

School Counselors and Self-Injurious Behaviors:  
Assessing Perceptions, Prevalence, and Training Issues

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### Abstract

Despite the fact that self-injurious behaviors are gaining increased attention in the schools, little is actually known about prevalence, treatment considerations, and school counselor training issues. This article will present the results from a national survey of American School Counselor Association (ASCA) members regarding their perceptions of self-injurious behaviors. Particular attention will be paid to training issues and best practices when working with students who self-injure.

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The topic of self-injurious behavior (SIB) has undergone resurgence in the professional literature as evidenced by a number of recent publications (e.g., Muehlenkamp & Gutierrez, 2004; Naomi, 2002; Stone, 2003; Wester & Trepal, 2005). In addition, SIB is receiving more attention in the media, with some likening the awareness of SIB to the focus on the eating disorder epidemic in the past 30 years (Conterio, Lader & Bloom, 1998; Nichols, 2000). As awareness of SIB increases in the general population, so does help-seeking (Conterio et al., 1998). However, with an increase in help-seeking for SIB, little is actually known about school counselor involvement with students who self injure in schools. Three articles about SIB that seem directed to school counselors are specific to legal and ethical challenges (Froeschle & Moyer, 2004), setting up school protocols and response teams (Onacki, 2005), and implications and strategies related to adolescents (White Kress, Gibson, & Reynolds, 2004). However, none of these articles includes empirical data related to what school counselors are currently experiencing in their schools. This study begins to fill the gap by providing empirical information about the number of reports of SIB school counselors receive each month as well as their perceptions of the characteristics of students in their schools who self-injure. In addition, information about SIB training was also collected from a national sample of school counselors. First, a brief review of SIB will be presented.

Self-injury has been defined as “all behaviors involving the deliberate infliction of direct physical harm [causing tissue damage] to one’s own body without the intent to die

as a consequence of the behavior” (Simeon & Favazza, 2001, p. 1). Thus, SIB encompasses an extensive array of behaviors, ranging from skin-cutting and hair-pulling to bone-breaking and self-surgery, with the most common types of SIB being cutting and burning (Sutton, 1999). Although SIB is in no way a suicide attempt, it has typically been mistaken by clinicians and medical doctors as one. This mistake may be due to either the high correlation between suicide and SIB (55% to 85% of self-injurers have been found to have made at least one suicide attempt; Stanley, Winchel, Molcho, Simeon & Stanley, 1992) or because the behaviors *appear* to be similar at times.

SIB has an onset in the early teens to mid-twenties (Favazza & Conterio, 1988), and has been seen in children as young as age three (White & Schultz, 2000). The prevalence of SIB has been increasing. In the 1970s, researchers and clinicians estimated that 1% of the general population (Lester, 1971) and 3% to 7% of the psychiatric population self-injured (Ballinger, 1971; Simeon & Favazza, 2001). More recent estimates are 4% of the general population, 21% of clinical populations (Briere & Gil, 1998), 12% to 35% of undergraduate students (Favazza, DeRosear & Conterio, 1989; Gratz, 2003), and 16% of high school students (Muehlenkamp & Gutierrez, 2004), with higher prevalence rates (up to 75%) among individuals diagnosed with Borderline Personality Disorder (Clarkin, Widiger & Frances, 1983). Although there is some idea of the prevalence of SIB in high school, very little is known about the prevalence rates in elementary or middle schools. In addition, most of the rates discussed above are only estimates, and are not based on empirical data. However, with the onset of SIB in early teen years, and a higher prevalence of SIB in high school students than in the general population, school counselors can play an important role in being a first line of defense

when it comes to distinguishing and intervening with these behaviors (White Kress et al., 2004).

There are numerous reasons why youth self-injure. These reasons include a lack of adaptive coping or problem-solving skills, the inability to regulate emotions or stop ruminating thoughts, low frustration tolerance, or attempting to gain a grip on reality or end feelings of dissociation (Alderman, 1997; Favazza, 1996; Gratz, 2003; Haines & Williams, 1997; Himber, 1994; Levenkron, 1998; Pattison & Kahan, 1983; Ross & Heath, 2002; Strong, 1998; Wester & Trepal, 2005). Furthermore, youth who self-injure may have experienced childhood trauma, such as physical and/or sexual abuse or neglect, come from families that are more conflictual or violent, or have experienced parental divorce or loss within the family (Conterio et al., 1998; Crowe, 1997; Himber, 1994; Levenkron, 1998; Paris, 1998; Simeon & Favazza, 2001; Suyemoto, 1998; Tantam & Whittaker, 1992; van der Kolk, Perry, & Herman, 1991; Zila & Kiselica, 2001).

#### Role of School Counselors with SIB

School counselors are charged with being proficient in a number of duties as reflected by their roles related to prevention and intervention and their responsibilities to address the academic, career, and personal/social needs of students (American School Counselor Association [ASCA], 2003). ASCA (2004) has a position statement indicating that school counselors need to provide comprehensive programs that prevent, and at minimum intervene with, behaviors that place students at risk. SIBs can clearly be conceptualized as placing a student “at risk” on a number of levels, including mental health, social, and academic – especially since SIB has been found to be related to a lack of coping or problem solving skills, childhood trauma, peer difficulties, or other

psychological problems (Favazza & Rosenthal, 1993; Kehrberg, 1997; Levenkron, 1998; Milnes, Owens & Blenkiron, 2002; Walsh & Rosen, 1988; Yaryura-Tobias, Neziroglu & Kaplan, 1995).

In many ways school counselors probably serve as the first line of defense for students who self injure. That is, school personnel and/or students might inform school counselors when they encounter a student who exhibits SIB. School counselors also may be the first point of contact for many family members trying to understand the behavior. In either scenario, given their limited background and training regarding assessment and treatment of SIB, school counselors would be well advised to consult with local mental health counselors and/or refer the student and his or her family to someone who has experience with SIB.

Because they will encounter students with SIB in schools, understanding their involvement with those students is important. The present study examined the number of reports of self-injury made to school counselors each month, as well as the perceptions of the type of SIB and the characteristics and types of students who engage in self-injury. In addition, school counselors were asked about their training in the area of SIB. The specific research questions were: What is the prevalence of self-injury reported in schools, including elementary, middle, and high school? What do school counselors report as the types of SIB occurring in their school, as well as the SIB that is most frequently seen and/or reported? What do school counselors perceive as the characteristics of the youth who engage in self-injury? Finally, what type of training, if any, have school counselors had in the area of SIB?

## Method

### *Participants*

Surveys were mailed to a random sample of 2,000 ASCA members regarding their experiences with self-injury in the schools. Of the 2000 surveys that were mailed, 65 were undeliverable (e.g., had moved, no forwarding address). Of the remaining viable surveys, 211 participants (11%) responded to the survey. The final sample was primarily female (87.2%,  $n=184$ ) and Caucasian (88.6%,  $n=187$ ), with 5.7% self-reporting their ethnicity as African American, 2.4% Hispanic/Latino/a, 2.4% other, and less than 1% as Asian American and Native American. The majority of the respondents indicated the highest level of degree attained was masters or specialist (MS or MS/EdS) (82.9%,  $n=175$ ), with 7% reporting a doctoral degree and 8.5% reporting only receiving a bachelors degree. The average age of all participants was 41.41 years old ( $SD=11.42$ ), with ages ranging from 22 to 63. However, not all 211 respondents were school counselors. Some individuals were removed from the final database due to missing data ( $n=15$ ) or for reporting that their primary position was a counselor educator ( $n=10$ ) or counseling student ( $n=24$ ). Thus the final sample used in the current study for analyses was 150 school counselors.

Of the final sample of 150 participants, 28.7% reported their primary position was an elementary school counselor ( $n=43$ ), 28% middle school counselor ( $n=42$ ), 40% high school counselor ( $n=60$ ) and 3% other ( $n=5$ ). Those that reported "school counselor: other" as their primary position reported that they were designated for specific grades only (e.g., 5<sup>th</sup> and 6<sup>th</sup> grades) or were at multiple levels of schools (e.g., middle and high schools).

*Procedure*

Each participant was mailed a survey packet including a cover letter outlining procedures for the survey, a consent form, the one-page survey, and a business reply envelope in which to return their response. Three weeks later, a reminder postcard was sent out to the members of the sample who had not already responded.

*Instrument*

The survey instrument was a 1-page survey designed by the authors. Questions included items regarding basic demographic information as well as items specific to SIB. Once the survey was created, counselor educators, from two universities, who specialized in the field of school counseling, edited the survey for appropriate language. The final survey consisted of 15 questions.

To ensure that respondents were currently practicing as school counselors, participants were asked to identify their “current primary role in the counseling field”, and to select only one option. In order to ensure that school counselors understood what was meant by “self-injury” a definition was provided on the survey form. This definition was the same one provided by Simeon and Favazza (2001) (see section above). To answer the question about the prevalence of SIB in the schools, school counselors were asked “What is the prevalence of self-injurious behaviors that are reported in your school?” Specifically, they were asked to report the number of reports of SIB they received per month. They were also asked if, in their professional opinion, they believed that the number of reports they indicated reflected the actual prevalence in their school, or did they feel that the actual prevalence was higher or lower than what was reported.

Participants were also asked to rank order 10 types of self-injurious behaviors that were typically reported in their school using numerical values from 1 (most frequent) to 10 (least frequent), leaving blank those SIBs they have not seen. The 10 behaviors that were included were taken from published literature and research on self-injury. They included cutting, burning, hair-pulling, pin-pricking, hitting oneself, head-banging, skin-picking, biting, swallowing foreign objects, and other – which allowed school counselors to identify any other SIB not listed.

Due to a lack of research examining the characteristics (e.g., groups of students, high-achiever, athletic, popular, etc.) of youth who self-injure, school counselors were asked to provide written responses to open-ended questions inquiring about the characteristics or groups of students in their school that self-injured. Walsh (2006) reported that a “new generation” of self-injurers is arising. He indicates that these individuals do not come from abusive or neglectful homes, nor do they have histories of trauma or the inability to function at school or work. Thus, the purpose of asking these open-ended questions was to gather information on the characteristics of youth who self-injure in today’s schools. The questions on the survey inquired “Based on your professional experience and your personal opinion, which group or clique of students tend to engage in self-injury?” and “What are some identifying characteristics of the group or clique of students you mentioned?” Open-ended questions were used so as not to bias or limit school counselors in their responses by providing specific labels for “groups” of students. Not all types or characteristics fit students within each school across the country, thus providing a check-box list may have also limited the responses that would have been given; thus, open-ended questions were provided.

## Results

### *Prevalence and Type of SIB*

Overall, school counselors reported an average of 2.29 ( $SD=2.61$ ) reports of SIB per month in their school, with numbers ranging from 0 to 15 per month. To determine if differences existed between elementary, middle, and high schools, an ANOVA with post hoc Sheffé was run. A significant difference was found between schools and prevalence rate ( $F(2,139) = 3.58, p < .05$ ). Post hoc tests revealed that elementary school counselors reported a statistically significantly lower rate of SIB than middle school counselors ( $M=1.45, SD=2.53$ ;  $M=2.96, SD=3.07$ , respectively). No significant difference existed between prevalence reported in high school ( $M=2.46, SD=2.29$ ) and elementary or middle school. School counselors were also asked if they believed the *actual* prevalence was higher than, the same as, or lower than the reported number of SIB. Seventy-four percent (74%) to 88% of school counselors reported they believed the actual prevalence was higher than what was reported in their school. Only 5% to 21% reported believing the actual prevalence was the same as what was reported, and 3% to 9% reported believing it was lower (with no elementary school counselors believing the actual prevalence was lower than what was reported).

### *Type of SIB Most Frequent in the Schools*

As can be seen in Table 1, cutting, hitting oneself and skin-picking were the highest ranked behaviors across all building levels; however, some differences did exist among elementary, middle, and high schools. The “most frequent” SIB for elementary school counselors was hitting oneself (32.6% elementary school counselors marked as 1), followed by cutting (27.9%) and head-banging (18.6%). However, middle school and

Table 1

Percentage rankings of the type of SIB reported as “most frequent” in the school

	All School Counselors (N=150)		Elementary School (n=43)		Middle School (n=42)		High School (n=60)	
	Most Frequent	Percent Observed	Most Frequent	Percent Observed	Most Frequent	Percent Observed	Most Frequent	Percent Observed
Cutting	<b>72.0</b> <sup>1</sup>	87.3 <sup>1</sup>	<b>27.9</b> <sup>2</sup>	60.5 <sup>3</sup>	<b>85.7</b> <sup>1</sup>	100 <sup>1</sup>	<b>93.3</b> <sup>1</sup>	98.3 <sup>1</sup>
Hair-pulling	4.0	54.0	9.3	51.2	<b>9.5</b> <sup>2</sup>	66.7 <sup>3</sup>	3.3	46.7
Hitting oneself	<b>10.7</b> <sup>2</sup>	49.3	<b>32.6</b> <sup>1</sup>	62.8 <sup>2</sup>	4.8	50.0	1.7	40.0
Skin picking	<b>7.3</b> <sup>3</sup>	67.3 <sup>2</sup>	16.3	65.1 <sup>1</sup>	4.8	81.0 <sup>2</sup>	1.7	60.0 <sup>3</sup>
Burning	2.7	54.7 <sup>3</sup>	4.7	27.9	4.8	64.3	1.7	66.7 <sup>2</sup>
Pin pricking	2.7	47.3	4.7	25.6	<b>7.1</b> <sup>3</sup>	64.3	<b>16.7</b> <sup>2</sup>	50.0
Head-banging	7.3	45.3	<b>18.6</b> <sup>3</sup>	55.8	2.4	47.6	1.7	36.7
Biting	1.3	32.7	4.7	37.2	2.4	31.0	<b>5.0</b> <sup>3</sup>	30.0
Swallowing foreign objects	.7	18.7	2.3	20.9	2.4	16.7	1.7	20.0
Other	2.7	19.3	2.3	16.3	<b>7.1</b> <sup>3</sup>	21.4	<b>5.0</b> <sup>3</sup>	18.3

Note. Superscript numbers indicate ranking within column; bold numbers indicate “most frequent” type of SIB

high school counselors both reported cutting as the “most frequent” SIB in their schools (85.7% middle school and 93.3% high school counselors marked as one in the rank order).

In addition, because participants could leave items blank, indicating they had not seen a particular behavior, the percentage of school counselors who marked each type of SIB was examined. Unanimously, the most common SIB seen across all school counselors was cutting, ranging from 60% to 100% of school counselors reporting having this SIB reported in their school (see Table 1). The second and third most common behaviors differed based on the participant being at the elementary, middle, or high school level. Specifically, skin-picking was the second or third most common SIB across all school counselors. Elementary school counselors reported hitting oneself as the second most common SIB and skin-picking as the third, while hair-pulling was the third most common SIB reported among middle school counselors, and burning as the second most common SIB reported at the high school level.

Those school counselors who listed “other” as the SIB type reported in their school typically mentioned erasure marks or burns, poking, stabbing, or writing on oneself with pen or pencil, carving, self-tattoos or piercing, eating disorders, starving, scratching, or suicide attempt. It is important to note; however, that although some school counselors reported these behaviors as self-injurious, eating disorders, starving, and suicide attempts are not considered forms of self-injury.

#### *Characteristics of Students Who Self-Injure*

Of the 150 participants, 97% (n=146) responded to the open-ended questions regarding characteristics of students who self injure. As can be seen in Table 2, the

responses were varied across all school counselors, signifying that self-injury occurs across many types or groups of students or that school counselors only remember specific characteristics of students who self-injure. Interestingly, the most common response was female students (28%) while less than 1% of school counselors reported that male students self-injure. Eleven percent wrote that students who have low self-esteem or are depressed self-injure, while 13% indicated that alternative youth (i.e., gothic kids, youth wearing black or who have piercings) tend to self-injure in their schools. Other responses indicated that youth self-injure due to high levels of pressure from oneself or others, strained family relationships, single parent families, being angry or anxious, no coping skills, high achiever or perfectionists. However, 19% of the school counselors specifically indicated that they could not identify a group or that self-injury did not limit itself to a particular group of youth in their school – once again denoting that self-injury is not limited to a particular youth or group of students.

#### *School Counselor Training*

The majority of school counselors (91.8%) indicated that they have had some form of training on the topic of SIB, with 86.7% reporting having had some form of professional training (i.e., workshop, class, conference) while 2.6% of school counselors indicated that their “training” came solely from the media or television. In order to examine if training related to the number of incidents reported bivariate correlations were run. The total amount of training (range from no training to 8 different forms of training about self-injury) was found to positively and significantly relate to reported prevalence of self-injury in one’s school ( $r=.32, p<.001$ ). The data suggest that as the amount of training increases, the prevalence of SIB reported increases.

Table 2

*Types of students who self-injure as reported by school counselors*

	All School Counselors (N=150)		Elementary School (n=43)		Middle School (n=42)		High School (n=60)	
	N	%	n	%	n	%	n	%
Gender:								
• Female	42	28.0	8	18.6	14	33.3	19	31.7
• Male	1	0.7	0	0	0	0	0	0
No specific clique	28	18.7	6	14.0	8	19.0	13	21.7
Alternative groups (e.g., gothic)	19	12.7	2	4.7	2	4.8	12	20.0
Low self-esteem or depressed	16	10.7	4	9.3	6	14.3	5	8.3
Miscellaneous	15	10.0	4	9.3	5	11.9	5	8.4
High achievers	14	9.3	4	9.3	6	14.3	4	6.7
Strained family relationships	14	9.3	5	11.6	3	7.1	6	10.0
Childhood trauma (e.g., abuse, neglect)	12	8.0	5	11.6	2	4.8	5	8.3
Excluded	11	7.3	4	9.3	2	4.8	4	6.7
Co-morbid diagnoses	11	7.3	8	18.6	0	0	3	5.0

Table 2 continued

*Types of students who self-injure as reported by school counselors*

	All School Counselors (N=150)		Elementary School (n=43)		Middle School (n=42)		High School (n=60)	
	N	%	n	%	n	%	n	%
Race:	9	7.0	2	4.7	3	7.2	4	6.7
• Caucasian	8	5.3	2	4.7	2	4.8	4	6.7
• Hispanic	1	0.7	0	0	1	2.4	0	0
No coping skills	8	5.3	4	9.3	2	4.8	2	3.3
Emotions (e.g., anger)	5	3.3	2	4.7	1	2.4	2	3.3
Low SES	4	2.7	1	2.3	1	2.4	2	3.3
Attention seekers	3	2.0	1	2.3	0	0	2	3.3
Popular students	3	2.0	0	0	2	4.8	1	1.7
Low achievers	3	2.0	2	4.7	0	0	1	1.7
GLBT	2	1.3	1	2.3	0		1	1.7
Pressure from self or others	2	1.3	0	0	2	4.8	0	0
Artistic or creative	2	1.3	0	0	0	0	1	1.7
Self-isolators	2	1.3	0	0	1	2.4	0	0
Substance abuse	2	1.3	0	0	0	0	2	3.3

## Discussion

The knowledge that nationwide, school counselors are indicating seeing an average of two or more reports of self-injury per month, with the actual prevalence perceived as being higher than what is reported, indicates the need for school counselor involvement. The rationale for school counselor involvement with students who self-injure is clear. First and foremost, students who self-injure may be hindered in their academic achievement and progress due to personal, behavioral, emotional or academic reasons. Researchers have found that individuals who self-injure lack coping or problem-solving skills (Haines & Williams, 1997), have difficulties with relationships or are dealing with childhood traumas (Crowe, 1997; Levenkron, 1998; Simeon & Favazza, 2001). They self-injure to regulate emotions, to stop thoughts or worries, deal with stressful events, express self-hatred or punishment, or to gain attention or get care from others (Alderman, 1997; Favazza, 1996; Gratz, 2003; Himber, 1994; Ross & Heath, 2002). Thus, these students may be dealing with physical or sexual abuse, emotions or problems that they feel unable to control or solve, or may feel neglected without the necessary coping mechanisms, thus resulting in self-injury. Similar to the reactions in children suffering from depression or anxiety (Evans, Van Velsor, & Schumacher, 2002; Kashani, & Orvaschel, 1990), we might conclude that if the problems continue without dissipating, it eventually may lead to an increase in frequency or severity of self-injury as well as a decrease in academic grades and/or interest in school activities.

In accordance with the ASCA (2003) National Model, school counselors can prepare to meet the needs of students who self-injure. Suggestions for direct service

interventions (e.g., guidance curriculum and individual planning) and systemic initiatives are presented below.

### *Education/Prevention - Guidance Curriculum*

One of the areas in which school counselors can have an impact on the development of SIB is in guidance curriculum. Given the known family (e.g., violence, loss, abuse) and individual (e.g., lack of problem solving or coping skills, low self-esteem, depression, female) characteristics that aid in the development and maintenance of SIB, school counselors may be able to target at-risk students and work with them on developing coping skills in individual or group counseling (White Kress et al., 2004). In addition, group guidance lessons, particularly at the elementary level, can include discussions of the topic of self-injury, problem-solving skills, and healthy lifestyles, along with other coping choices. Students can also be encouraged to identify and explore feelings, as well as healthy coping choices. Since they may not have a foundation for these outlets at home, the school counselor can serve as an important guide for the development of coping skills.

If students are aware that the topic is on the table, then at least they know that there is someone with whom they can discuss their self-injury. These students may not have had many other adults in their lives whom they could trust, so school counselors may have to work extra hard to build trust and rapport. Given that these are often secret behaviors, care should be taken when discussing SIB, making sure that trust has been established (White Kress et al., 2004). Sometimes a school counselor may find out about the SIB from a source other than the student (i.e., friend of the student, school staff). If students do not disclose self-injury on their own, then school counselors may

bring it up with them simply by asking students if they have ever hurt themselves, for example, have they cut or burned themselves or picked at their skin? If the response is yes, then further inquiry as to the frequency, reasons, and/or situations that invoke this behavior may be warranted to better understand if the behavior is actually self-injury.

### *Individual Student Planning*

This component of service delivery is based on individualized career and education planning and working with a student who self-injures based on his or her individual circumstances (i.e., prior diagnoses, career issues) while being mindful of the SIB. For example, a student who has stopped self-injuring may be concerned about a summer internship. Their concerns may be different from the typical considerations of wages and hours and may involve uniforms (i.e., do they have to show bare arms or legs) and explanations of scarring (i.e., what do I say if someone asks me about my scars).

With the knowledge that some youth who self-injure have had past experiences with trauma, or have low self-esteem, possible depression, or low stress tolerance levels, their mental health, diagnoses, and coping abilities may also need to be a consideration when helping students with career decision choices or curriculum choices throughout their education. School counselors can also help students decide what possible stepping stones need to occur (e.g., personal counseling, alternative coping methods) prior to their applying for or entering a high stress education or profession. Additionally, scars and marks on one's body may be a consideration when planning additional coursework and curriculum in the school setting. Some concerns may be around other students seeing their scars or marks from self-injury. Thus consideration in

scheduling coursework such as gym class may need to come into play during student planning. Although most students are required to schedule physical education, school counselors could collaborate with teachers to generate ways to avoid unnecessary disclosure or embarrassment.

### *Responsive/Intervention Services*

The importance of establishing relationships between the school, the home, and the community cannot be underestimated (Onacki, 2005; Taylor & Adelman, 2000). Most school systems have provisions in place that allow school counselors/personnel time to make an informed assessment of a potentially harmful situation before deciding on a course of action. Some aspects of the behavior itself should be assessed, such as impulsivity of the student, chronic nature of the behavior, whether the student has ever had or currently has severe wounds or has used extreme methods to self-injure (see Wester & Trepal, 2005; White Kress, 2003 for more information on assessment).

In addition to assessing aspects of the SIB, a school counselor needs to establish a rapport with the student (Onacki, 2005) and evaluate the potential family variables (i.e., is the family aware of the SIB, is there some family role in the SIB) so that the best course of action can be determined. Usually, it would be best for the student and the school counselor to work together to decide how to discuss the SIB with the students' family. Necessary referrals can be facilitated from that point.

On first contact, a family may be upset or distressed about the SIB (Onacki, 2005), thus a responsibility of the school counselor should be to facilitate the conversation between the student and parent regarding the behavior and the situations leading up to the SIB. The school counselor can serve as a key point of referral for the

family providing education about SIB, including distinguishing myths (such as all SIB is suicidal), and making referrals. School counselors should keep an up-to-date list of practitioners and agencies in their area that treat youth who self-injure for families of all income levels.

### *Program and System Support*

The final area in which a school counselor can intervene is through systemic efforts. There are several interventions which can occur on a large scale that can impact the treatment of students who self-injure. For example, many times teachers, coaches, nurses, and other staff members are the first people to notice or hear of a student who is self-injuring. They may feel unprepared to deal with the student directly due to lack of education on SIB or a mistaken assumption that all SIB is a form of suicide attempt. The school counselor can take a proactive role and offer in-service educational sessions on self-injury including information on recognizing and intervening with a student suspected of engaging in self-injury, as well as specific recommendations for talking to the student. An important aspect of the training could include the dispelling of the suicide myth.

The school counselor can also work at organizing a school response team that might include the school nurse, counselor, and administrator (Onacki, 2005). This team could work toward the development of a school-wide protocol regarding self-injuring students so that any school personnel who are confronted with or find out about a self-injuring student have knowledge, a protocol for referral, and are able to determine how to respond.

## Training

In addition to working with their school systems, delivering services to students and training faculty, school counselors should continue to seek out training opportunities in the area of self-injury. The current study found a slight, but significant, positive relationship between training and prevalence of self-injury reported in the school. The positive relationship may be for multiple reasons, including knowledge of self-injury, a positive and nonjudgmental manner in which the school counselor reacts when a student informs him/her about their SIB, knowledge to ask a question regarding self-injury and ability to recognize signs of self-injury.

Training is also necessary since shifts have occurred in our knowledge of SIB. A few decades ago, it was proposed that the “typical” self-injuring person was a middle-class, single, female in her teens or early twenties (Favazza & Conterio, 1988). However, today there is considerable disagreement regarding male/female patterns of self-injury as well as debate regarding potential characteristics and comorbid diagnoses that might be correlated with self-injury (Muehlenkamp, 2005). Thus, it is important for school counselors to pursue current continuing education on self-injury to ensure that they have a current conceptualization of risk factors, relationships, interventions and assessment methods.

### *Limitations*

There are two major limitations in this study. First, although ASCA is a large organization, not every school counselor is a member and therefore the sample was limited to those school counselors who are also members of ASCA. The ASCA website reports a current membership of more than 18,000 while The National Center for

Education Statistics (NCES) reported that during the 1999-2000 school year, there were 96,000 school counselors serving students in the United States (Bairu, 2001). The survey may reflect the experiences and opinions of ASCA members and may not be representative of school counselors nationwide. Secondly, the sample size was small, with a response rate of approximately 11%. However, this is one of the first empirical studies to examine the prevalence and characteristics of self-injury in the schools from school counselors' perspective. Nevertheless, these two limitations put together suggest the need for future researchers to continue to investigate self-injury in the schools.

### Conclusion

Self-injurious behaviors are receiving widespread attention both in the media and the professional literature. Scant research has been done on school counselors' experiences with SIB, including prevalence and training issues. This study found that although school counselors indicate having an average of two reports of self-injury in their school per month, with the majority indicating that they believe the prevalence is higher than what is reported to them. This reported prevalence rate in schools indicates a need for school counselor involvement, as well as continued training. Most of the school counselors reported having some training in this area; however, some participants listed behaviors on the survey that are not considered to be self-injury (e.g., suicide attempt, eating disorder, starvation, drugs). Not fully understanding the types of behaviors or the reasons behind self-injury can lead to negative responses or inappropriate services being provided in the schools. Continued training is imperative since school counselors are in a unique position to respond to students who self injure on a number of levels and need to have the most up-to-date knowledge on related

characteristics and aspects of assessment. In addition, future research should examine the extent of school counselors' involvement with and confidence in working with these students.

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