

SLD (from p. 6)

have to learn theories and tests that assess cognitive/psychological processes shown to be informative about understanding and remediating learning problems in the basic academic skills and language in general. This will require educators to learn what is now known about the psychological processes required for learning and performing proficiently, for example, in reading.

At the most basic level a functional or behavioral approach to the assessment of SLD will require school psychologists to understand and conduct formative assessment, single-subject data analysis, and to use specific measures for evaluating academic progress, such as Curriculum-Based Measurement and its lower extension, the Dynamic Indicators of Early Basic Literacy Skills. Another basic requirement for assessing learning problems and disabilities is the application of a functional framework - antecedents, behaviors, consequences, functions, and replacement behaviors - to observations and modifications of the instructional environment.

As already indicated, assessment of specific cognitive/achievement discrepancy is eliminated in the three-tier approach. Yet the assessment of general intelligence may not be eliminated from SLD unless it is eliminated from mental retardation or mental retardation is ruled out by another means. Since there is no ability achievement discrepancy in the three-tier approach, it requires that "significantly sub-average in academic performance" be defined. If it is operationalized by an academic cut-off score or level, disproportionate representation of some ethnic minorities in special education may worsen. And general cognitive ability (g) may be a necessary consideration when de-

termining the presence of a discrete psychological processing weakness of the disability rather than generalized cognitive processing weaknesses.

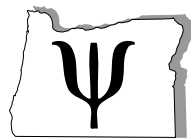
As I mentioned, the changes to SLD listed in Lloyd-Jones' presentation appear to be primarily refinements, refinements that, nonetheless, reflect state of the art advances in defining, assessing, and remediating learning problems and disabilities. The changes in the definition of SLD can also be understood as a significant change in emphasis from the underachievement (unexpected) criterion as measured by an ability-achievement discrepancy to an emphasis on the specific psychological/cognitive processing weaknesses now known to be essential for learning and performing the basic academic skills. It is a change from an emphasis on general cognitive ability (g) to specific academically relevant cognitive abilities, for example, as comprehensively described as the Cattell-Horn-Carroll model. Yet I believe that the most valuable changes to SLD previewed by Lloyd-Jones are the requirements of (1) formative assessments and (2) providing instruction and/or interventions proven to be effective as early possible in a student's school career.

(Valuable comments were made by Allan Lloyd-Jones in review of this article.)

OSPA Bulletin electronic edition?

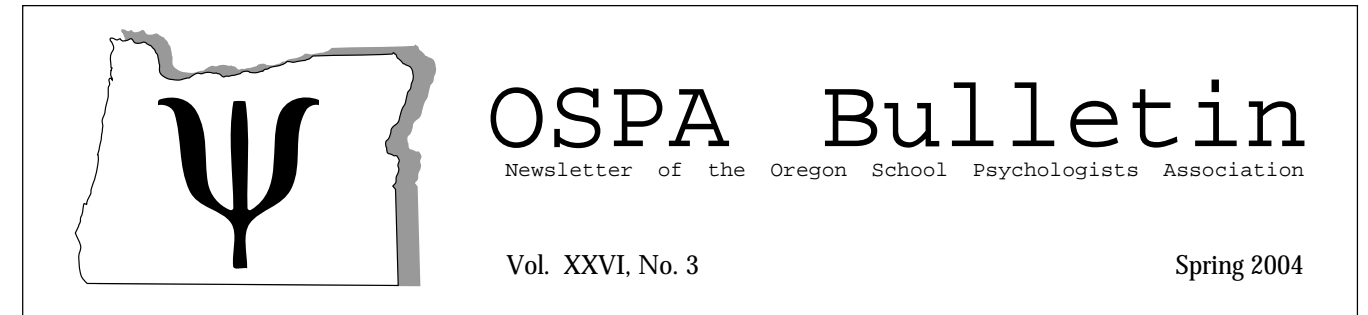
An increasing number of state newsletters are being published in PDF format, to be read on-line or printed out at home or at the office. It saves both paper and time. If you have comments about this idea, please let the editor know (streight@rsiss.net)

Oregon School Psychologists Association



OSPA
#419
25 NW 23rd Place, Suite 6
Portland Oregon 97210-5599

The Oregon School Psychologists Association provides leadership in creating a brighter future for all Oregon children through professional affiliation, collaborative problem-solving, and promotion of practices that are both innovative and based on solid psychological and educational research.



Resilience: Why We Need It

The National Institute of Mental Health claims that up to 8.3% of adolescents in the United States suffer from depression. Major depression is the primary cause of disability both in this country and around the world; the prevalence of depression is increasing as time goes on, and its onset is occurring earlier. Moreover, depression often persists, recurs, and continues into adulthood. Those children who suffer from early onset depression are set up for more severe illness in adult life.

When we look at statistics regarding the increase in depression over the past eight or nine decades, we are staggered by the changes. Data from the last youth risk survey taken in Oregon suggest that about 35,000 (22%) of Oregon high school students considered suicide during the year preceding the survey. The national average is even higher, at 24%. Nine percent

of those thinking about suicide, in both Oregon and nationwide, made a suicide attempt, and close to a third of those who attempted were treated medically for the results of their actions.

However, the numbers of children that can be helped are every bit as impressive. Nearly 80% of individuals who receive appropriate treatment for depression improve, according to the National Institute of Health and the National Institute of Mental Health. In the past fifteen years, programs have been developed to help individuals before they start suffering from internalizing disorders.

In the early 1990's, Martin Seligman and colleagues at the University of Pennsylvania carried out one of the early experiments attempting to build resilience in school children by working with groups of fifth- and sixth-graders in two different

school districts. Seligman's researchers showed that effective programs can markedly slow the natural increase in depression as children mature.

Ken Merrell and colleagues at the University of Oregon have been engaged in similar work. Their goal is to develop effective programs for elementary and high school students: programs that are easily administered by teachers who have only a modicum of training. Results from the first years of work are encouraging. Moreover, like other fine programs coming out the University of Oregon, there is no charge for use of the program. The article below, by Merrell's colleagues Dianna Carrizales and Oanh Tran, is but an introduction to this program, which we hope will continue to be used, tested, and improved.

Promoting Social and Emotional Resilience in Schools *The Strong Kids and Strong Teens Curricula*

by Dianna Carrizales and Oanh Tran

The Issue

Educational professionals know that internalizing disorders such as depression, anxiety, and social withdrawal can be genuine threats to a student's academic performance. Despite this knowledge, state and local budgetary restraints combined with stringent accountability measures often force districts to focus their resources on issues that more directly impact a student's academic life such as literacy and numeracy. In addition, although externalizing behavioral problems such as violence and truancy receive administrative attention and the validation of budgetary sup-

port, resource allocation still tends to center on those disorders that are directly disruptive to the academic process.

In many cases, because of their insidious characteristics, internalizing disorders do not appear on an educational professional's radar until the behaviors associated with the disorders have attained some level of visibility (such as suicide attempts or specific phobias). Quite frequently, once they are "visible," internalizing disorders require immediate and intensive individual attention, which from a systems-level perspective, can be both restrictive and expensive.

Due to the unique nature of some

childhood disorders, individual treatments and reactive interventions will always be a necessary component in educational settings; however, in view of the reduction of resources faced by many schools, the one-on-one approach is no longer a sufficient method of intervention and, if adhered to, will allow many preventable student issues to escalate to grander dimensions. Fortunately, the positive side to the increasing focus on diminishing resources and efficient resource allocation is that educators are presented with the opportunity to become more reliant on prevention as the practical and proactive approach to students' emotional and academic health.

continues on p. 2

Promoting Social and Emotional Resilience (from p. 1)

Prevention

When approaching student outcomes through an avenue of prevention, one popular model used in the field of education (for academic and behavioral functioning) is the public health model which is most often represented by a three-leveled triangle. Because emotional factors contribute directly to academic and behavioral functioning, the same public health model is now becoming valuable in the prevention, early intervention, and systems-level intervention of students' social and emotional health in academic settings. This three-leveled prevention model is based on the theory that, at any given point in a school year, 80-85% of the student body will fall into a low-risk category for behavioral, academic, or emotional problems (the base of the triangle); 5-15% may be at some risk for these issues (the middle of the triangle); and 3-5% will fall into a high-risk category exhibiting behaviors that require immediate intervention (the peak of the triangle).

Risk and Resilience

Risk factors for social and emotional problems in school, and arguably in life in general, can stem from any number of events be they biological, familial, psychological, cognitive, or behavioral habits (see Table 1). Each factor may have a solitary role of varying intensity or may contribute to or exacerbate the existence of other mental health issues for a student. Research investigating childhood risk and its contributing factors continues to find that resilience is a common element that separates children who succeed from children who struggle, and this is a critical finding for the field of education where student success is often challenged by numerous external factors.

The Oregon Resiliency Project

The Oregon Resiliency Project (ORP) was created to continue the investigation into the social-emotional health of students in schools by continuing research in the area of risk and resilience. ORP is directed by Dr. Ken Merrell, professor of school psychology at the University of Oregon. The ORP team includes Dr. Merrell, several graduate students from the UO College of Education, and partners in public schools and agency settings nationally. ORP activities conducted to date lend credence to the social-emotional learning theory that resilience can be learned and that the construct of resilience should not be considered solely as an innate personality trait. Using information gathered from years of research on the constructs of risk and resilience, and employing the principles of social emotional learning, the ORP team developed the *Strong Kids* and *Strong Teens* social emotional learning curricula for use in school settings.

With respect to these curricula, ORP activities have included: the development of teacher in-service training workshops (1-2 hours long) to increase teacher awareness of internalizing disorders in students; the implementation of best practices for working with students with emotional problems; and the incorporation of resilience training into classrooms. As a research team, ORP actively seeks to collaborate with school systems interested in using the *Strong Kids* and *Strong Teens* curricula to promote emotional resilience in their students.

Strong Kids and Strong Teens

The *Strong Kids* and *Strong Teens* curricula each consist of 12 easy-to-use lessons designed for small group presentation from middle school through the end of high school. The carefully designed 45-50 minute lessons feature teacher scripting for ease of implementation. To document progress of both individual symptoms and student knowledge of the topics covered, the first and last lessons include optional pre/post tests respectively. An additional "Booster" lesson is included in the curricula and provides the opportunity for later review.

The *Strong Kids* and *Strong Teens* curricula are similar in scope. The difference between the two curricula is simply the age appropriateness of the vocabulary and subject matter used to provide examples. The *Strong Kids* curriculum is aimed specifically at concerns and content relevant to intermediate- and middle school-aged students in grades 4 – 8 whereas the *Strong Teens* curriculum is aimed specifically at concerns and content relevant to adolescents, or high school-aged students (grades 9 – 12). The 12 lessons are as follows:

- Lesson 1: About Strong Kids (purpose of Strong Kids, overview of curricula, pre-test, rules and expectations, introductory activities)
- Lesson 2: Understanding Your Emotions, Part 1 (increasing awareness of emotions and emotional variability)
- Lesson 3: Understanding Your Emotions, Part 2 (increasing awareness of ways of expressing emotion, comfort and discomfort with emotions, connections between feelings and events)
- Lesson 4: Dealing With Anger (learning to express anger in appropriate rather than maladaptive ways)
- Lesson 5: Understanding Other's Feelings (empathy training)
- Lesson 6: Clear Thinking, Part 1 (introduction to cognitive processes)
- Lesson 7: Clear Thinking, Part 2 (cognitive restructuring)
- Lesson 8: Power of Positive Thinking (learned optimism and attribution retraining)
- Lesson 9: Solving People Problems (conflict resolution training)
- Lesson 10: Letting Go of Stress (relaxation training)
- Lesson 11: Achieving Your Goals (goal setting and increasing positive activities)
- Lesson 12: Finishing UP! (review, post-test, how to get help if needed)
- Booster Lesson (later review)

Implementing Strong Kids or Strong Teens in Your School

Before implementing curricula such as *Strong Kids* or *Strong Teens*, it is important that school personnel are appropriately prepared. To begin, school personnel should: (a) consider how the prevention program fits with the school's existing academic and behavioral structures; (b) identify the populations for which *Strong Kids/Strong Teens* will be used (i.e., general education classrooms, select small groups, at-risk students, students in special educa-

continues on p. 9

Oregon Resilience Project (from p. 2)

tion); (c) present a strong case regarding the benefits of program to the other staff members and students to get full support and collaboration; (d) consider a team approach to leading the prevention group (i.e., collaboration with another trained presenter); (e) consider using the pre- and post-tests to document the effectiveness of the curricula; and (f) utilize ORP team-resources for training and consultation to assist with questions surrounding unique implementation challenges.

Conclusion

Currently school psychologists' caseloads are laden with the responsibility of thousands of children across several schools. Among these numbers, students demonstrating need due to academic difficulties, behavioral problems, and/or severe and obvious emotional disorders will, by necessity, receive the most immediate attention. School psychologists are not unaware of this problem but are often placed in a position of having to treat the most immediate and dire situations first, regardless of how genuinely they would like to take a more systems-level approach.

When practitioners are forced to treat only the top 3-5% of students, their impact is limited to only those students. For practitioners to be broadly effective in decreasing the academic, behavioral, and psychological problems that students face, a universal intervention and prevention model should be considered as it has more reach for all students at all levels of the triangle,

even those that appear to have no immediate or visible issues. Although a universal intervention may seem weaker than a more targeted intervention, its reach impacts a larger proportion of students, thus providing them with opportunities to be successful in school. Students at the peak of the triangle will not suffer from this type of approach as they will still require and receive more substantive attention in the form of wrap-around services.

School psychologists can make the difference in students' emotional health and in their educational environments by promoting prevention and intervention approaches that target a broader base of students. In the case of *Strong Kids* and *Strong Teens*, this approach will expose students to social emotional learning thus fostering resilience against risk factors for students long before we know they exist. As we embrace emotional learning as a premise for prevention, it is important that we remember that: **Resilience can be learned!**

Individuals who are interested in learning more about the Oregon Resiliency Project, or downloading at no cost the *Strong Kids* and *Strong Teens* curricula, should view the project website at <http://orp.uoregon.edu>. In addition to providing download links for these curricula, the ORP website also includes general information on social-emotional learning, helpful links, and practical handouts for parents and teachers, which are also available at no cost.

Dianna Carrizales and Oahn Tran are graduate students at the University of Oregon. They are part of the Oregon Resiliency Project team working Ken Merrell

Table 1: Risk factors: examples and sources

Risk Factor	Examples
Biological	<ul style="list-style-type: none"> • Abnormal functioning of brain chemicals (neurotransmitters) • Temperamental predisposition • Endocrine abnormalities that interfere with the regulation of hormone levels.
Family factors	<ul style="list-style-type: none"> • Strained family relations • Family mood disorders • Family patterns of response to conflict • Childhood parental attachment patterns
Psychological factors	<ul style="list-style-type: none"> • Death of loved ones • Parental divorce • Hospitalization and chronic illness • Abuse • Disaster • Separation
Cognitive factors	<ul style="list-style-type: none"> • Self-perception (such as positive or negative attributions) • Learned helplessness • Distortions in perception of events
Behavioral factors	<ul style="list-style-type: none"> • Self-isolation

A Preview of Specific Learning Disability After IDEA 2003

by Ruben Lopez, Assessment Specialist for the California Association of School Psychologists. (This article is reprinted, with minor excerpts, from the Winter 2003 issue of CASPTODAY.)

A preview of how specific learning disability may be defined and assessed in California after the coming Reauthorization of the Individuals with Disabilities Education Act (IDEA) was given at the October 2002 CASP Board Meeting. The preview came in the form of a presentation made by Allan Lloyd-Jones, consultant for the California Department of Education (CDE), Special Education Division on assessment and evaluation issues. I will discuss what Lloyd-Jones' presentation appears to say about defining and assessing specific learning disability (SLD) and the implications for school psychologists.

Although... there are likely to be changes in SLD in California, most of the changes appear to be refinements rather than radical departures from what at present is thought and done about specific learning disabilities. But it is my opinion that the changes will require most school psychologists to acquire new knowledge and skills and to adopt new practices in assessment, consultation, and direct intervention. The changes will require new knowledge and skills, for example, in the areas of the psychology of learning to read, formative assessment, and effective instruction and curriculum.

Lloyd-Jones' presentation on learning problems and disabilities was titled "A Three-Tiered Approach to Addressing Learning Needs." He reported that sources of the three-tiered approach were the National Association of State Directors of Special Education (NASDSE) and Dr. Virginia Berninger of the University of Washington. Many of the concepts that appear to underlie the approach are found in the chapter titled "Rethinking Learning Disabilities" in the book *Rethinking Special Education for a New Century* (2001) available at www.fordhamfoundation.org. Dr. Berninger presented a detailed version of a very similar three-tiered approach to helping students with learning problems in her article titled "Research Update on Assessment-Intervention Links: Scientifically Supported Practices to Prevent and Treat Reading and Writing Problems in School Setting." Her article appeared in the fall 2002 issue of CASP TODAY.

At least in a general way, the three-tier approach to addressing learning problems and disabilities is likely to be familiar to most school psychologists. Much of it is familiar in the existing legal regulations and in current practice in California's public schools. At least tiers II and III are steps parents and educators in California now take to help students with learning problems.

Tier III parallels the current step of special education evaluation for determining a student's eligibility for special education. Tier II parallels the step that now precedes a special education evaluation, known as pre-referral (special education) activities, often consisting of a review and interventions by a student study team (SST).

Although some schools may provide tier I activities, most schools don't. At tier I all students in kindergarten or the first grade or only students having learning problems are screened for early

identification, instruction, and/or interventions intended to prevent learning disabilities. At present most schools in California don't screen students to identify those needing instruction to prevent learning disabilities.

The tiers or steps of the approach presented by Lloyd Jones are (I) screening for prevention, (II) monitoring response to potent instruction/intervention, and (III) evaluating for special education eligibility. They are sequenced from I to III, putting formal evaluation for specific learning disability last, in existing special education terms, the approach requires the provision of effective instruction and the collection of evidence showing that a student's needs cannot be met in general education as part of the identification of specific learning disability.

As is true of the procedural steps of the three-tier approach, the SLD definition and the associated assessment targets and tools are not likely to be totally unfamiliar to most school psychologists. Despite the recommendation that the definition of SLD should be exclusively functional - defined only in terms of a student's responses to the instructional environment - the three-tier approach defines SLD and problems in learning in *both* structural and functional terms.

SLD is indicated to be structural in nature in the three tier model by the use of measures to identify the processing weakness of the disability. Even at tier I, the step at which SLD is to be prevented, tests to measure phonological processing, rapid automatic naming, graphomotor fluency, and vocabulary are used. Such measures and constructs are included in all the tiers. Therefore, the approach not only defines SLD in structural terms, it also applies structural concepts and measures to the prevention and pre-referral steps to addressing learning problems.

But the approach also defines SLD and learning problems in functional terms. Although some may disagree with my definition, a functional approach to solving learning problems means in part assessing and changing the interactions between an instructional environment and a student's responses to that environment. Based on this definition, the three-tier definition of SLD is functional because it requires educators to (1) "monitor and record academic growth" [measure the student's learning responses] and (2) "provide additional instruction for 'at risk students'" [provide an instructional environment addressing a student's needs].

Therefore, rather than the definition of SLD in California likely being exclusively functional or structural, Lloyd-Jones' presentation indicates that the definition is likely to be both functional and structural. This means that assessments of SLD will likely continue to be comprehensive, including behavioral/environmental cognitive, biological, and educational factors. Those assessing and addressing learning problems and specific learning disabilities will, consequently,

continues on p. 10

State Association News/Business

Give OSPA Your Email Address!

By Philip Bowser
webmaster@ospaonline.com

Please send your email address to me! Why?

It is time and cost efficient to contact OSPA members via email. Besides speed of delivery, it saves paper and postage expense. Plus it reduces the amount of time that volunteer leaders spend in folding, stuffing, sealing, addressing, stamping, and running to the post office. Yet only a fraction of OSPA members have given their email addresses to the Association and, over time, many of these have gone bad.

All over the world, more and more people use the Internet for communications and business transactions. Just a few weeks ago, the National Association of School Psychologists held an election online. To allow participation by those who do not have access to email, the familiar paper ballot was available upon request. Only two members requested a paper ballot, and only one paper ballot was returned. Thousands of votes were cast at

a secure website. So it appears that it may be time for OSPA to develop our electronic publishing efforts even more. But we cannot do that unless we have an accurate and complete list of member email addresses.

OSPA distributes the list of email addresses to other OSPA members in the directory. But that's it. OSPA does not sell or give away your email address to businesses.

The easiest way to deliver your email address to OSPA is to send some email (using the internet service at which you prefer to receive OSPA communications) to me at: webmaster@ospaonline.com. I can then electronically transfer your address to a database without having to re-type it. That reduces the chance that my clumsy fingers will render your address inoperable.

Let's shoot for 100% participation! All OSPA members—even if you think your current email is OK—send me a note anyway! That will help us to correct errors in the current list.

Thanks for your help with this project

Fall Conference Planned for Coast

Program information and registration for the OSPA fall conference will be in the mail by late May, with what is probably OSPA's biggest fall conference venture ever. The regular conference will take place on Thursday and Friday, October 7 and 8 at The Inn at Spanish Head, in Lincoln City. Presenters include Randy Kamphaus, Dawn Miller, and Jeff Sprague, among others.

Kamphaus is co-author of the BASC, a new version of which will be available in the fall of 2004. He will make one presentation on the national dilemma of how best to respond to children's behavioral and emotional needs, and a second in which his goal is to help practitioners reconcile—both theoretically and practically—the classification systems presented us by medical, psychological, and educational models, especially DSM and IDEA.

Kansas's Dawn Miller will introduce participants to the problem-solving process Kansas has developed, including how it has been implemented in schools and the influence the model has had on special education eligibility. The process can be extended to both school-wide and target groups.

The University of Oregon's Jeff Sprague will make two presentations on school climate and school discipline, making a case for supporting positive discipline for all students.

New this year is a Wednesday pre-conference, with Woodcock-Johnson co-author Kevin McGrew, who will present an all-day session on Cattell-Horn-Carroll (CHC) theory assessment methods, looking at cross battery assessment in the context of changes stemming from NCLB and IDEA (e.g., response-to-intervention models).



The *OSPA Bulletin*, the official publication of the Oregon School Psychologists Association, is published four times a year and distributed to members as a membership benefit. OSPA is a nonprofit, non-partisan, educational association of professional school psychologists. It is dedicated to providing for the educational and mental health needs of all children and to advocating for their achievement of independence, dignity, and purpose of life.

Spokesperson: Shannon Van Horn
shannon@workshed.com

Co-Treasurers: Karen O'Brien
541.440.4038
kobrien@harborside.com

Phil Bowser
541.440.4308
pbowser@sorcom.com

NASP Delegate: Karen O'Brien
541.440.4038
kobrien@harborside.com

OSPA Web Site:
<http://www.ospaonline.com>

The contents of this publication and the opinions expressed by its contributors do not necessarily reflect the opinions or policy of OSPA or the National Association of School Psychologists (NASP) or their elected officials. Other newsletters for school psychologists may freely reprint from this bulletin. However, a reciprocal agreement is assumed. If this is not the case, please contact the editor in writing.

The *OSPA Bulletin* invites contributions. Professional issues and news, articles, questions, reviews, letters and graphic works should be sent to David Streight, 7735 SW 87th, Portland OR, 97223, or streight@rsiss.net. Changes of address should be sent to the same address.

Bulletin deadlines for future issues:
Summer, June 15, 2004
Fall, September 15, 2004

Self-Mutilation: An Epidemic on the Rise

by Laurie Craigen, Williamsburg James City County School District
(Reprinted from *School Psychology in Virginia*, Spring, 2003)

Introduction

Several psychologists have coined self-mutilation as the "new anorexia" affecting thousands of teens in America. Although the prevalence of self-inflicted violence is difficult to determine exactly, it has been estimated that approximately 960,000 to 1.8 million individuals in the United States engage in these behaviors. In spite of this emerging phenomenon, self-injury remains a taboo subject, a behavior that is considered grotesque or outlandish and is highly stigmatized by medical professionals and the lay public alike (Favazza, 1998).

Defining Self-Harm

Favazza and Rosenthal (1993) identify pathological self-mutilation as the deliberate alteration or destruction of body tissue without conscious suicidal intent. A common example of self-mutilation behavior is cutting the skin with a knife or razor until pain is felt or blood has been drawn. This behavior, which has been popularized through the media, is commonly referred to as "cutting." Although cutting is the most popular form of self-injurious behavior, burning, self-hitting, interference with wound healing, hair pulling and bone breaking are also types of self-harming behaviors.

Society accepts some forms of self-harm as normal. Examples of culturally approved behaviors include ear piercing, eyebrow plucking, and small tattoos. Because these behaviors are considered beauty enhancing and socially accepted, they are not characterized as pathological or destructive.

The majority of people who obtain these tolerate the pain for the purpose of attaining a finished product such as a piercing or a tattoo.

Self-injurious behavior can be divided into two dimensions—dissociative and non-dissociative. Many dissociative cutters are not aware that they have harmed themselves until they notice the blood running from the wound. If a student has been identified as a dissociative cutter, ask him/her if he/she is feeling numbness in other areas of his/her life. In the case of non-dissociative cutting, numbness is not the goal; instead feeling pain is. It can be argued that the non-dissociative cutter is marginally healthier than the dissociative cutter.

Stanley et al. (2001) report that approximately 55%-85% of self-mutilators have made at least one attempt at suicide. However, it is important to recognize that self-harm is not a failed suicide attempt. The majority of people who harm themselves are doing so

to keep themselves alive. Although suicide and self-mutilation appear to possess the same intended goal of pain relief, their desired outcomes are not similar. Those who cut or injure themselves seek to escape from intense affect or achieve some level of focus. For most members of this population, the sight of blood and intensity of pain from superficial wounds would accomplish the desired effect, dissociation or management of affect. Following the act of cutting, these individuals usually report feeling better (Levenkron, 1998). Death is the intent for those who seek to commit suicide. With these individuals, feelings of depression and despair predominate.

Characteristics of Individuals Who Self-Harm

Self-mutilating behavior has been studied in a variety of racial, chronological, ethnic, gender, and socioeconomic populations. However, the phenomenon appears most commonly associated with middle- to upper-class adolescent girls or young women (Simpson, 2003). The research shows that there are a fair number of self-mutilators who come from a background of physical and/or sexual abuse or from a home with at least one alcoholic parent. Many teens who self-mutilate want to keep their secret. For example, these teens will not usually participate in activities that require changing clothes at school or will change in secret when no one is around.

Why Do They Hurt Themselves?

The reasons why someone self-injures are numerous and can vary from occurrence to occurrence. Some of the reasons are:

- To release anger, pain, stress, fear or anxiety.
- To gain control. The teen may feel out of control regarding his/her life, and practice these behaviors in an attempt to regain that control.
- To use physical pain to ward off emotional pain.
- To inflict pain on oneself as a substitute for anger toward another, and possibly the unconscious desire to inflict pain on that person.
- To escape from emptiness, depression, and feelings of unreality.
- To provide relief. When intense feelings build, self-injurers are overwhelmed and unable to cope. By causing pain, they reduce the level of emotional and physiological arousal to a bearable one.
- To escape numbness. Many of those who self-injure say they do it in order to feel something, to know that they're still alive.
- To ground in reality, as a way of dealing with feelings of depersonalization and dissociation.
- To prevent suicide.
- To communicate a need for support.

continues on p. 7

Treatment Approaches

Treatment for self-mutilating students takes a number of different approaches and strategies. The following list addresses the Do's and Don'ts of working with this population.

DO

Assess the lethality of the wound. If necessary, refer the student to the school nurse or send the student to the hospital. Unfortunately, there is no clear-cut ethical standard for dealing with issues of self-harm. How we choose to treat this issue will be based on our perception of the risk-benefit ratio.

Conduct a suicide risk assessment. Although the two behaviors are distinct, it is important to determine the intent of the injury.

Attempt to understand why the child is partaking in these behaviors.

Each time you meet with the student, ask whether or not there are any new injuries. Then ask him/her to reveal to you the wound. With each new cut, ask him/her to verbalize the feelings before, during, and after the act. Routine discussions of injuries and discussing what to do about them increases trust, begins to integrate the student's sense of relationship to another person, and replaces self-mutilation without attachment. The goal of this process is to have the self-mutilator relinquish his/her privacy and isolation, in favor of something more attractive—connection to another person.

• Push the student to clarify the reason behind every self-harming behavior until the act itself becomes unnecessary.

• Help the student find words to express his/her pain ("If your wounds could speak, what would they say about you?")

• Show that you see and care about the person in the pain *behind* the self injury.

• Make it clear that self-injury is okay to talk about, and that it can be understood.

• Make a list of people he/she can use as support. Many of these students have difficulties forming and maintaining relationships. Thus, the professional working with this student has to model what an appropriate/trusting relationship may look like.

• Make statements that demonstrate your understanding of the self-harmer's feelings ("I'll see you're having a bad time again. Do you want to talk about it" versus "Don't you see how crazy this is? I don't know what we are going to do with you.")

• Make contact and use a chain of helpers, professional and nonprofessional: psychotherapists, family counselors, physicians, nurses, parents, siblings, and close friends. (However, use caution with this because particular family members/close friends could be part of the problem.) This means that confidentiality is more diffused among those individuals who will be involved in helping the self-mutilator. However, it does not mean that the content of the therapy sessions goes be-

yond those clinically participating in treatment.

• Find alternatives/additional coping behaviors the student can utilize in place of his/her self-harming behaviors.

• Break down the barriers; merely knowing that someone is a self-mutilator is not enough. You need to build a developmental history that will tell you, diagnostically, of any underlying personality, mood, anxiety, or neurological disorders that could affect the outcome of treatment, as well as determining the intensity of that treatment.

DON'T

• Don't scold/admonish the student for cutting.

• Don't make the student stop his/her actions. The self-harming behaviors are coping strategies, and if forced to stop, he/she is likely to replace this behavior with another, possibly more serious form of self-harm.

• Don't let your own feelings about the child's behavior get in the way. Students are good at reading our expressions and body language, and can easily sense our disgust or fear. The helper must be comfortable talking casually with the child about his/her wounds.

• Don't miss, cancel, or show up late for appointments. Your task is to model an appropriate attachment with the student and he/she is counting on you to be consistent.

Conclusion

Self-mutilation is prevalent and increasing within the adolescent population in the United States. As a school psychologist, it is probable that you will encounter a self-mutilator at your school, if you haven't already. Thus, it is imperative that all mental health professionals come to a greater understanding and acceptance of this phenomenon to insure that those who practice the behavior continue to receive effective care.

Resources

Alderman, Tracey. (1997). *The Scarred Soul: Understanding and Ending Self-Inflicted Violence*. Oakland, CA: New Harbinger Publications, Inc.

Favazza, A.R. & Rosenthal, R.J. (1993). "Diagnostic issues in self-mutilation." *Hospital and Psychiatry*, 44, 134-140.

Levenkron, Steven. (1998). *Cutting: Understanding and Overcoming Self-Mutilation*. New York: W.W. Norton and Company.

Stanley, B., Gameroff, M.J., Michalsen, V., & Mann, J.J. (2001). "Are suicide attempters who self-mutilate a unique population?" *American Journal of Psychiatry*, 158(3), 427-432.

Zila, L.M. & Kiselica, M. S. (2001). "Understanding and counseling self-mutilation in female adolescents and young adults." *Journal of Counseling & Development*, 79, 46-53.

*OSPA Fall Conference
October 6-8, The Inn at
Spanish Head
see p. 3*