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Nonsuicidal Self-Injury: Helping Handout for School

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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

many, self-injury effects an immediate sense of calm and relief, almost like a painkiller, which is likely the result of the brain's release of substances that act as an opiate to manage the damage and pain (Hasking et al., 2016). Some youth report social reasons for self-injury. They feel invisible to others and use self-injury to manage the effects of not receiving the affirmation they need. NSSI also may occur when the behavior is modeled by friends, peers, or the media (Nock, 2009). Connecting the potential functions of NSSI behavior to appropriate interventions is a complex task that is achieved over time by a trained mental health professional and is beyond the scope of teachers. However, teachers play key roles in preventing NSSI and responding effectively when they suspect NSSI. Teachers should also work collaboratively with the school's crisis response team when students are identified as engaging in NSSI behaviors.

RECOMMENDATIONS

Most schools have existing crisis response teams and protocols for managing students' suicidal or threatening behavior. Comprehensive management of NSSI behaviors should be part of these teams' responsibilities. The team is responsible for designing a written protocol, based on guidelines from current research, which addresses the unique needs of the educational environment to facilitate consistent, appropriate, and timely responses to self-injury. Several elements specific to NSSI should be part of planning and intervention, including (a) ensuring that team members and the broader school staff are properly prepared to recognize NSSI, (b) delivering a coordinated response when NSSI behaviors are identified, and (c) developing prevention strategies.

Developing the School's Capacity to Manage NSSI

The protocol should clearly define the expertise needed on the team as well as the distinct roles and responsibilities of school staff in working collaboratively with the team.

1. ***Staff the team appropriately.*** Crisis response team members are responsible for risk assessment and ongoing support. Therefore, the team should include an administrator and school-based mental health service providers (e.g., school psychologist, social worker, counselor) who are qualified to recognize self-injury behavior, assess risk, provide support to the student, and establish and follow consistent procedures for how to secure assistance and make appropriate referrals (Lieberman, 2004). The school nurse also should be a team member, with the responsibility of assessing the extent of self-injury (tissue damage, injury on atypical locations) and referring the student for medical attention, if needed.
2. ***Teach staff to recognize the signs of self-injury.*** All school staff members should have sufficient knowledge to identify NSSI and refer students immediately. Specifically, the team should provide training for staff in detecting NSSI and distinguishing between direct and indirect self-harm (Lieberman et al., 2008), as defined:
   - *Direct self-injury.* Direct injury includes cutting of the wrist, arm, or body; severe self-scratching; self-burning; self-hitting; picking of wounds; crude self-inflicted tattoos; disfiguring hair pulling and removal; excessive accident-proneness; and any communication regarding self-harm or suicidal themes, including talk of or jokes about suicide, or poetry, writings, artwork, texts, postings on those themes.
   - *Indirect self-injury*. Indirect injury includes eating-disordered behavior; substance use that is suggestive of 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); or unapproved discontinuation of prescribed medications.
3. ***Teach staff to respond appropriately to signs of NSSI.*** Few teachers are prepared to respond to self-injury effectively. Because the initial adult response can affect students' willingness to further disclose their distress, the following responses are important:
   - Convey a willingness to listen and understand, acknowledge the student's distress, provide reassurance of support, and commit to offering help.
   - Respond with a calm, reassuring, and nonjudgmental compassion. Avoid affectively charged reactions such as intense concern, anguish, fear, repulsion, shock, disgust, avoidance, condemnation, ridicule, or threats. Emotional reactions may leave the student feeling embarrassed and hesitant. Also refrain from showing excessive interest

in the self-injury or asking the student to relive details, as it could act as a trigger. If it is difficult to not show discomfort, be honest with the student and seek help from a colleague whom the student trusts.
- Show concern and connectedness while not invading the student's space. For example, you could say: "I can see that you are hurting. I'd like to help. Tell me a little about your self-injuring." Or you could say: "I might not be the right person to talk to, but I can find someone who is."
- Reassure the student that the self-injury is a coping skill to manage intense emotions.
- Refrain from being directive or sounding as if you expect immediate change. Consider saying: "You must be feeling upset about something. I'd like to help you." Or: "It's probably hard to imagine right now, but many people learn healthier ways to cope. Let's find someone to help."
- Match the student's language. For example, if they use the word "cutting" to describe the behavior, use the same word when you refer to the behavior, rather than introducing a different descriptor. Many students who self-injure struggle with communication regarding emotions; therefore, avoid pressuring them, as this may evoke strong defensiveness and shutting down.
- Do not promise the student confidentiality. The crisis team's mental health professional will require reporting of self-injurious behaviors to parents.
- Supervise, refer, and accompany the student to the school mental health professional and share knowledge of the potentially self-harming behavior.
- Emphasize hope for the future and remind the student that self-injury is treatable.
- If peers made the self-injury disclosure, meet with them later and acknowledge that they have done the right thing, without sharing confidential information.

Delivering a Coordinated Response When NSSI Behaviors Are Identified

The school's crisis response team must develop a systematic approach to manage NSSI behaviors once they are identified. The team must identify and address immediate medical needs, determine appropriate support resources (e.g., parents, private mental health professional), notify the parents or guardian, and coordinate with relevant community resources. The protocol should establish procedures for risk assessment, include guidelines for parental notification and referrals, outline plans for ongoing support, and delineate methods for managing potential contagion (Lieberman & Poland, 2016).

4. ***Conduct a risk assessment.*** The team's mental health professional will conduct a risk assessment including the following elements:
   - Assess the student individually and maintain supervision until the student is deemed safe or put in the care of a parent or guardian.
   - Assess the student's suicidal ideation and suicide risk. Self-injury is one of the strongest predictors of a future suicide attempt. Therefore, every adolescent who presents with self-injury must be assessed for suicidal ideation and history of suicidal behavior (Hasking et al., 2016).
   - Assess indirect methods of self-injury (e.g., eating disorders, substance abuse, risk-taking behavior, and noncompliance of medication) and the presence of coexisting disorders.
   - Document all actions (Lieberman, 2010).
5. ***Notify the student's parents or guardian of identified risk.*** Established guidelines and state regulations require schools to notify students' parents or guardian about the outcome of the risk assessment, preferably during a face-to-face conference, to give them resources to seek help for their child (Hasking et al., 2016). If the student is at imminent risk for suicide, the school must make this clear to parents or guardian and take the following additional actions:
   - Let the student know that the school is required to inform the parent or guardian if the student's behavior is deemed to be harmful to self. This notification will occur except in cases in which notifying the parents may place the student in danger (e.g., in cases of suspected abuse). In such circumstances, the school's duty to inform parents is satisfied through contact with the local children's protective services agency.
   - Whenever possible, permit the student to remain in the room during conversations regarding the self-injury with the parent or guardian and school staff.

- Share basic education about self-injury with parents to foster a nonjudgmental understanding of the behavior, highlight the behavior as a symptom of serious distress, emphasize the importance of ongoing monitoring for suicide risk, and normalize parental reactions (Hasking et al., 2016).
- If parents do not respond to suggestions for help, contact the local children's protective services agency.

6. ***Make appropriate referrals.*** Depending on the outcome of the assessment, the school mental health professional will guide the parent toward possible options, such as referral to community resources for immediate treatment or assistance, referral to outpatient treatment, or emergency assistance if the student is at imminent risk. Offer to assist parents in contacting a community practitioner with experience working with adolescents who engage in NSSI. In addition, provide the following ongoing support:
   - Request a signed release for the exchange of confidential information to allow communication with the community provider. Treatment can take time and, as appropriate, should be supported and reinforced at school.
   - Follow up to ensure that parents have secured timely support. If parents are having difficulty accessing support in the community, continue to problem solve with them in order to overcome obstacles to treatment.
7. ***Provide ongoing support.*** School personnel (e.g., counselors, nurses, social workers) should follow up with the student upon the return to campus. These supports should include the following:
   - Implement a safety plan to engage the student collaboratively on identifying supports, triggers, appropriate coping strategies, and emergency contacts at school. Allow the student to have choices about next steps.
   - Coordinate interventions between private practitioners, families, and school staff to identify triggers, key functions, and severity of the self-injury.
8. ***Teach the student coping strategies to replace NSSI behaviors.*** School-based mental health providers should work collaboratively with community partners to help the student replace NSSI behavior with more adaptive strategies. Replacement skills can include mindful breathing, visualization techniques, physical exercise, artistic expression, writing, listening to music, connecting with others, and diversion methods. Additional treatment elements include the following:
   - Use cognitive restructuring to change negative thinking and cognitive distortions. These include, for example, challenging automatic thoughts, identifying core beliefs, and recognizing thought distortions (such as overgeneralization, or all-or-nothing thinking).
   - Help students plan ahead for situations that trigger emotional responses. For example, if earning a failing grade on an exam often leads to NSSI behavior, assist the student in engaging in behaviors to reduce the likelihood of poor exam grades in the future. In addition, help them identify effective coping skills in advance that they can use when anticipating negative outcomes, such as a poor grade.
   - Help students connect the function of their behavior with a proven strategy. For example, if the student engages in NSSI to manage intense anxiety, help them practice and refine an anxiety reduction technique that has worked for them at other times.
   - Teach students how to reduce emotional intensity quickly (e.g., changing body temperature, paced breathing, intense exercise).
9. ***Manage contagion in the classroom and school.*** Contagion following an incident is a real possibility. Therefore, school personnel should take the following steps to avoid triggering self-injury in others:
   - Have one-on-one conversations with students about self-injury, rather than in groups. Focus on several topics, including self-injury as a mental health problem that can be treated, the signs of emotional stress and at-risk behaviors, alternative coping strategies, and access to adult assistance within the school. These individual conversations should include students who self-injure and those who are affected by another student's self-injury.
   - Refrain from publicizing incidents, such as through class assemblies, articles in school newspapers, or video sessions on the topic of self-injury.
   - Monitor social media and chat groups focused on self-injury (Lieberman, 2010). Explain to students that communicating (e.g., talking, texting, posting photos) about self-injury can

increase the likelihood that others will engage in self-injury, and gently discourage them from doing so.
- In collaboration with parents, suggest that self-injuring students cover new wounds when possible, as viewing new wounds can trigger others to harm themselves (Hasking et al., 2016).

Preventing NSSI Through Teaching Emotion Regulation and Coping Strategies

As noted above, NSSI behaviors are efforts some students use to cope with overwhelming emotions or to manage unmet social needs. Therefore, schools should provide instruction to all students about healthy coping strategies to prevent NSSI behaviors.

10. ***Use an evidence-based curriculum for staff and students.*** The *Signs of Self-Injury Prevention Program* (Jacobs, Walsh, & Pigeon, 2009) is a systematic approach to ensure that incidents of self-injury will be responded to in a consistent, compassionate, and well-informed manner. It consists of a manual and DVD for school staff and high school students and is supported by research. In addition, consider implementing a school-wide social–emotional learning (SEL) program to assist adolescents in improving how they manage emotions, interpersonal interactions, and decision-making. Choose a program that has demonstrated improved outcomes in empirical studies with regard to the issues pertaining to this population (see CASEL.org). For example, dialectical behavior therapy (DBT) STEPS-A is an SEL curriculum with established efficacy for self-injuring adolescents. The curriculum can be delivered in any classroom (Mazza, Dexter-Mazza, Miller, Rathus, & Murphy, 2016).
11. ***Teach identification of emotions.*** Teach students that they can experience several feelings at one time, as adolescents may often be overwhelmed by a mix of emotions that they cannot easily disentangle. Use emotional education to address difficulties in identifying, accepting, and managing emotion; to highlight negative thinking styles; and to explore coping alternatives such as mindfulness.
12. ***Teach social communication skills.*** Teach students how to effectively make a request and how to assert their needs and opinions appropriately to improve their social exchanges and social problem-solving.
13. ***Teach students how to access help.*** Raise awareness among students regarding available resources and how to access them at school. Prepare students to know what to do if a friend seeks their support. Encourage them to report observed or suspected instances of NSSI to trusted adults at school or at home.

RECOMMENDED RESOURCES

Websites

http://selfinjury.bctr.cornell.edu

The website of the Cornell Research Program on Self-Injury and Recovery 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.

http://www.selfinjury.com/

The website for S.A.F.E. (Self-Abuse Finally Ends) Alternatives offers resources to help end self-injurious behavior, based on a nationally recognized treatment approach, professional network, and educational resource base.

http://sioutreach.org/

The Self-injury Outreach and Support 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.

http://www.nova.edu/suicideprevention/

This website has a link to a video on self-injury that offers information on the incidence of self-injury, associated risk factors, the relationship between self-injury and suicide, and interviews with individuals who have struggled with self-injury.

Books

Mazza, J. J., Dexter-Mazza, E. T., Miller, A. L., Rathus, J. H., & Murphy, H. E. (2016). *DBT skills in schools: Skills training for emotional problem solving for adolescents (DBT STEPS-A).* New York, NY: Guilford Press.

This manual offers a nonclinical application of school-based dialectical behavior therapy (DBT) skills, including a social–emotional learning

curriculum (including lesson plans, handouts, and reproducible tools) for students in grades 6–12.

Miller, D. N., & Brock, S. E. (2011). *Identifying, assessing, and treating self-injury at school.* New York, NY: Springer Science and Business Media.

Geared toward education personnel, this book offers a practical framework from a school-based perspective, including causes of self-injury, current research, warning signs, and interventions.

Related Helping Handouts

Anxiety: Helping Handout for School and Home
Depression: Helping Handout for Home
Depression: Helping Handout for School
Nonsuicidal Self-Injury: Helping Handout for Home
Suicidal Thinking and Threats: Helping Handout for Home
Suicidal Thinking and Threats: Helping Handout for School
Test and Performance Anxiety: Helping Handout for School and Home
Trauma: Helping Handout for Home
Trauma: Helping Handout for School

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