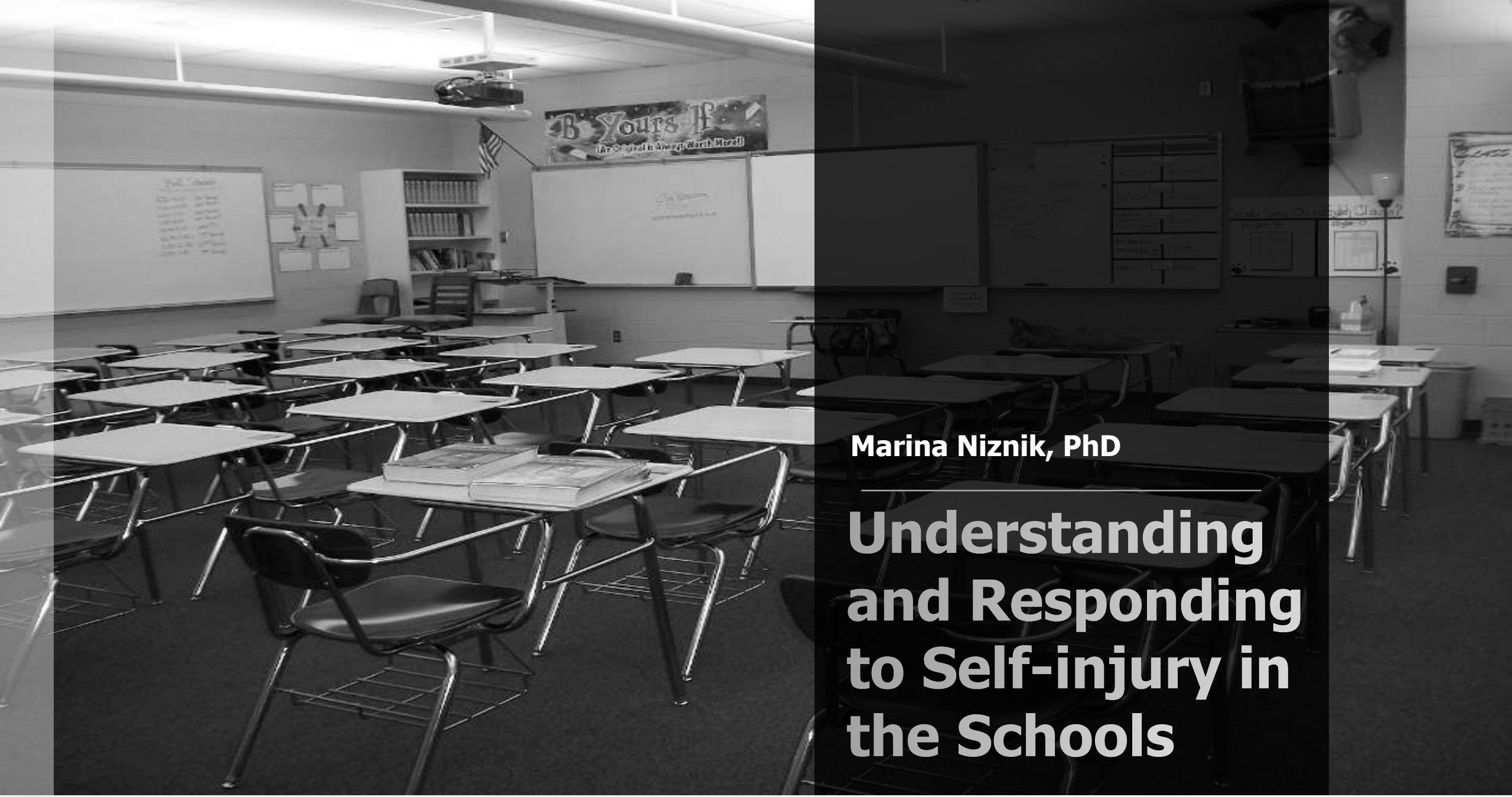


Marina Niznik, PhD

Understanding and Responding to Self-injury in the Schools

Impact of Self-injury in the Schools

Why We Need a School-based Solution

- **14-18%** of teenagers in the school environment engage in self-injury
(Hasking et al., 2016; Glenn, Franklin, & Nock, 2016)
- **92%** of counselors report that they have counseled a student who has engaged in self-injury yet the majority feel ill-equipped to do so
(Duggan et al, 2011)
- **80%** of identified students in need of mental health services did not receive them and those that did, received them at school
(Mazza, Dexter-Mazza, Miller, Rathus, & Murphy, 2016).

Reasons for School-based Efforts

- **School is most suitable place for prevention** of self-injury and suicide because:
  - The behavior is **common** among adolescents
  - **Accessibility** to at-risk adolescents at school
  - Prevention and treatment are **less stigmatizing** at schools than treatment facilities
    (Shaffer & Gould, 2000)

Signs of Self-Injury Noted by School Staff

Physical

- Cuts
- Burns
- Bruises
- Scratches
- Torn or punctured skin
- Carvings
- Interference with wound healing

Situational

- Inappropriate dress for the climate
- Avoidance of activities that require removal of any clothing
- Risk taking behaviors (e.g., wall punching, jumping from high places or running into traffic
- Implausible stories that may explain one, but not all, physical injuries

Expressive

- Creative work focused on self-injury, such as:
  - poems, stories, drawings Social-emotional isolation, disconnectedness, withdrawal
- Mood changes
- Secretive behaviors (e.g., spending unusual amounts of time in isolated areas on campus)

Definition of NSSI

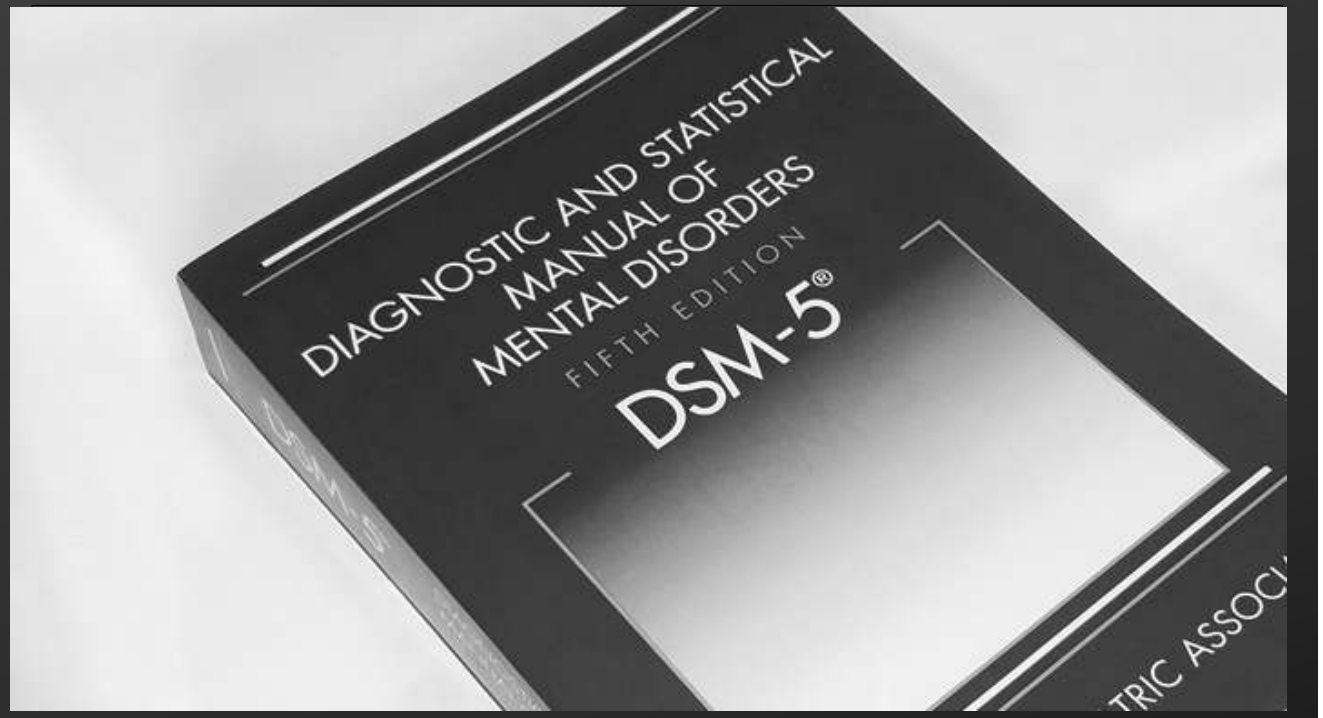
NSSI is a variety of **behaviors** in which an individual **intentionally inflicts harm** to their body for **purposes not socially recognized or sanctioned** and without suicidal intent

Previous Terms

> Deliberate self-harm

> Self-mutilation

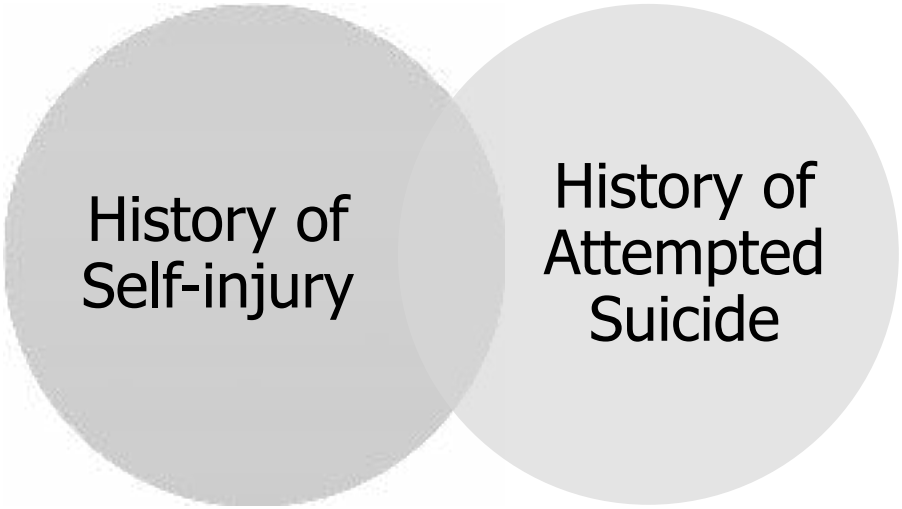
> Parasuicide



Current Term

Nonsuicidal Self-Injury (NSSI)

Under Conditions for Further Study (DSM-5, 2013)



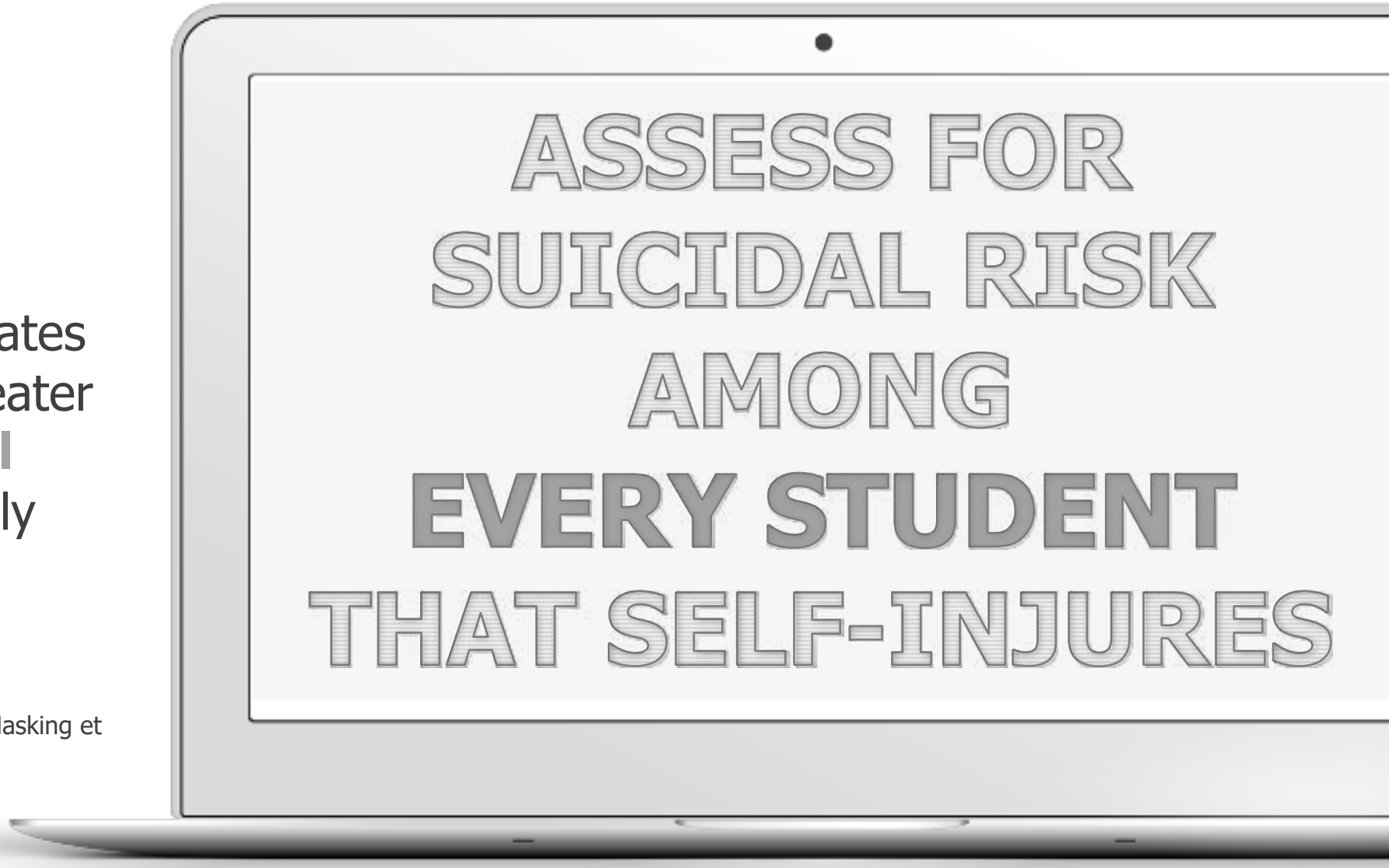
- Among high school students, **16% report thinking about suicide** each year
- Each year, **8% of high school students attempt to take their lives**
- Among high school students, **the rate of self-injury is significantly higher** than the rate of suicide

Self-injury and Suicide

Self-injury is one of the strongest predictors of a future suicide attempt
(Asarnow, & Mehlum, 2019; Glenn et al., 2017)

Emerging research indicates that **self-injury** is a greater **risk factor for suicidal behavior** than previously believed

(Asarnow, & Mehlum, 2019 Glenn et al., 2017; Hasking et al., 2016; Walsh 2012)



Comparison of High School vs Inpatient Samples

Community

Among a high school sample:

21% reported having self-injured

16% reported suicidal ideation

5% reported a suicide attempt

(Walsh, 2012)

Clinical

Among an inpatient sample:

70% of those that had self-injured had made a suicide attempt in their lifetime

(Nock, Joiner, Gordon, Lloyd-Richardson, Prinstein, 2006)

55% had done so multiple times

Differences Between Self-injury and Suicide

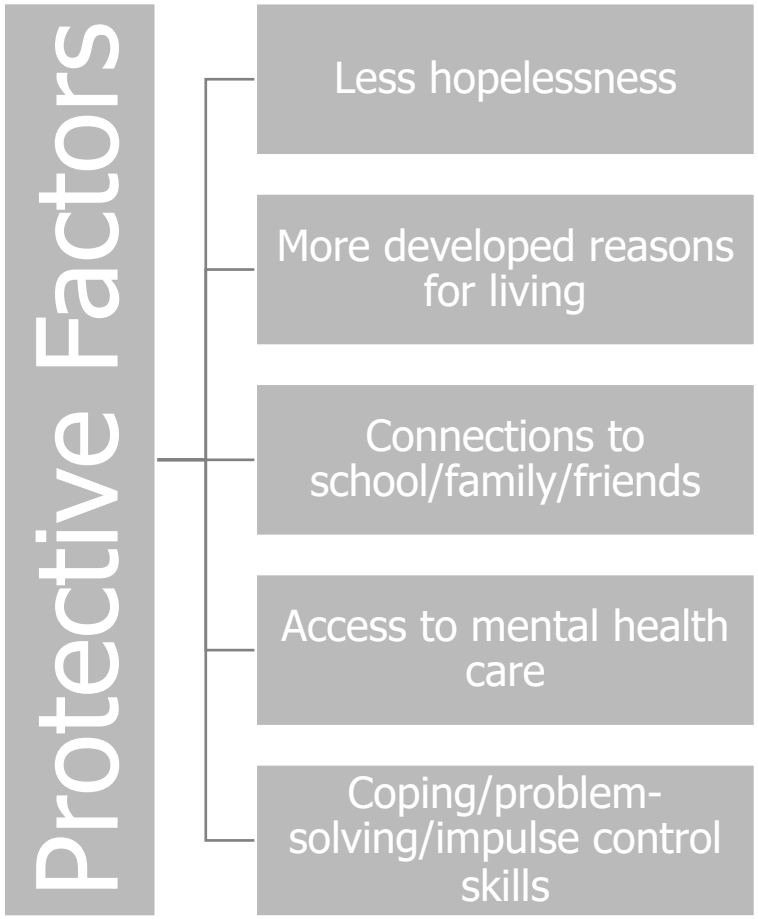
	SELF-INJURY	SUICIDE
INTENT	"I cut to feel better."	"I want to die so the pain will end."
LETHALITY	Commonly use low-lethality, sharp objects	Firearms, hanging, poison, jumping, <2% from cutting
FREQUENCY	20-30 episodes per year	<2 episodes a year
ONSET	Early adolescence (12-14 years of age)	Later adolescence
# of METHODS	70% use multiple methods	Most use same method repeatedly

Differences (continued)

	SELF-INJURY	SUICIDE
PSYCHOLOGICAL PAIN	To alleviate intermittent, uncomfortable distress	To escape from excruciating intolerable pain accompanied by cognitive distortions
THINKING	Disorganized thinking	Constricted thinking
HOPELESSNESS	Maintain a sense of control and hope for future	Feel a loss of control and no future
AFTERMATH	Immediate relief of distress	Feel no better or feel worse
REMOVAL OF MEANS	Virtually impossible & contraindicated	Removal of means saves their life

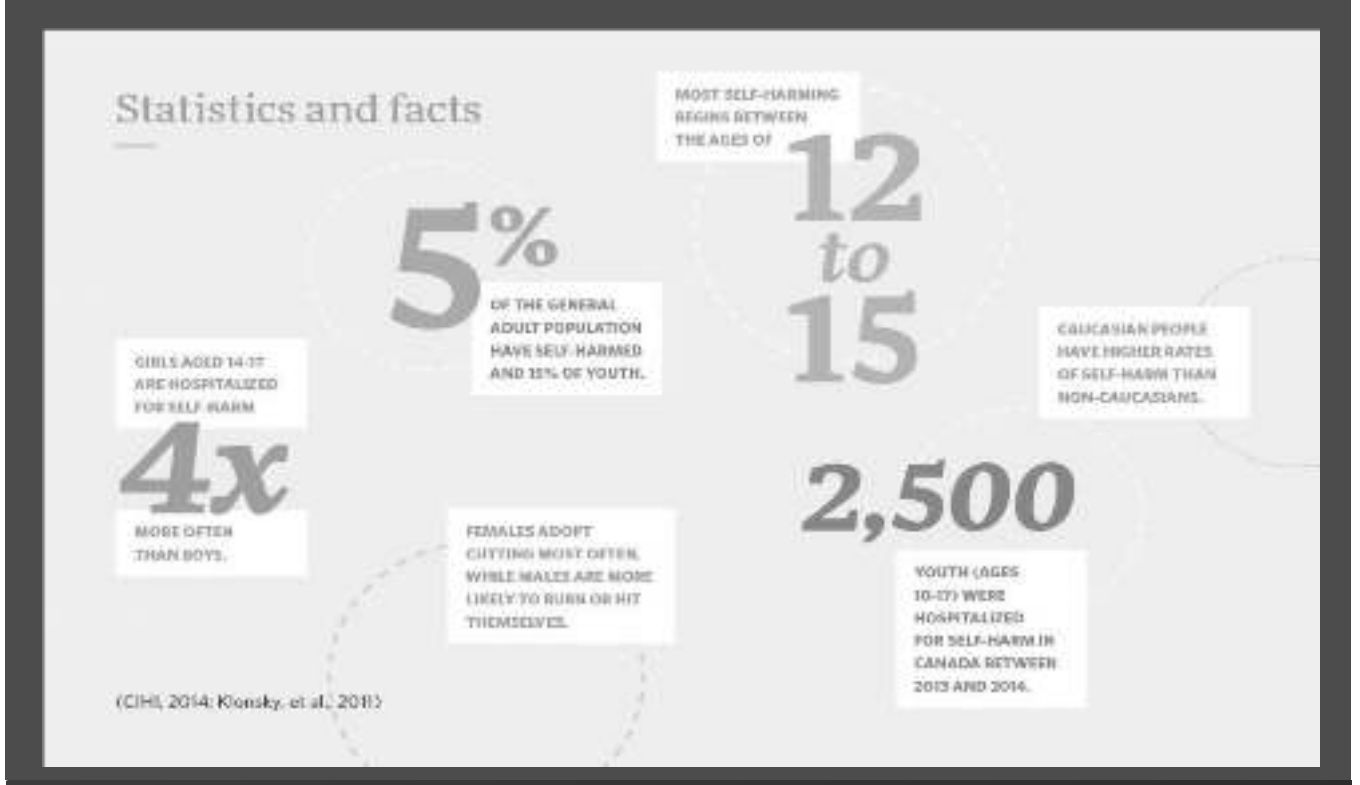
Risk/Protective Factors for Suicide among Self-injurers

(Hasking et al., 2016)



(Walsh, 2012)

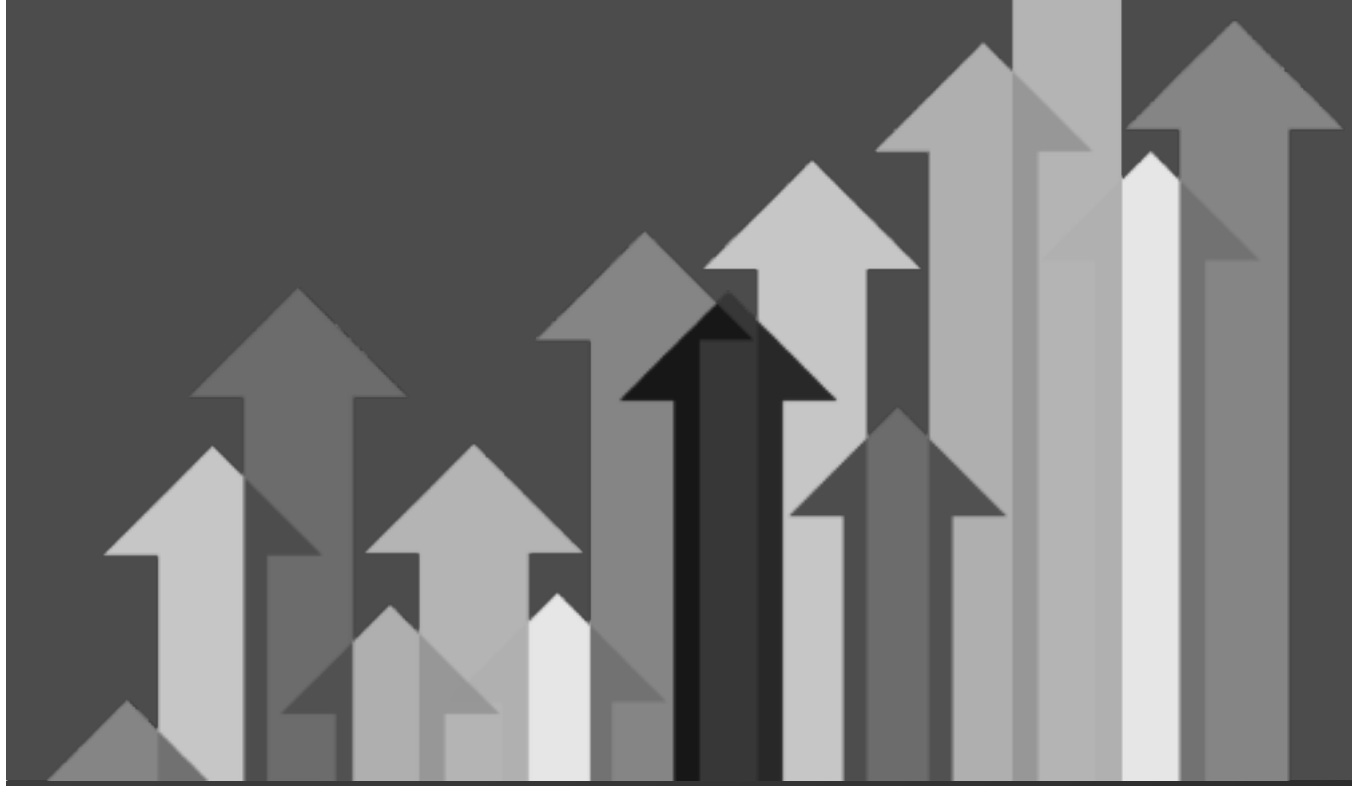
Understanding Self-injury in the Schools



Prevalence

- **18%** of teens in school setting engage in self-injury
  (Hasking et at., 2016)
- **30%** of teens do so repetitively
  (Muehlenkamp, Clases, Havertape, & Plener, 2012)
- **50%** of adolescents among the clinical population have had at least one incident of self-injury.

Developmental Course



There is no typical profile of an individual who self-injures

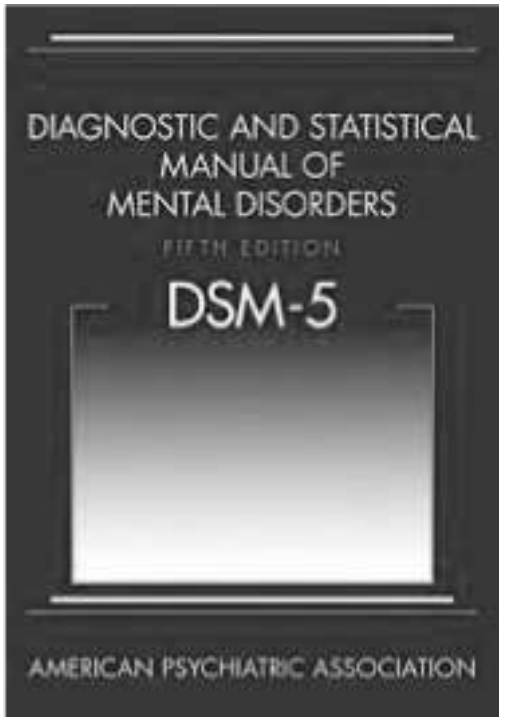
- Self-injury behavior **begins around 13–14 years of age**
  (Nock, 2009)
- Without treatment, self-injury **can persist into adulthood**
- Self-injury occurs at **equal rates for boys and girls**
  (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006).
- **Females present with more severe methods of self-injury** and are more likely to be in treatment
  (Hollander, 2017)
- **Adolescents who repeatedly engage in self-injury are at greater risk** for long-term mental health issues, suicidality, and risk-taking behaviors

DSM-5 Proposed Criteria

A. *In the past year, the individual has,* ***on 5 or more days, engaged in intentional self-inflicted damage*** *to the surface of his or her body, of a sort likely to induce bleeding or bruising or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the* ***expectation that the injury will lead to only minor or moderate physical harm****. The absence of suicidal intent is either reported by the patient or can be inferred by individual's repeated engagement in a behavior that the individual knows, or has learned, is not likely to result in death.*

B. *The individual engages in the self-injurious behavior with one or more of the following expectations:*

- *To* ***obtain relief from a negative feeling*** *or cognitive state*
- *To* ***resolve an interpersonal difficulty***
- *To* ***induce a positive feeling state***



DSM-5 Proposed Criteria–continued

C. *The intentional self-injury is **associated with at least one** of the following:*

1. ***Interpersonal difficulties** or **negative feelings or thoughts**, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.*
2. *Prior to engaging in the act, a **period of preoccupation with the intended behavior** that is difficult to control*
3. ***Thinking about self-injury that occurs frequently**, even when it is not acted upon.*

D. *The behavior is not socially sanctioned (e.g., body piercing, tattooing, part of religious or cultural ritual) and is not restricted to picking a scab or nail biting.*

E. *The behavior and its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.*

F. *The behavior does not occur exclusively during states of psychosis, delirium, intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental or medical disorder (e.g., psychotic disorder, pervasive developmental disorder, mental retardation, Lesch-Nyhan Syndrome, stereotypic movement disorder with self-injury, trichotillomania, excoriation).*

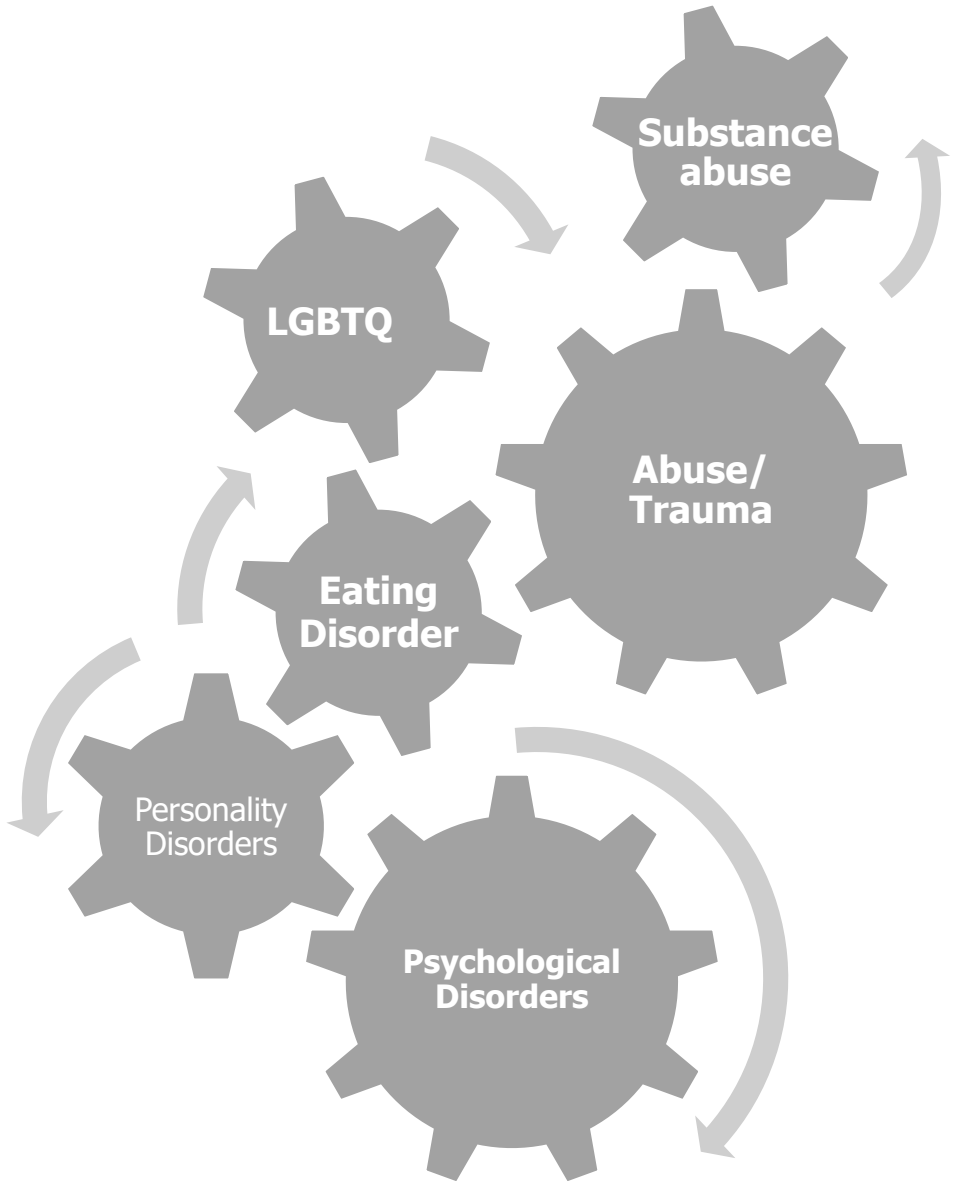
(DSM-5, 2013 p. 803-805)

Nonclinical Population Factors

There has been an increase in self-injury in teens without psychiatric disorders

- **Environmental Influences:**
  - High stress at school
  - Multitasking expectation
  - Diminished sense of community
- **Peer Group Influences:**
  - Normative rites of passage
  - Peers that support self-injury
  - Desensitization due to increased social acceptability of piercings/body art
- **Internal Psychological Elements:**
  - Need for sense of control
  - Need for tension release
  - Inadequate self-soothing skills
- **Direct Media Influences:**
  - Graphic depictions glorifying self-injury
  - Online groups dedicated to self-injury

(Walsh, 2012)



Comorbidity

The rate of diagnosable mental disorders among those engaging in self-injury (88%) approximates the rate of mental disorders among those engaging in suicide attempts. (Nock, Joiner, Gordon, Lloyd-Richardson, Prinstein, 2006)

Reasons why adolescents self-injure

Reasons vary over time and most adolescents report more than one reason for self-injury

- To feel physical pain when **psychological pain** is overwhelming
- To feel physical pain to combat **numbness**
- To keep **trauma** from intruding
- To **prevent killing themselves**
- To gain the **attention of others**
- To discharge **tension**
- To gain a sense of **control**
- To **punish** themselves
- To **avoid** doing other things to cope (i.e., using substances)

"Self injury is the result of a very complex, opportune and clever interaction between cognitive, affective, behavioral, environmental, biological and psychological factors."

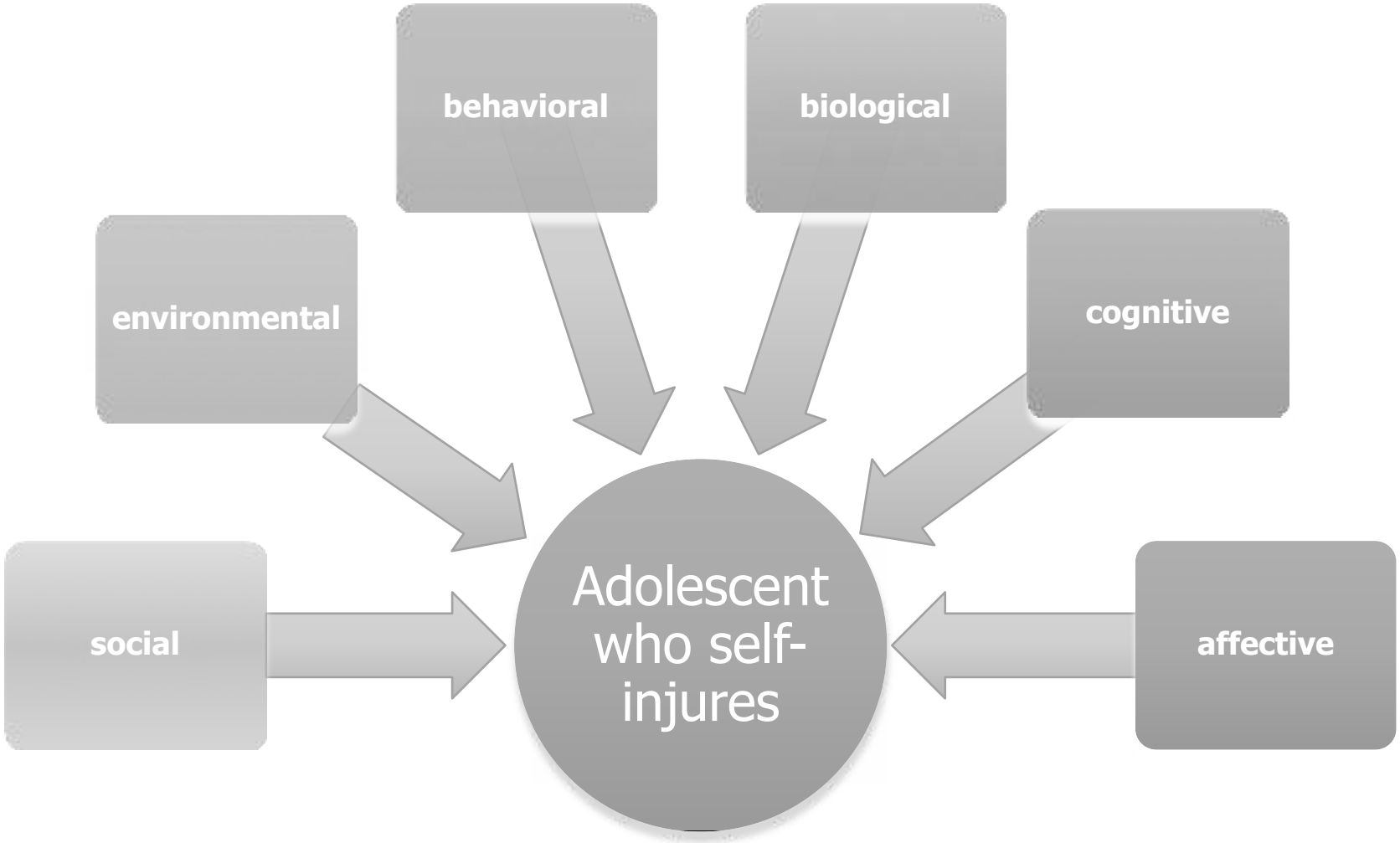
(Lieberman & Poland)

Associated Factors

- Adolescent age
- Female gender
- Contact with others who self-injure
- Bullying
- Adverse Child Experiences (i.e., abuse or neglect)
- Neurobiological differences in:
  - HPA axis
  - Opioid system
  - Processing of emotionality

  (Brown & Plener, 2017)

Contributing Factors of Self-injury

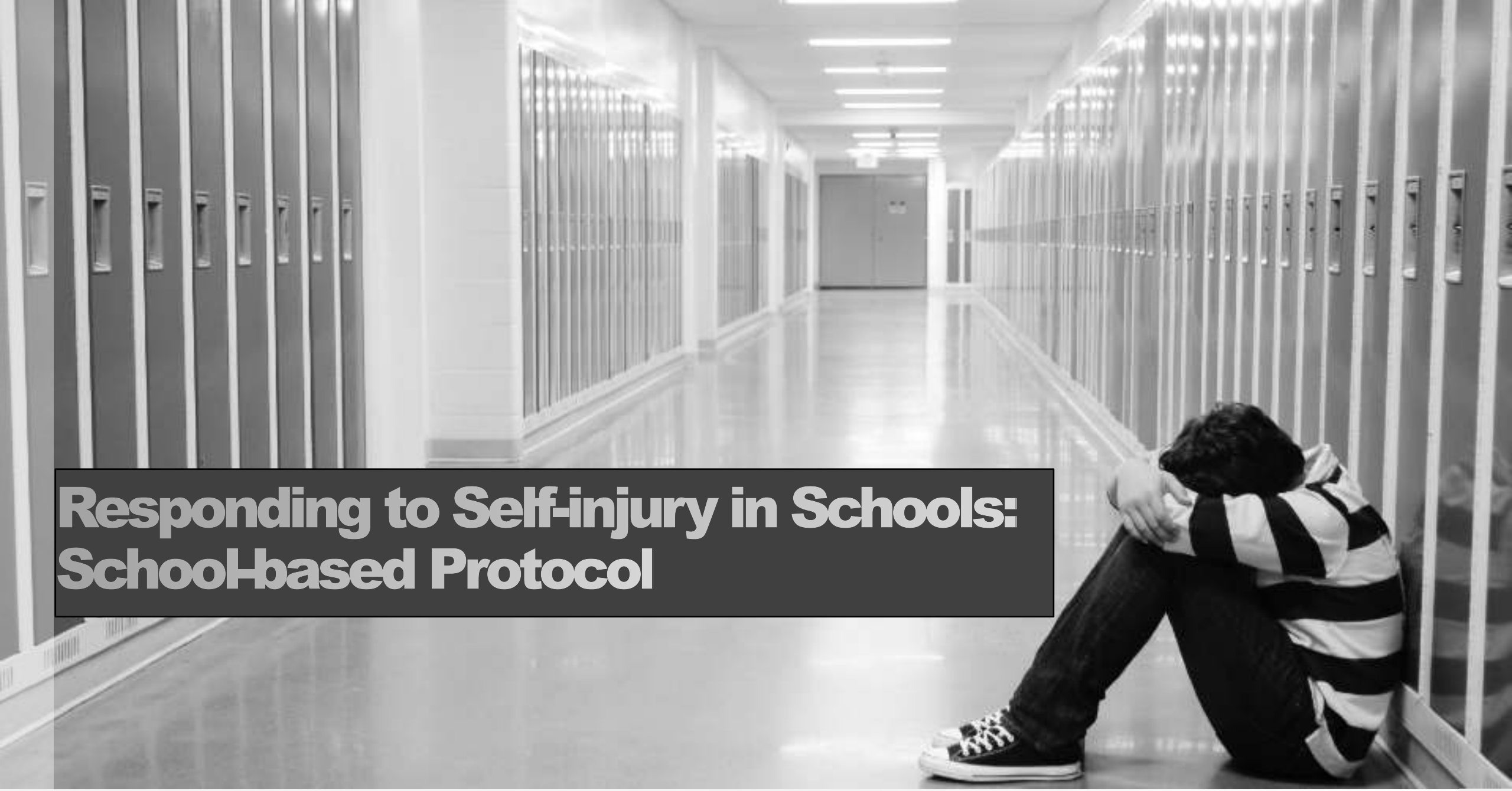


Contagion

"Social contagion is when multiple students in the same group, engage in acts of self-injury within a short period of time."

(Lieberman & Poland, 2006)

- Having a friend who self-injures is a strong predictor of self-injury, therefore **adolescents may trigger self-injury in each other**
(Walsh & Muehlenkamp, 2013)
- **Social contagion is exacerbated in environments such as schools**, which is one reason for the increased prevalence of self-injury
(Plante, 2007)



Responding to Self-injury in Schools: School-based Protocol

Role of School Team in Managing Self-Injury

1

All School Staff Are Trained to Recognize Signs of Self-Injury

- Staff recognize signs of self-injury or suicidal ideation
- Staff supervise student and immediately refer to designated team member

2

School Psychologist Assesses Identified Student

- Assess directly in all areas of concern
- Assess suicidal ideation and comorbid issues

3

Team Notifies, Refers, and Provides On-going Support

- Inform parents
- Refer for medical and psychological treatment
- Obtain releases for exchange of information

Staff the team appropriately

Establish a Crisis Response Team and outline specific roles and responsibilities for members

Administrator

Establishes procedures and ensures the team follows them consistently

School-based Mental Health Provider

Assesses, notifies, and refers

School Nurse

Assesses extent of self-injury damage and determines the need for medical treatment

Teach staff to recognize the signs of self-injury

Identify both direct and indirect signs of self-injury

Direct self-injury:

- cutting of the wrist, arm, or body
- severe self-scratching or picking of wounds
- self-burning
- self-hitting
- crude self-inflicted tattoos
- disfiguring hair pulling and removal
- communication regarding self-harm/suicidal themes, talk of suicide; poetry, writings, artwork, texts, postings

Indirect self-injury:

- eating-disordered behavior
- substance abuse or addiction
- risk-taking behaviors, such as physical risks (e.g., standing on the edge of a roof); situational risks (e.g., walking alone at night in a high- crime area); sexual risks (e.g., unprotected sex with strangers)
- unapproved discontinuation of prescribed medications

Teach staff how to respond to student who is self-injuring

Convey a willingness to listen and understand

- Respond with a calm, reassuring, and nonjudgmental compassion
- Show concern and connectedness while not invading the student's space
- Reassure the student that the self-injury is a coping skill to manage intense emotions
- Consider saying: "You must be feeling upset about something. I'd like to help you."
- "It's probably hard to imagine right now, but many people learn healthier ways to cope. Let's find someone to help."

Teach staff how to respond to student who is self-injuring (continued)

Offer reassurance for hope and support

- Match language the student uses in describing their self-injury
- **Do NOT** promise confidentiality
- Emphasize hope for the future and remind the student that self-injury is treatable
- Supervise and accompany the student to the school mental health professional to share knowledge of the self-harming behavior

Assess student
Notify parent
Refer for treatment

Self-injury is one of the strongest predictors of a future suicide attempt

Risk Assessment

- Assess student individually for suicidal risk
- Assess co-existing disorders
- Supervise until deemed safe
- Document all actions

Parental Notification

- Required to inform parent if behavior is harmful to self (except when would endanger student)
- Share basic education about self-injury

Appropriate Referral

- Guide parent toward possible referrals: to community resources, outpatient treatment, or emergency assistance if imminent risk
- Request signed release to exchange information

Provide follow-up support

On-going support

- Follow up upon their return to campus
- Implement a safety plan--identifying supports, triggers, appropriate coping strategies, and emergency contacts at school
- Coordinate interventions between private practitioners, families, and school staff to identify triggers, key functions, and severity of the self-injury

Teach coping strategies to replace self-injury behaviors

Collaborate with community partners

- Replacement skills can include mindful breathing, visualization techniques, physical exercise, artistic expression, writing, listening to music, connecting with others, and diversion methods
- Use cognitive restructuring to change negative thinking and cognitive distortions. For example, challenging automatic thoughts, identifying core beliefs, and recognizing thought distortions
- Help students plan ahead for situations that trigger emotional responses
- Help students connect the function of their behavior with a proven strategy
- Teach students how to reduce emotional intensity quickly

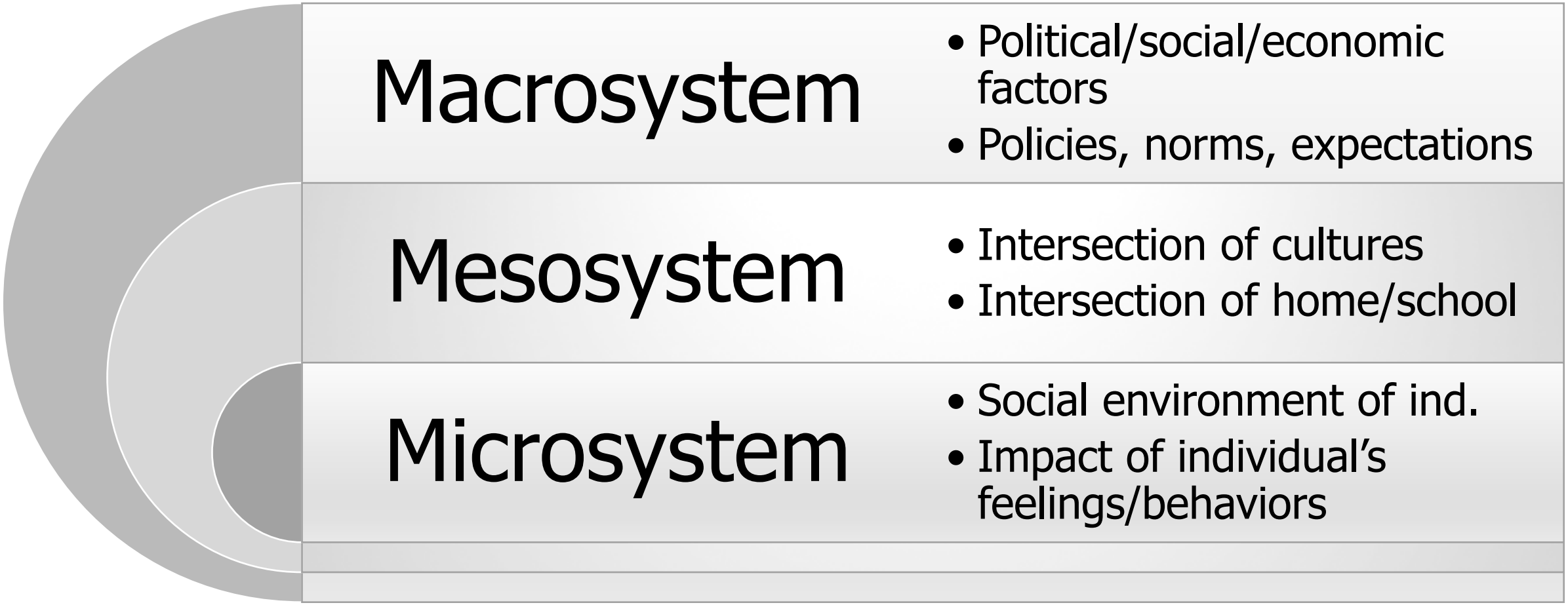
Minimize contagion

Take steps to avoid triggering self-injury in others

- Meet one-on-one about self-injury, **NOT** in groups; focus on treatability
- Refrain from publicizing incidents, such as through class assemblies, articles in school newspapers, or video sessions
- Monitor social media focused on self-injury
- In collaboration with parents, suggest that self-injuring students cover new wounds

Cultural Considerations

Ecological Perspective—Nonlinear & Dynamic



Self-injury Prevalence in the World

Country	Lifetime Prevalence	Research
Australia	**14%**	Martin, et al. (2010)
Canada	**15%**	Laye-Gindhu & Schonert-Reichl (2005)
China (city of Dujiang-yan)	**26%** **29%**	Liu, et al. (2018) Tang, et al. (2018)
Germany	**18%**	Donath et al., (2019)
Hong Kong	**15%** **32%**	You et al. (2011) Shek & Yu (2012)
Japan	**20%**	Tresno & Mearns (2016)
Korea	**12%**	Lee (2016)

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Cautions Regarding Generalizations

- **Definition** of self-injury
- Sample **population description**
- **U.S. or abroad**
- Ecological **framework** conditions

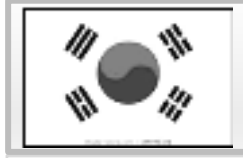
Emerging Research : Asian Countries

Self-Injury Risk Factors among Asian Samples

CHINESE

- Female **gender**
- Adverse life events--trauma
- Poor relationships
- **Loneliness**
- **Father's education**

Tang, et al. (2018)
Liang, et al., (2013)



KOREAN

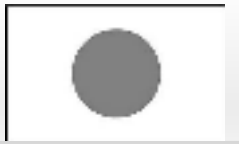
- Depression/**Emotional distress**
- **Alexithymia--difficulty identifying feelings**
- **Academic stress**
- Poor relationship: **parents**
- Poor relationship: **peers**

Lee (2016)

VIETNAMESE

- Female **gender**
- Depression
- **Urban residency**
- **Feeling hopeless**
- **Feeling unsafe or** victim of domestic violence
- **Alcohol consumption**

Le & Blum, (2011)

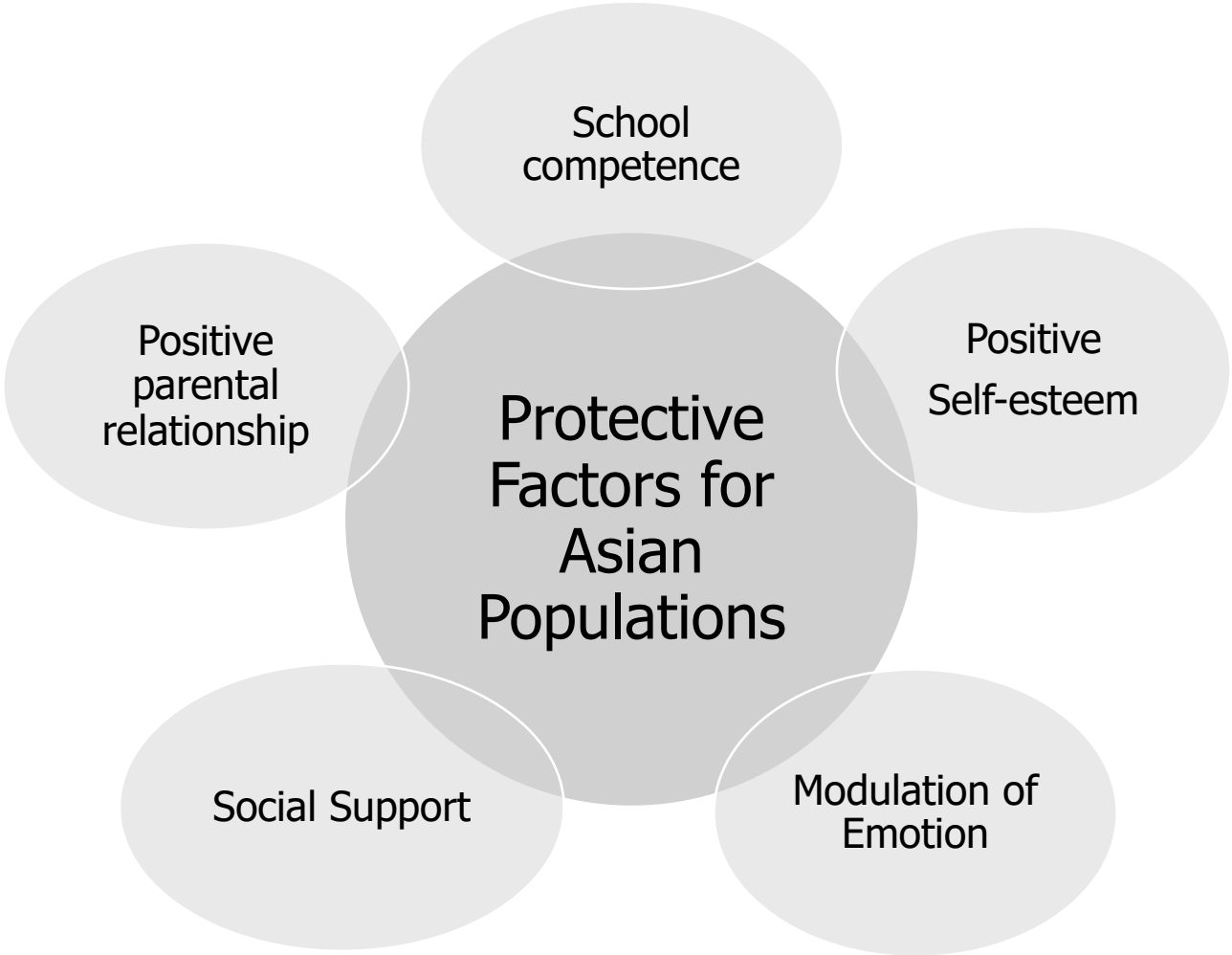


JAPANESE

- Child maltreatment
- **Difficulty with mood regulation**
- Poor relationship: **limited paternal support**
- **Negative home environment**
- **Bullying at school**

Tresno & Mearns, (2016)

Protective Factors from Self-Injury (Combined)



Asian American Students

Self-injury Treatment Issues among Asian American Students

Lispon, S.K., Kern, A., Eisenberg, D., & Breland-Nobel, M. (2018).

- Asian American students with mental health conditions have the lowest prevalence of treatment (20%)
- 80% of cases going untreated
- International Asian students are even less likely to seek treatment
- Asian college students have the highest rates of distress at intake--delays from symptom onset to treatment may be resulting in higher levels of need
- Missed opportunities for prevention and early intervention

Factors Impacting Depression Among Asian Americans, Native Hawaiians, and Pacific Islander

Wyatt et al., (2015)

Risk Factors

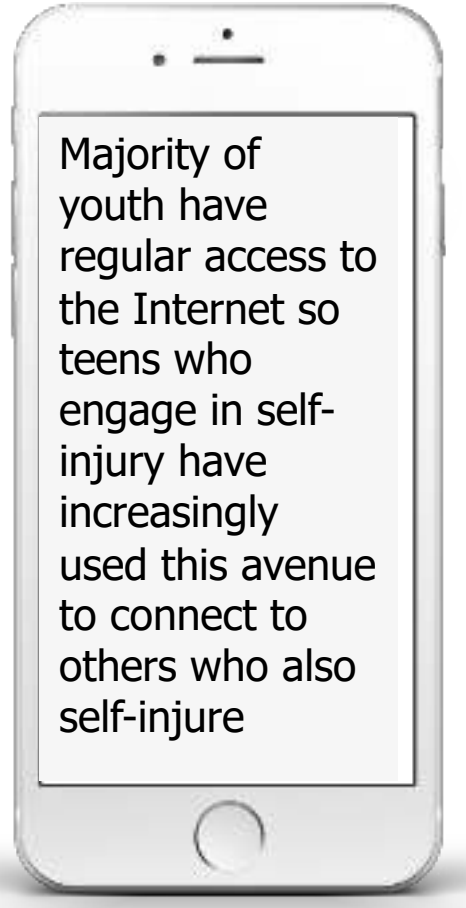
- **Discrimination**
- **Marginalization in Asian culture**
- **Acculturation**
- **Discrepancy in acculturation between parents and children**
- **Parental conflict**
- **Unsupportive parenting/low parental warmth/alienation**

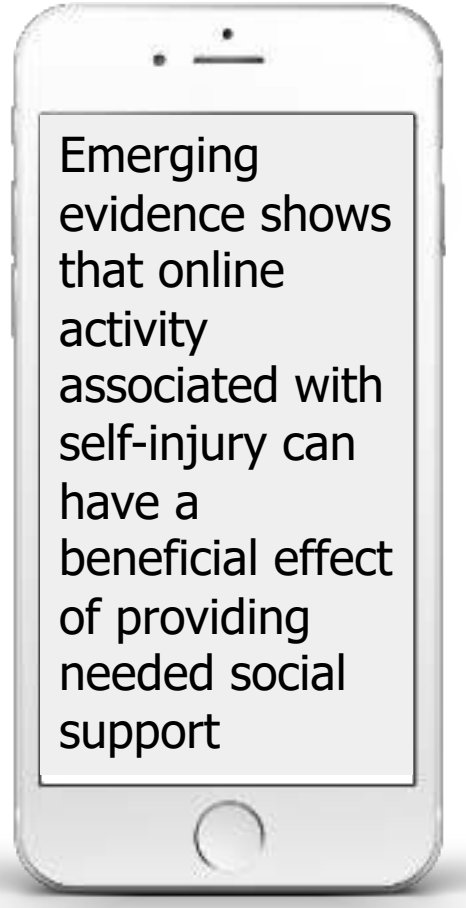
Protective Factors

- **Emotional support**
- **Peer support**
- **Family support and cohesion**
- **Strong ethnic identity**
- **Longer stay in U.S/English proficiency**
- **School involvement**
- **Spirituality**

Social Media and Self-injury

Online Self-Injury Activity





Online Activity Surrounding Self-injury

- **42 million searches** of self-injury per year on Google
- **2 million views** of the top 100 YouTube videos with self-injury
  - 90% showed photographs
  - 28% of videos showing self-injury action
- **30%** of questions posted to "Yahoo! Answers" database on self-injury were were posted with the intent of seeking validation for it

Facebook takes steps to stop suicides on Live

Jessica Guynn, USA TODAY Published 6:03 a.m. ET March 1, 2017 | **Updated 4:56 p.m. ET March 1, 2017**

In January, a 14-year-old girl hung herself in her Florida foster home and a 33-year-old aspiring actor shot himself in a car on a Los Angeles street, both on Facebook Live. A young Turkish man who had broken up with his girlfriend told viewers before committing suicide on Facebook Live in October: "No one believed when I said will kill myself. So watch this."

Need for Social Media Platform Responses

Sample of news stories that have lead to formal responses

Social Media Policies on Posting Self-Injury Images

- We will not allow any graphic images of self-harm, such as cutting on Instagram – even if it would previously have been allowed as admission.
- We will not show non-graphic, self-harm related content – such as healed scars – in search, hashtags and the explore tab, and we won't be recommending it.
- We are blurring any non-graphic self-harm related content with a sensitivity screen, so that images are not immediately visible.

- Experts unanimously reaffirmed that Facebook should allow people to share admissions of self harm and suicidal thoughts, but should not allow people to share content promoting it.
- Experts also advised that some graphic images of self-harm, particularly cutting, can have the potential to unintentionally promote self-harm even when they are shared in the context of admission or a path to recovery. As a result, we will no longer allow graphic cutting images.

- After we assess a report of self-harm or suicide, we will contact the reported user and let him or her know that someone who cares about them identified that they might be at risk. We will provide available online and hotline resources and encourage them to seek help.
  - Is this person posting comments about death or feelings that death is the only option?
  - Is he or she posting comments about having attempted suicide in the past?
  - Is he or she describing or posting photos of self-harm or identifying him or herself as suicidal?

Resources

Resources–Websites

Cornell Research Program on Self-Injury and Recovery

www.selfinjury.bctr.cornell.edu

Site shares new research and insight about self-injury and translates the growing body of knowledge about self-injury into resources and tools useful for those seeking to better understand, treat, and prevent it.

S.A.F.E. (Self-Abuse Finally Ends)

www. selfinjury.com

Site offers resources to help end self-injurious behavior, based on a nationally recognized treatment approach, professional network, and educational resource base.

Self-injury Outreach and Support

www.sioutreach.org

Website provides resources about self-injury to individuals who self-injure, those who have recovered, as well as their caregivers and families, friends, teachers and the health professionals who work with them.

Harmless

www.harmless.org.uk

A user led organization that provides a range of services about self harm and suicide prevention including support, information, training and consultancy to people who self harm, their friends and families and professionals.

International Society for the Study of Self-Injury

www. itriples.org

Group promotes the understanding, prevention, and treatment of nonsuicidal self-injury (NSSI) and foster well-being among those with lived NSSI experience and those impacted by NSSI.

Resources—Crisis Lines

1-800-TLC-TEEN

Teen Line

Phone lines are answered by teen peers. Emails answered by adults or peers.

1-866-488-7386

The Trevor Project (LGBTQ)

Crisis intervention and suicide prevention for LGBTQ young people under 25.
TrevorText
Text "START" to 678678

1-800-DON'T-CUT

S.A.F.E. Alternatives

Help and information are available by calling or on website.

This is **not** a crisis hotline.

1-800-334-HELP

Self Injury Foundation24-hour national crisis line.

Provides 24/7, free and confidential support for people in distress, and best practices for professionals.

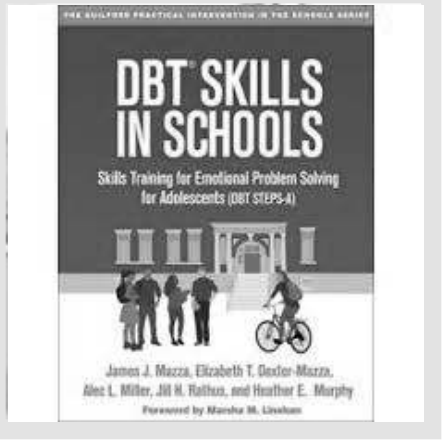
1-800-273-TALK

JED foundation

A nonprofit that exists to protect emotional health and prevent suicide for teens and young adults

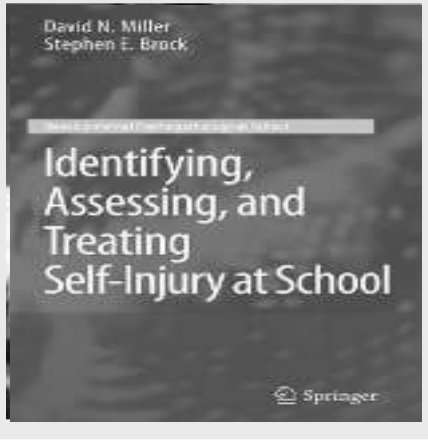
Text "START" to 741-741

Resources—Books for Educators



Mazza, J., Dexter-Mazza, E., Miller, A., Rathus, J. & Murphy, H. (2016)

DBT® Skills in Schools: Skills raining for Emotional Problem Solving for Adolescents



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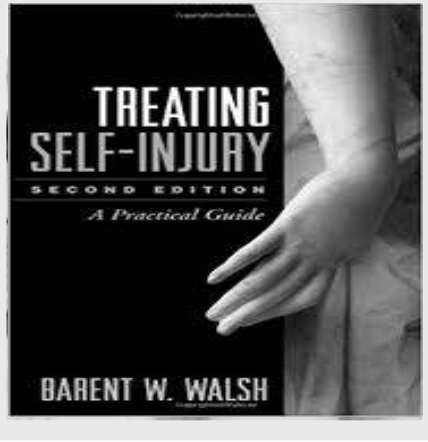
Identifying, assessing, and treating self-injury at school



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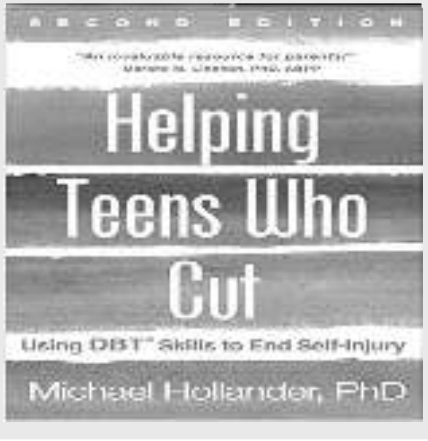
Treating Self-injury: Second edition



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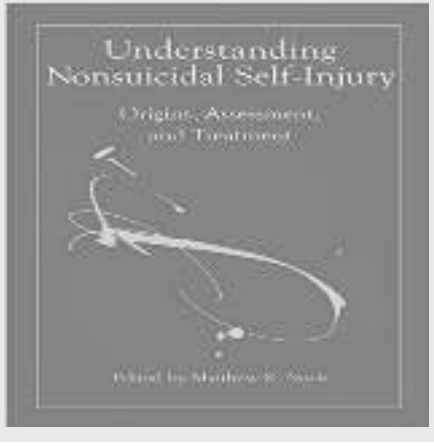
Helping teens who cut: Using DBT skills to end self-injury: Second Edition



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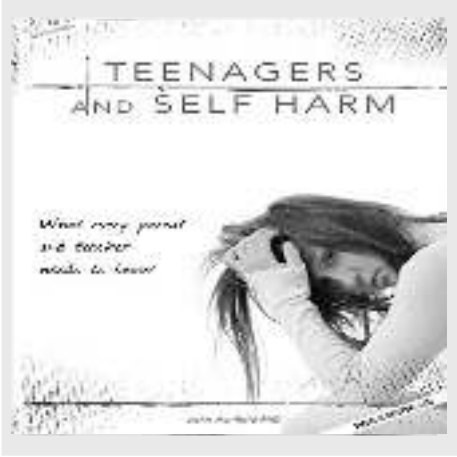
Understanding nonsuicidal self-injury: Origins, assessment, and treatment

Resources—Books for Parents

Whitlock, J. (2019)

Healing Self-Injury



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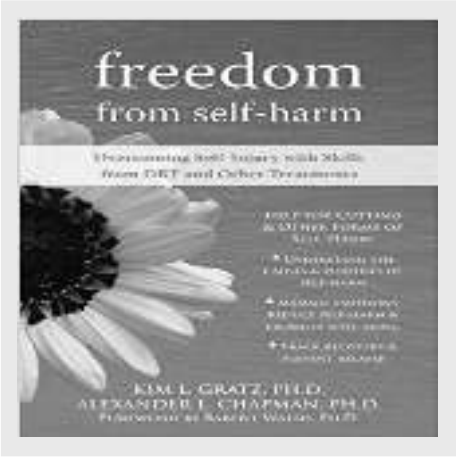
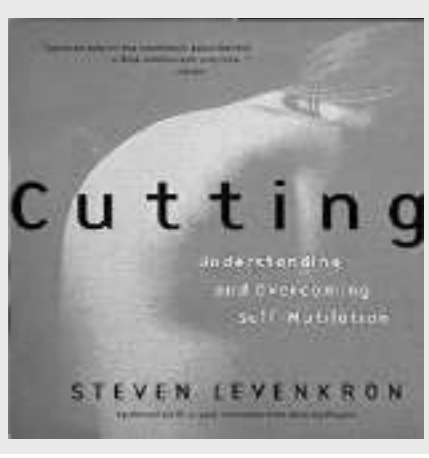


Gratz, K., & Chapman, A.(2009)

Freedom from self-harm: Overcoming self-injury with skills from DBT and other treatments



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Resources—Handouts for School and Home

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HELPING HANDOUTS: SUPPORTING STUDENTS AT SCHOOL AND HOME

NATIONAL ASSOCIATION OF School Psychologists

Nonsuicidal Self-Injury (NSSI): Helping Handout for Home

RICHARD LIEBERMAN, SCOTT POLAND, & MARINA NIZNIK

INTRODUCTION

Nonsuicidal self-injury (NSSI) among adolescents is gaining increased recognition, in social media in particular, and parents are often concerned about how to respond to this complex behavior. NSSI has been referred to by many names, including parasuicide, self-mutilation, deliberate self-harm, and self-inflicted violence. NSSI includes a variety of behaviors in which individuals intentionally inflict harm to their bodies without the intention of dying. It is important for parents to realize that youth do not engage in these behaviors as a suicide attempt. A young person who is suicidal wants to be out of pain. A person who cuts wants to feel better. An estimated 14–18% of teenagers engage in this behavior to manage overwhelming emotions and psychological distress (Whitlock & Rodham, 2013).

NSSI behaviors can include cutting, burning, carving, bruising, hair pulling, scratching, needle pricking, or interference with wound healing, as well as punching objects or oneself. Youth may use a variety of objects including razors, scissors, knives, pen tops, pieces of glass, fingernails, and broken objects. Arms, legs, and the abdomen are commonly targeted because these can be easily concealed by clothing.

Parents may first notice changes in mood, withdrawal from people and activities, and secretive and/or avoidant behaviors. However, parents should be alert to unexplained cuts, burns, or bruises; inappropriate dress for the climate and season; avoidance of activities that require removal of clothing; and art, poems, or essays that focus on self-injury. Such behaviors indicate that parents should take action.

There is no typical profile of an individual who self-injures. Although people often assume that NSSI occurs more frequently in girls, these behaviors actually occur in boys and girls at equal rates. Most NSSI behaviors begin around 13–14 years of age and, without treatment, can persist into adulthood (Nock, 2009). The majority will use NSSI episodically, or every once in a while, to seek relief from distressing thoughts. Some adolescents will engage in NSSI repeatedly, with the result of new scars mixed with old. These youth may have experienced serious trauma or may be coping with mental illness. Although adolescents with mental illness make up an estimated 9 out of 10 cases (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006), there has been an increase in NSSI in youth without psychiatric disorders. These youth are challenged by intense stress, inadequate self-soothing skills, negative thoughts about themselves, and peer influences that support self-injury (Walsh, 2012).

The overwhelming majority of youth have regular access to the Internet, therefore it is not surprising that teens who engage in NSSI have increasingly used this avenue to gain information and connect to others who also self-injure. Engaging in online NSSI activity may reinforce the behavior and could trigger injurious behaviors. However, emerging evidence indicates that online activity associated with NSSI also can have the beneficial effect of providing needed social support (Mahdy & Lewis, 2013).

WHAT TO CONSIDER WHEN SELECTING INTERVENTIONS AND SUPPORTS

NSSI behaviors serve different functions for youth, and these functions provide clues as to how parents and therapists should proceed with treatment plans. The two most common functions of NSSI are to create a desirable state of relief and to get the attention of

HELPING HANDOUTS: SUPPORTING STUDENTS AT SCHOOL AND HOME

NATIONAL ASSOCIATION OF School Psychologists

Nonsuicidal Self-Injury (NSSI): Helping Handout for School

RICHARD LIEBERMAN, SCOTT POLAND, & MARINA NIZNIK

INTRODUCTION

Nonsuicidal self-injury (NSSI) occurs among 14–18% of youth in the school environment (Hasking et al., 2016). School personnel are among the first adults to become aware of students engaging in self-injury. They often notice unexplained cuts, burns, or bruises; inappropriate dress for the climate or season; avoidance of activities that require removal of clothing; and work focused on self-injury (such as art, poems, or essays). Other times, a peer may bring the issue to the attention of school staff. One reason for an increasing prevalence of self-injury in schools is social contagion, which is when multiple students in the same peer group engage in acts of self-injury within a short period of time (Lieberman, Toste, & Heath, 2008).

Previously referred to as parasuicide, self-mutilation, deliberate self-harm, and self-inflicted violence, NSSI is "intentional, self-effected, low-lethality bodily harm of a socially unacceptable nature, performed to reduce and/or communicate psychological distress" (Walsh, 2012, p. 4). This behavior is most commonly considered a coping device to manage overwhelming emotions and psychological distress without suicidal intent. Behaviors can include cutting, burning, bruising, hair pulling, scratching, needle pricking, and interference with wound healing. Behaviors may also include punching or hitting objects or oneself, ripping or tearing skin, or carving one's skin using a variety of objects, including razors, scissors, knives, pen tops, pieces of glass, fingernails, and broken objects (DSM-5; APA, 2013).

NSSI often begins in middle adolescence and occurs equally across genders (Nock, 2009). Without effective treatment, self-injury will persist into adulthood for most students. The majority of students who self-injure also have diagnosable psychiatric issues and may be experiencing eating disorders, depression, anxiety, bipolar disorders, externalizing disorders, substance abuse, and adverse childhood experiences, including a history of sexual abuse. More recently, however, self-injury is also occurring outside the context of psychological illness. These youth are instead challenged with intense stress, inadequate self-soothing skills, negative thoughts about themselves, and peer influences that support self-injury (Walsh, 2012). With the burgeoning of online communities that mimic real-life, careful monitoring may help determine if students' online activity is normalizing, reinforcing, and increasing the self-injuring behavior, or if such online activity is providing needed social support and therefore decreasing incidents of NSSI.

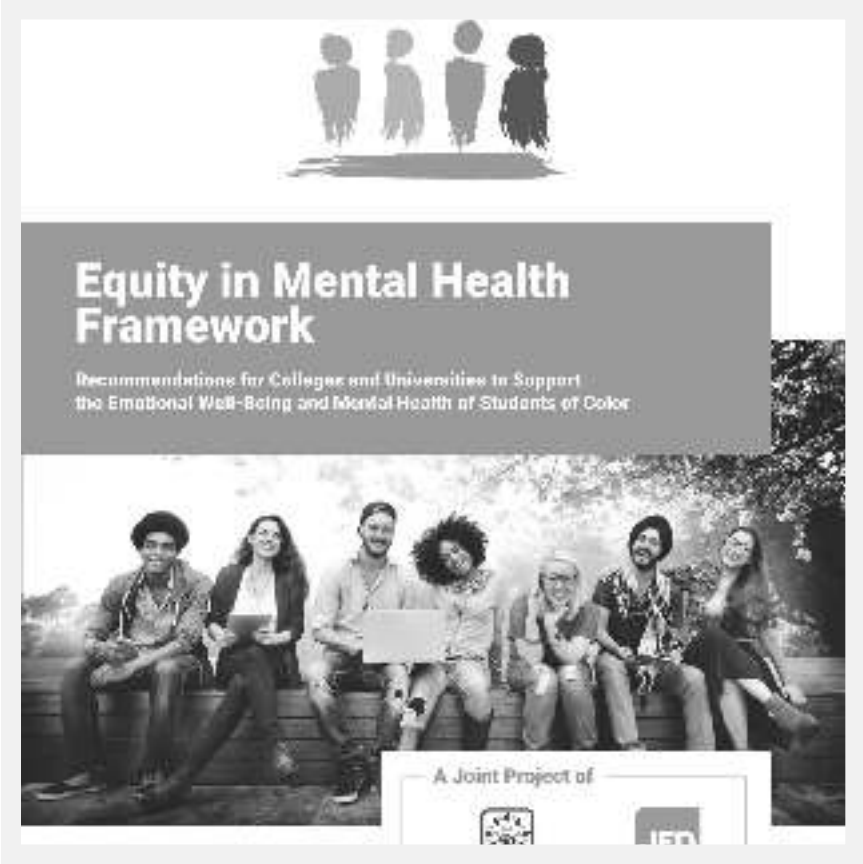
WHAT TO CONSIDER WHEN SELECTING INTERVENTIONS AND SUPPORTS

Understanding the function of NSSI is a key to treatment, though adolescents typically report more than one reason, which often changes over time (Hasking et al., 2016). The most commonly reported function of self-injury among adolescents is the regulation of intolerable distress (Hasking et al., 2016) that is a result of experiencing too much emotion (e.g., anger, shame, guilt, anxiety, tension, sadness, frustration, or even contempt) or too little emotion (e.g., emotional emptiness or feelings of numbness; Walsh, 2012). Self-injury increases the teens' feeling that they are alive. Less often, teens engage in NSSI to manage disturbing thoughts associated with trauma or major mental illness.

NSSI can also be viewed as a method to regulate biological needs and increase naturally occurring brain chemicals that result in feelings of well-being. For

Resource—Students of Color

Recommendations for Colleges and Universities to Support the Mental Health of Students of Color



https://equityinmentalhealth.org

Thank You!

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