2016) thematically examined 27 empirical studies investigating the perceived effects of online behavior among those who self-injure. The authors reported both perceived benefits of online NSSI activity (i.e., mitigation of social isolation, recovery encouragement, emotional self-disclosure, and curbing NSSI urges) as well as perceived risks (i.e., NSSI reinforcement, triggering NSSI urges, and stigmatization of NSSI; Lewis & Seko, 2016). In addition, previous researchers have found that a portion of individuals engaging in NSSI do so to influence others (Doyle et al., 2017; Nock, 2008), and thus may be particularly attracted to sharing NSSI images online. Given the complex role of the internet in self-injury, it seems imperative that clinicians broach the subject with clients who self-injure.

Our results also demonstrated a strong belief among clinicians ($n = 78$; 83%) that NSSI can be an addictive behavior for some clients, which supports the stance of previous researchers who conceptualize NSSI as a behavioral addiction (Buser & Buser, 2013). The conceptualization of NSSI as an addictive behavior, with particular emphasis on the stimulation of the endogenous opioid system, has important implications for treatment. Evidence-based addictions treatment strategies such as 12-step support group attendance (Connors et al., 2001) and motivational interviewing (Miller & Rollnick, 2013) can be helpful approaches for working with client NSSI.

Finally, we examined clinicians' training experience and perceived competence related to NSSI. Less than half of our participants ($n = 42$; 44.7%) received NSSI training in their graduate-level coursework. The number of clinicians seeking NSSI training via continuing education ($n = 55$; 58.5%) and self-study ($n = 38$; 40.4%) is indicative of the desire for more knowledge related to self-injury. In addition, roughly 23% ($n = 22$) of our sample felt less than "somewhat competent" when addressing NSSI in their clinical work. This perceived incompetency reflects the reported lack of training related to NSSI treatment. Ultimately, this data highlights the opportunity to substantially improve NSSI training to increase clinical competence.

Implications for Counselors

The results of the current study have implications for clinical work with NSSI, specifically in the realms of assessment and treatment. Although many clinicians in our study reported effective assessment measures related to NSSI, an important step for improving assessment might be to include a separate NSSI item on intake forms distinct from suicidal behavior. Sixteen clinicians (17%) in our study said their intake form did not inquire about NSSI, and 22 (23.4%) said the item was written in conjunction with suicidal ideation and attempts. The combination of NSSI and suicidal thoughts or ideations on an intake form can make client conceptualization and treatment goals challenging. NSSI and suicide attempts have markedly different motives (Favazza, 1998; Walsh, 2012; Wester & Trepal, 2017); therefore, listing the behaviors as two separate intake items may best serve both clinicians and clients. Specifically, clinicians could provide a definition of NSSI (Favazza, 1998) on the form to help clients understand the terminology. For clients who indicate that they are engaging in NSSI, clinicians can then utilize formal assessment instruments or the proposed NSSI Disorder diagnostic criteria in the *DSM-5* (APA, 2013) to gain a thorough understanding of the behavior. Additionally, clinicians may

best serve clients by assessing NSSI with all individuals, regardless of gender, age, racial, or ethnic identification, by asking a broad question such as “Have you ever deliberately hurt yourself?” rather than “Have you ever cut yourself?” to be inclusive of multiple forms of NSSI.

With regard to treatment strategies for NSSI, several useful approaches exist. Dialectical behavior therapy (Linehan, 1993) is a counseling method combining cognitive-behavioral and mindfulness techniques for work with clients diagnosed with borderline personality disorder (BPD). NSSI can be associated with BPD given that self-mutilation is listed as a diagnostic criterion for the disorder (APA, 2013). Researchers have found empirical support for the efficacy of dialectical behavior therapy with regard to NSSI (Choate, 2012; Muehlenkamp, 2006); thus, this treatment approach may be useful for clients with BPD and NSSI. Self-injury also can exist apart from a BPD diagnosis (Muehlenkamp, 2005). In these instances, treatment for self-injurious behavior (T-SIB; Andover et al., 2015) may be a useful approach. T-SIB is a 9-week intervention designed for young adults who self-injure. The intervention includes providing psychoeducation, increasing motivation to change, conducting functional analysis, developing replacement behaviors, increasing distress tolerance, and cognitive restructuring (Andover et al., 2015, 2017). Some empirical support exists for the efficacy of T-SIB among young adults, and the treatment manual provides detailed information for clinicians using the approach (Andover et al., 2015, 2017).

Regardless of the therapeutic intervention, it would behoove clinicians to inquire about clients’ online activities related to NSSI to inform treatment plans and goals. Clients’ online activities could include watching NSSI videos; viewing NSSI images; posting and sharing NSSI images on SNS; communicating with others who self-injure via chatrooms and NSSI websites; or seeking information related to how to conceal, clean, or perform NSSI. As part of their recovery plan, it may be helpful for clients and counselors to develop strategies for healthy online behaviors to minimize triggers, urges, or the normalization of NSSI. Even for clients who describe using the internet to find support for their NSSI, clinicians have the opportunity to describe potential risks with NSSI online activity as well (Lewis & Seko, 2016).

Limitations and Future Research

This study is not without limitations. First, our final participant sample consisted of only 94 licensed clinicians, which reflected a 15.7% response rate. Although this is fairly typical for online surveys (Poynton et al., 2019), there were many potential respondents who did not participate, and we were unable to determine if non-respondents differed significantly from respondents. Additionally, in order to obtain a nationally representative sample, we utilized the clinician database found on *Psychology Today*. Thus, our participants were limited to only those clinicians who registered for that particular website. Furthermore, although our questionnaire was robust, we did not inquire about the nature of internet use among clients with NSSI. Future researchers may choose to assess whether clients primarily use the internet for education related to NSSI, to find support, to share images, or to read others’ accounts of NSSI behaviors. Finally, we utilized only licensed clinicians for this study. Future researchers may choose to replicate this study with specific types of counselors such as school counselors, inpatient counselors, and outpatient counselors to assess experiences with individuals who self-injure. In these various settings, researchers may inquire as to how clinicians code for NSSI, given that it is not included in the *DSM-5* proper.

Conclusion

Nonsuicidal self-injury is a prevalent concern among clients seeking clinical services. We sought to understand clinicians' experiences working with NSSI by surveying a national sample of licensed practitioners ($N = 94$). As demonstrated by our results, NSSI affects individuals across age ranges and gender identifications, although it is most prevalent among White female adolescents. Our findings indicate that the majority of clinicians (97.9%) worked with at least one client who engaged in NSSI in the past year. Furthermore, the majority of our sample (83.0%) supported the stance that NSSI can be an addictive behavior. Finally, our study indicates a need for more training related to NSSI in graduate programs and an emphasis on differentiating between NSSI and suicide attempts on intake forms and in clinical work.

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