

Duty to Warn and Protect Against Self-Destructive

Behaviors and Interpersonal Violence

Danica G. Hays, Laurie M. Craigen, Jasmine Knight, Amanda Healey, and April Sikes

Old Dominion University

Abstract

Professional school counselors are likely to work with students who are experiencing mental health issues including self-injury, eating disorders, depression and suicidality, as well as those associated with dating violence and bullying. This paper discusses two key areas school counselors are encouraged to reflect upon in determining if there is a duty to warn and protect in these instances. Implications for school counselor practice are provided.

Duty to Warn and Protect Against Self-Destructive Behaviors and Interpersonal Violence

The American Counseling Association [ACA] (ACA, 2005) and the American School Counseling Association [ASCA] (ASCA, 2004) have established standards and best practices for counseling minors. Professional school counselors may have difficulty applying these standards to some of the current issues facing youth including self-destructive behaviors (e.g., self-injury, eating disorders, depression, suicide) and those associated with interpersonal violence (e.g., dating violence, bullying). Because professional school counselors may be the first professional a minor discloses these issues to, they need to not only be aware of related ethical and legal issues surrounding adolescent mental health in order to protect themselves, the student, and others within school and community settings. The purpose of this paper is to discuss school counselors' duty to warn and protect clients when addressing self-destructive behaviors and interpersonal violence among adolescents. Before discussing this key ethical and legal obligations, it is important for school counselors to have a good working knowledge of youth-related self-destructive behaviors and interpersonal violence. While each issue is outlined separately, it should be noted that there is significant overlap and an amalgamation of the two.

Self-Destructive Behaviors

Some of the common self-destructive behaviors include self-injury, eating disorders, depression and suicide. Each is described below.

Self-injury. Self-injury is the deliberate alteration or destruction of body tissue without conscious suicidal intent (Favazza & Rosenthal, 1993; Simeon & Hollander,

2001); put another way, it is self-inflicting bodily harm of a socially unacceptable nature performed to reduce psychological distress (Craigien, Healey, Walley, Byrd, & Schuster, 2008). Some common outward manifestations of self-injury include cutting, burning, and wound interference, and in more extreme cases bone breaking, limb amputation, and eye enucleation, have been seen. Students who engage in self-injury may have blood or burn stains on their clothing, wear loose fitting clothing in an attempt to hide their wounds, become defensive when asked about the topic of self-injury, and have a predilection toward knives, needles, scissors, razors, or paper clips, or in fact possess some of these tools commonly associated with acts of self-injury (Favazza & Conterio, 1989; Levenkron, 1998; Zila & Kiselica, 2001).

It is estimated that about 13% of the adolescent general population and approximately 40-61% of adolescents, in an inpatient setting, engage in self-injury (Darche, 1990; Ross & Heath, 2002). However, accurate incidence rates are difficult to determine because of the unwillingness of participants to come forward. Also, there exists no widely agreed upon definition of "self-injury." Because of this, the Centers for Disease Control (CDC), for example, includes self-injurious behavior in the same category as non-fatal suicide attempts (see www.cdc.org).

Eating disorders. Eating disorders are marked by severe disturbances in behaviors related to eating, and encompass more than simply restricting food intake, but also include behaviors such as over-eating, or bingeing. Youths displaying these tendencies typically have a distorted body image and fear of gaining weight; they may engage in compulsive, compensatory behaviors that include fasting, dieting, over exercise, laxative and diuretic use, and in some cases purging. Some seemingly less

apparent indicators include sudden weight loss, changes in eating patterns, lethargy, dental problems, changes in complexion, abnormal hair growth, bruising, low blood pressure, amenorrhea, defensiveness, and poor concentration (American Psychiatric Association [APA], 2000). The *Diagnostic and Statistical Manual* (APA, 2000) recognizes two primary eating disorders- Anorexia Nervosa (AN) and Bulimia Nervosa (BN).

Occurrences over a lifetime of AN, for females (0.9% of total population) is three times higher than for males (0.3% of population), and for BN those rates are also three times higher for females than males (1.5% of total population) (Hudson, Hiripi, Pope, & Kessler, 2007). In the case of both AN and BN, about 90% of the reported cases involve women. The symptoms for each tend to emerge during different periods though, for AN they tend to occur in mid-adolescence and those symptoms associated with BN in late-adolescence or early adulthood (APA, 2000).

Depression and suicide. Depression is the clinical term used to describe a state of intense sadness, melancholia or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living. Indicators may include low affect, depressed or irritable mood, loss of interest or pleasure in routine activities, appetite or sleep disturbance, significant loss or weight gain, restlessness, lethargy, feelings of worthlessness, poor concentration, and suicidal contemplation (APA, 2000). Research suggests that up to as much as 8.3% of adolescents in the U.S. suffer from some form of depression. A study of 9- to 17-year-olds estimated that the prevalence of any form of depression was more than 6% in a 6-month period, with 4.9% having major depression (Shaffer, Fisher, Dulcan, et al., 1996).

Suicide, on the other hand, is the act of intentionally terminating one's own life. About 15% of those who are clinically depressed commit suicide. Clearly this makes depression, and other issues surrounding suicide very important concerns for school counselors and others who work with adolescents. Approximately 1 in 65,000 ages 10 to 14 commit suicide each year. Reports gathered from hospital emergency rooms indicate that 2.9% of females attempt suicide, annually (Substance Abuse and Mental Health Services Administration, 2005). Suicide has now become the third leading cause of death in adolescents and young adults (Suicide Awareness Voices of Education, 2008).

Interpersonal Concerns

Dating violence. Violence among adolescents who are dating has also become an ever growing issue. Dating violence refers to physical, sexual and/or emotional harm experienced in the context of a dating relationship. With approximately 72% of 8th and 9th graders reporting that they are in fact, "dating" (CDC, 2005), a percentage that only increases with age, this issue warrants great attention among middle school and high school counselors. Indicators of adolescent dating violence can be deceiving, because some of these indicators are shared by other issues discussed previously, but they include: physical signs of injury, eating disorders, substance abuse, pregnancy, depression, anxiety, isolation, somatization, suicidal thoughts and/or attempts, poor academic performance and truancy (Ackard & Neumark-Sztainer, 2002; Alabama Coalition Against Dating Violence, n.d., Amar & Gennaro, 2005; Holt & Espelage, 2005). Women ages 16 to 24 experience the highest per capita rates of intimate violence-- nearly 20 in 1000 women (U.S. Department of Justice, 2000). Further, with estimates

ranging from 20-60% indicating that adolescents and young college women are currently in what can be characterized as an abusive relationship, this issue too becomes an important one for school counselors to both recognize and address (Holt & Espelage, 2005).

Bullying. Bullying is the act of intentionally causing harm to others through verbal harassment, physical assault, or other, more subtle, methods of coercion such as manipulation . Some characteristics shared by adolescents who carry out this behavior can occur very early on, and include one or more of the following: intimidation of other children, siblings, as well as becoming aggressive, obstinate, and unreasonable (Kidscape, n.d.). Those being targeted may; be frightened of walking to and from school, be unwilling to go to school (or be 'school phobic' perform poorly at school, withdraw from others, stammer, lacking confidence, refuse to address problem, as well as have unexplained bruises, cuts, and scratches.

There are also different interpretations and definitions, not to mention, varying levels of aggression. For example, more subtle forms of aggression- known as relational, like gossiping, are rarely reported due to the ease of misinterpretation. Bullying, in a form such as physical assault, is less likely to be misinterpreted, and therefore gets reported more often. The fact that there is such a broad spectrum of aggressive behaviors makes it difficult to capture accurate prevalence statistics. In spite of this challenge, when youths were asked about bullying, almost 30% reported being involved in bullying as either a bully, a target of bullying, or both

Statistics and symptomology related to the aforementioned adolescent mental health issues indicate that it is very likely that school counselors will encounter students

experiencing one or more forms of either self destructive behaviors, or interpersonal violence, whereby they may have a duty to warn and protect these individuals. First, however, we must outline what in fact, a duty to warn and protect is, then we will examine two key issues surrounding a school counselor's duty to warn and protect: (1) who do school counselors have a duty to warn and protect; and (2) at what level of risk is that duty warranted?

Duty to Warn and Protect

School counselors have an ethical and legal obligation to warn and protect, to prevent their clients, in this case the students, from harming themselves or others when there is clear and imminent danger. Harm, in this case, could include self-injury, eating disorders, suicide, and violence toward others, as outlined above. This obligation to warn and protect supersedes the school counselor's confidentiality established in the counselor-client relationship. This legal precedent was established in the case of *Tarasoff v. Regents of the University of California* where it was established that the psychologist in this case should have had a duty to warn an identified third party (Tatiana Tarasoff) of an intended and, ultimately carried out, murder plot, by another University of California student (Prosenjit Poddar).

Tarasoff and subsequent cases have set the legal precedent for therapists, including school counselors, to protect their client, their client's family and/or the surrounding community. Three principles guide this duty to warn and protect: (a) there is a foreseeable harm i.e., the threat is concrete and "believable"; (b) there is an identifiable victim or target, including, the adolescent themselves; and (c) the therapist's

intervention is feasible, i.e., the school counselor can exert “reasonable care” to protect a victim or target (Keith-Speigel & Koocher, 1998).

Who is the Client?

Determining if there is a duty to warn and protect involves acknowledging who, in the case of adolescents, is the client. Additionally, it is important to consider potential third parties (identified potential victims) such as peers, teachers, and so forth. While counselors generally have a professional responsibility to act in the best interests of clients, school counselors may be accountable to other interests when there is a duty to warn and protect, particularly if the students exhibit violent tendencies toward their partners or peers. School counselors are charged with determining who the “third party” is.

Determining who the client and the third party are becomes complex in light of ethical guidelines. The ACA Code of Ethics (ACA, 2005) asserts that, “the primary responsibility of counselors is to respect the dignity and to promote the welfare of clients” (Standard A.1.a, p. 4), and the ASCA Ethical Standards for School Counselors (2004) states that a professional school counselor “has a primary obligation to the student, who is to be treated with respect as a unique individual” (Standard A.1.a) and “recognizes his/her primary obligation for confidentiality is to the student but balances that obligation with an understanding of the legal and inherent rights of parents/guardians to be the guiding voice in their children’s lives” (Standard A.2.g).

While these guidelines were put in place to protect the confidentiality of minors and engage them in the counseling process (Froeshcle & Moyer, 2004; Ledyard, 1998), it is important to weigh these against the parent’s legal rights. Since parents are the

ones who dictate the professional services provided to their children (Glossoff, 2002), parental rights generally override those of the minor (Bodenhorn, 2006; Isaacs & Stone, 2001) State laws do not provide clear guidelines on these rights though, Froeshcle and Moyer provide the following insight in their book.....“ethically the child is the client but legally the parent is the client” (Froeshcle & Moyer, 2004, p.234). Under this interpretation the parent can be considered the “client,” in so far as they must be allowed to make final judgment decisions on behalf of students’ well-being. When self-destructive behaviors or violence involving a student become evident, school counselors may have difficulty disclosing to the child’s parent or guardian (if he or she is to be regarded as the “client”), instead of the actual student being counseled. Some clear questions come to mind when faced with such decisions such as whether or not parents should be informed when their children are exhibiting signs of depression. Should parents be informed when their child is a victim of physical aggression? Some would say, yes, however this could lead to parents retaliating, and, in some cases exacerbating a situation which would have otherwise been resolved more mutually. Finally, are there instances when school counselors should communicate with parents about self-injury and eating disorders as well as instances where they should not?

Because there is no collective method for determining who the client is based on the conflict between legal and ethical standards, the following questions were developed to help guide counselors in determining who the client is when dealing with self-destructive behaviors and interpersonal issues:

- What is your state’s stance on duty to warn and protect individuals concerning these mental health issues?

- What is your school's policy regarding the reporting each of these issues?
- Are these policies clear and have they been adequately promulgated to parents and students?
- What role do parents play in counseling services at your school?
- What legal rights do each of the parties involved have in obtaining or disclosing sensitive information occurring in the counseling relationship?
- How would either party benefit, or be negatively affected, by full disclosure?

Answers to these questions can be useful in determining the validity of a school counselor's responsibility to warn others and protect the client.

According to ASCA Ethical Standards (2004), school counselors should "inform parents/guardians or appropriate authorities when the student's condition indicates a clear and imminent danger to the student or others (Standard A.7.a)." This begs the question; At what point does the situation become a clear and imminent danger to the counselee or others, therefore requiring a duty to warn and protect?

Level of Danger

A part of assessing whether a duty to warn and protect is relevant involves determining the acuteness of the student's condition. The mental health issues discussed herein can have grave consequences, especially if school counselors do not fulfill their duty to warn and protect these at risk youths as well as others involved. In working with and assessing mental health concerns of adolescents, it is of paramount importance to understand the severity of the suspected issue in order to adequately address the issue of breaching confidentiality with the student. In order to provide some clarity on risk factors and aid the counselor in determining the level of danger, risk

factors for common adolescent issues that range in severity are outlined below. Also, a range of risk indicators to help determine level of danger for self-destructive behaviors and interpersonal violence are provided in Tables 1 and 2. These tables should serve as a framework, or starting point for assessing level of danger only. The information provided, which did not previously exist, will greatly assist school counselors in determining some of the steps they should be taking, and with whom they should collaborate in protecting both students and parents.

Self-Injury

Given the multitude of ethical and legal ramifications involved in working with student who may be engaging in self injury, it is important to understand how self injury typically manifests itself and the level of danger it represents. The average age when this type condition begins to appear is between 14 and 16, the majority of those participating in this behavior are Caucasian females (Centers for Disease Control, 2006) and is *not* typically associated with increased danger unless onset is coincident with a psychotic episode (Walsh, 2005). In the past the argument given for reporting self-injury centered around whether the act(s) could possibly result in unintentional death or were simply confusing the act with a suicidal intention. However, a suicide attempt and self-injury are two very different acts, with different results and rationale, although research indicates the two are related. Typically, self-injury occurs in reaction to intense emotions, leading, in some cases to suicidal idealizations. However, Pattison and Kahan (1983) found that only 41% of those who self-injure reported having suicidal idealizations while engaging in self injury. School counselors should always be cognizant of other indicators pointing to the possibility of suicidal tendencies in cases of

self-injury but should not assume they exist. Other diagnoses associated with self-injury include: major depression, borderline personality disorder, posttraumatic stress disorder, and eating disorders. Self-injury can also be linked with acute stress as it relates to bullying and dating violence. A more complete list of risk factors for self-injury can be found in Table 1.

Eating Disorders

Factors indicating the presence of an eating disorder in adolescents depend on the duration of the disorder. Those factors differ in the beginning stages of the disorder and move up in severity as the disorder persists (see Table 1). Eating disorders typically begin in early to late adolescence and with time the severity of the symptoms increases. Purging as a form of eating disorder has also been linked to heightened impulsivity which could include self-injury and in some cases suicidal tendencies (Favaro & Santonastso, 2002). Levitt and Sanson (2007) found that for individuals with Bulimia Nervosa, self-injurious behaviors were often confused with suicide attempts. Eating disorders are often accompanied by perceptual distortions in body image. These perceptual distortions can be associated with more serious eating disorders and/or greatly increase the duration of the disorder (Anderson, Lundgren, Shapiro, & Paulosky, 2004).

Depression and Suicide

For adolescents experiencing depression, there are several instances that can lead to suicidality. Therefore, it is extremely important to be able to recognize the severity and treat signs of depression before it is too late. An extensive list of those indicators associated with depression and suicide can be found in Table 1, and should

Table 1

Continuum of Danger Related to Self-Destructive Behaviors

SELF-INJURY				
	Mild Risk	Moderate Risk	High Risk	Severe Risk
Onset	Early adolescence, Late Adolescence, and Young adulthood		In association with a psychotic episode	
Duration	Less than 1 month	Less than 3-6 months	More than 1 year	Occurring over several years
Severity	Superficial injury, cared for by an individual	Wounds leading to tissue damage but do not require medical attention	Deep wounds that are re-opened or not cared for and require medical attention	
Impulsivity	Planned; associated with emotional state		Impulsive and/or compulsion related to ritual	Compulsion or necessity without care of consequences
Location	Hidden, typically on appendages with the location remaining the same throughout the duration of self-injury	Near major arteries and veins (e.g., wrist)	Sudden change and occurring in prominent or sexually associated areas	
Intent	Coping with emotional turmoil	Self-punishment	Self-punishment without care of death	

State of Consciousness	Lucid and aware of actions	Dissociation and/or use of alcohol or drugs		
Psychiatric Diagnosis	Danger associated with the severity of symptoms associated with a particular mental illness that is co-occurring with self-injury; high levels of negative affect			
<i>EATING DISORDERS</i>				
	Mild Risk	Moderate Risk	High Risk	Severe Risk
Onset	Early to Late adolescence and Young adulthood		Children under 12	<i>Not applicable</i>
Duration	Less than 1 month	Less than 3-6 months	More than 1 year	Occurring over several years
Method	Single diagnosis and method: exercise, binging and purging, starvation		Multiple methods and mixed diagnoses	
Body Image	Attitudinal dissatisfaction		Perceptual Distortions	
Physical and Behavioral Symptoms	Dietary restraint, low blood pressure, bad breath, increased exercise, baggy clothes, sudden weight loss, lethargy, pale complexion		Yellowing and rotting teeth, goes to bathroom immediately after eating, sensitivity to cold, growth of lanugo, amenorrhea	
Psychological Symptoms	Excuses regarding food consumption; erratic mood, difficulty concentrating		Ritualistic eating, refusal to eat, mood swings, depression, self-injury, suicidal ideation	

<i>DEPRESSION AND SUICIDE</i>				
	Mild Risk	Moderate Risk	High Risk	Severe Risk
Onset	Early to Late adolescence and Young adulthood		Children under 12	<i>Not applicable</i>
Duration	Less than 1 month	Less than 3-6 months	More than 1 year	Occurring over several years
Relational Issues	Lack of social support and positive peer relationships		Isolation from peers and family, giving away belongings, exposure to suicidal behavior from others	
Self-Esteem	Lack of confidence with peers, emotionally sensitive, body-image issues		Highly emotionally sensitive, misinterprets others feelings toward them to be negative	
Physical Symptoms	Lethargy, poor hygiene, crying spells, loss of interest in activities, poor sleeping and eating patterns		Self-injury, constantly tired, appearance disheveled, slow speech	Threats to commit suicide or attempts to commit suicide, drug use
Psychological Symptoms	Disruptive behaviors, anxiety, drug or alcohol abuse, mood disturbance, expression of guilt feelings, nervousness, distracted		Aggressive behaviors, impulsivity, Bipolar disorder, apathy	Psychosis, extensive history of aggression, sudden change in behavior

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Likelihood of Duty to Warn and Protect increases

be closely studied. Suicidal tendencies have also been linked to substance abuse, anxiety, mood disturbance, and disruptive behaviors. Risk factors strongly correlated with successful attempts of suicide include highly aggressive behaviors as well as a history of aggression, psychosis, impulsivity, and bipolar disorder (Renaud, Berlim, McGirr, Tousignant, & Turecki, 2008). Becker and Grilo (2008) found gender differences among adolescents in an inpatient setting impacted how each risk factor affected the severity of their depression; however, low self-esteem was one factor that strongly correlated with suicide among both males and females.

Dating Violence

There has been a lot of research related to dating violence and subsequent effects on adolescents and their behavior. Many of the risk factors associated with dating violence uncovered in these studies are summarized in Table 2. Dating violence and rape are also linked to higher rates of disordered eating behaviors, suicidal thoughts or even attempts, and states of lower emotional well being and self-esteem (Ackard & Neumark-Sztainer, 2002). Early signs of dating violence include increased interpersonal sensitivity and depression (Amar & Gennaro, 2005), as well as poor academic performance (Hanson, 2002). Dating violence has also been associated with an increase in the diagnosis of a psychiatric disorders (Ehrensaft, Moffitt, & Caspi, 2006), increased levels of anxiety and depression (Holt & Espelage, 2005), disregard for one's safety, and a decrease in sense of self and distancing from family and friends (Howard, Beck, Kerr, & Shattuck, 2005). Witnessing domestic violence early on also increases the likelihood of later becoming a victim (Balif-Spanvill, Clayton, & Hendrix, 2007), as domestic violence may be interpreted as a normative display of commitment.

Table 2

Continuum of Danger for Interpersonal Violence

DATING VIOLENCE				
	Mild Risk	Moderate Risk	High Risk	Severe Risk
Onset	Early to Late adolescence and Young adulthood		Recurrent onset	
Duration	Less than 1 month	Less than 3-6 months	More than 1 year	Occurring over several years
Family Issues	Lack of social support, low SES, poor parental relationships, single parent home			
Self-Esteem	Interpersonal sensitivity, lack of self-worth, pleasing behaviors, interpretation of violence as a sign of commitment, loss of sense of self			
Physical and Behavioral Symptoms	Poor academic performance, unexplained bruises and injuries, truancy		Self-injury, drug use and peer drinking	
Psychological Symptoms	Depression, anxiety, avoidant, indecisive, changes in mood or personality		Psychiatric disorder, emotional outburst, isolation, risky behaviors	

BULLYING				
	Mild Risk	Moderate Risk	High Risk	Severe Risk
Onset	Childhood and adolescence		Recurrent Onset	
Duration	Less than 1 month	Less than 3-6 months	More than 1 year	Occurring over several years
Self-Esteem and Relational Issues	Lack of self worth, emotional sensitivity, isolation			
Physical and Behavioral Symptoms	Poor grades, unexplained bruises and injuries, starts stealing or asking for money, somatic symptoms, crying spells		Truancy	
Psychological Symptoms	Fear of school, distress and anxiety, dependency and issues of separation		Aggression and unreasonable behavior, bullying	Suicide attempt or threat

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Likelihood of Duty to Warn and Protect increases

Further, victimization is associated with the likelihood of continued long-term involvement in abusive relationships (Alan Guttmacher Institute, 2004).

Bullying. Bullying continues to be a mounting problem in our schools and communities, eroding adolescent's feelings of safety and ultimately diminishing their ability to develop healthy social interactions. It not only takes place on school grounds, but is now taking place over the internet with ever increasing frequency (Mitchell, Yabara, & Finkelhor, 2007). Hazler, Miller, and Carney (2001) found that the social and emotional damage that resulted from bullying was most harmful in terms of the overall psychological well-being of those being victimized. Reactionary consequences can include depression, delinquency, and substance abuse (Mitchell et al., 2007). It is, consequently, important for counselors exposed to this type of behavior to be able to recognize the warning signs of adolescent victimization and deal with it in an appropriate and timely manner.

Implications for School Counselor Practice

School counselors will inevitably encounter students experiencing one or more of the issues discussed here, and they will very likely encounter instances where they may be called upon to warn, and at the same time protect, those adolescents in their charge. It is therefore important for those counselors to be able to distinguish: Who their client is; and what, if any, is the level of danger? As these issues affect school counselors directly, practice in appropriately assessing, ongoing education, and intentional collaboration and consultation, become ever more important.

In order to fulfill their duty to warn and protect the individual as well as the school administration and community at large, a thorough assessment of adolescent mental

health issues must first take place. Accurate detection of self-destructive behaviors and interpersonal violence require using psychometrically sound and culturally-appropriate instrumentation and screening tools. While there are some assessment tools currently being used for issues relating to suicide and depression, many of these tools have methodological flaws (e.g., low reliability and validity, lack of factor analytic procedures, and cultural limitations). School counselors are therefore, strongly encouraged, when using existing tools, to closely examine the psychometric properties of each and be aware of their limitations. Further, there are no tools which address adolescent dating violence or bullying. In cases where no assessments tools are available, school counselors should be collaboratively developing uniform protocol to be used among professionals in the school system to screen for self-destructive behaviors and interpersonal violence.

It is also apparent that better training for all school personnel (e.g., school counselors, teachers, administrators) on the common mental health concerns facing adolescents is needed. It is envisioned that this may take place in the form of in-service trainings that focus on psychoeducation regarding each of the mental health issues as well as the associated risk indicators of each, and the ethical and legal considerations. School counselors should receive professional development regarding these issues through pursuing the many educational opportunities and workshops currently available.

It should be evident that a school counselor's duty to warn and protect has great implications. Youths today face a more robust sociological arena than their parents. School counselors should collaborate with parents and students whenever possible in order to simultaneously protect students and promote an environment in which they feel

comfortable talking about issues and seeking help- and protect the parent's right to have input in their child's development. While it may not always be clear what must be done, the consequences of not doing so will be far greater for both the student as well as the community as a whole. Awareness is clearly at the center of all of these issues, making it imperative for school counselors to tackle these issues as part of a full spectrum prevention and education effort. Brochures or assemblies, for example, which might spark either parents or students into recognizing, before it is too late, some of these mental health issues are some suggestions. Professional school counselors should also make parents and students aware of their duty to warn and protect so both parties understand the possible limitations to confidentiality as well as the ethical and legal parameters. Once an overall policy is developed this information should then be disseminated to both parents and students. The need for counselors, including school counselors, to work within their own communities with other mental health and school professionals as well as other influential community stakeholders (e.g., religious institutions, YMCA, medical professionals) cannot be overstated. At a macro level, self-destructive behaviors and interpersonal violence among adolescents and the accompanying ethical and legal responsibilities must be addressed in local or national school counseling association (e.g., ASCA) conferences, and included in future counseling publications.

Greater attention being paid to self-destructive behaviors and interpersonal violence among the student population is long overdue among school counselors. The alarming frequency of adolescent mental health issues coupled with ethical and legal accountability is an important emerging area for school counselors.

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Author Note

Danica G. Hays, PhD, LPC, NCC, is an assistant professor in Counseling at Old Dominion University. Her research interests include assessment and diagnosis, domestic violence intervention, qualitative methodology, and privilege and oppression issues in counselor preparation and community and school mental health. Dr. Hays leads a research program entitled, Healthy Relationships, that seeks to prevent dating violence among adolescents. Correspondence concerning this manuscript should be addressed to Danica G. Hays, Old Dominion University, 110 Education Building, Norfolk, VA 23529, dhays@odu.edu

Laurie M. Craigen, PhD, LPC, is an Assistant Professor of Human Services at Old Dominion University. She received her Ed.S. in School Psychology and her PhD in Counselor Education from the College of William and Mary. Laurie is also a practicing Licensed Professional Counselor, and currently works with children, adolescents, adults, and families. Her research interests include professional development, self-injury, and dating violence.

Jasmine Knight, M.S.Ed., is a doctoral student in the Ph.D. program in Counseling at Old Dominion University. She is a practicing elementary school counselor in the Newport News public school system. Her research interests include relational aggression and career development.

Amanda C. Healey, M.A., LPC-MHSP, NCC is a Counseling Doctoral student and teaching assistant at Old Dominion University. Her school counseling interests include adolescent self injury and gender issues. Amanda Healey specializes in Community Counseling, Marriage and Family Counseling, and Women's Studies.

April Sikes, M.Ed., LPC, NCC is a doctoral candidate in the Ph.D. program in Counseling at Old Dominion University. She is a licensed professional school counselor, licensed professional counselor, and national certified counselor. She has served as a school counselor in elementary and middle school settings, investigated reports of child abuse and neglect as a case manager, and provided therapeutic and clinical services for families of abused children. She has presented and co-presented on a variety of subjects, including play therapy in elementary and middle school settings, school counselors and the use of children's literature, child abuse and neglect, and ethical and legal issues in school counseling.