THE CUTTING EDGE: UNDERSTANDING AND ADDRESSING NON-SUICIDAL SELF-INJURY IN YOUTH

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A REMINDER TO TAKE CARE OF YOURSELF

LEARNING OBJECTIVES

- Background
- Common presentation in youth
- Comorbidity
- Detection and intervention
- Resources
- Q & A

NON-SUICIDAL SELF-INJURY (NSSI)

Deliberate, direct, and self-inflicted destruction of body tissue resulting in immediate tissue damage, for purposes not socially sanctioned and without suicidal intent.

WHY WORRY ABOUT IT?

Harbinger of other more lethal conditions

- **Indicates underlying distress that may increase risk for suicide thoughts and behaviors and / or other chronic conditions**

It can cause unintended severe injury

It can lead to lasting disfiguration

It can be contagious

It is stressful for those who love and/or live with someone who uses it

PREVALENCE

Lifetime NSSI estimates range from 7% – 25.6% (up to 65% in clinical populations)Recent review shows:

- 17.2% among adolescents (in most studies 12-18)
- 13.4% among young adults (most studies 18-25)
- 5.5% among adults
  - 75-80% of all report NSSI is repeat (13% single incident)
  - An estimated 6-10% are current and repeat

MOST COMMON SELF-INJURY BEHAVIORS (17%-50%)

- Severely scratching or pinching skin with fingernails or other objects
- Cutting wrists, arms, legs, torso or other areas of the body
- Banging or punching objects to the point of bruising or bleeding
- Punching or banging oneself to the point of bruising or bleeding
- Biting to the point that bleeding occurs or marks remain on skin

LESS COMMON SELF-INJURY BEHAVIORS (8%-12%)

- Ripping or tearing skin
- Pulling out hair, eyelashes, or eyebrows with the overt intention of hurting oneself
- Intentionally preventing wounds from healing
- Burning wrists, hands, arms, legs, torso or other areas of the body
- Rubbing glass into skin or stuck sharp objects such as needles, pins, and staples into the skin

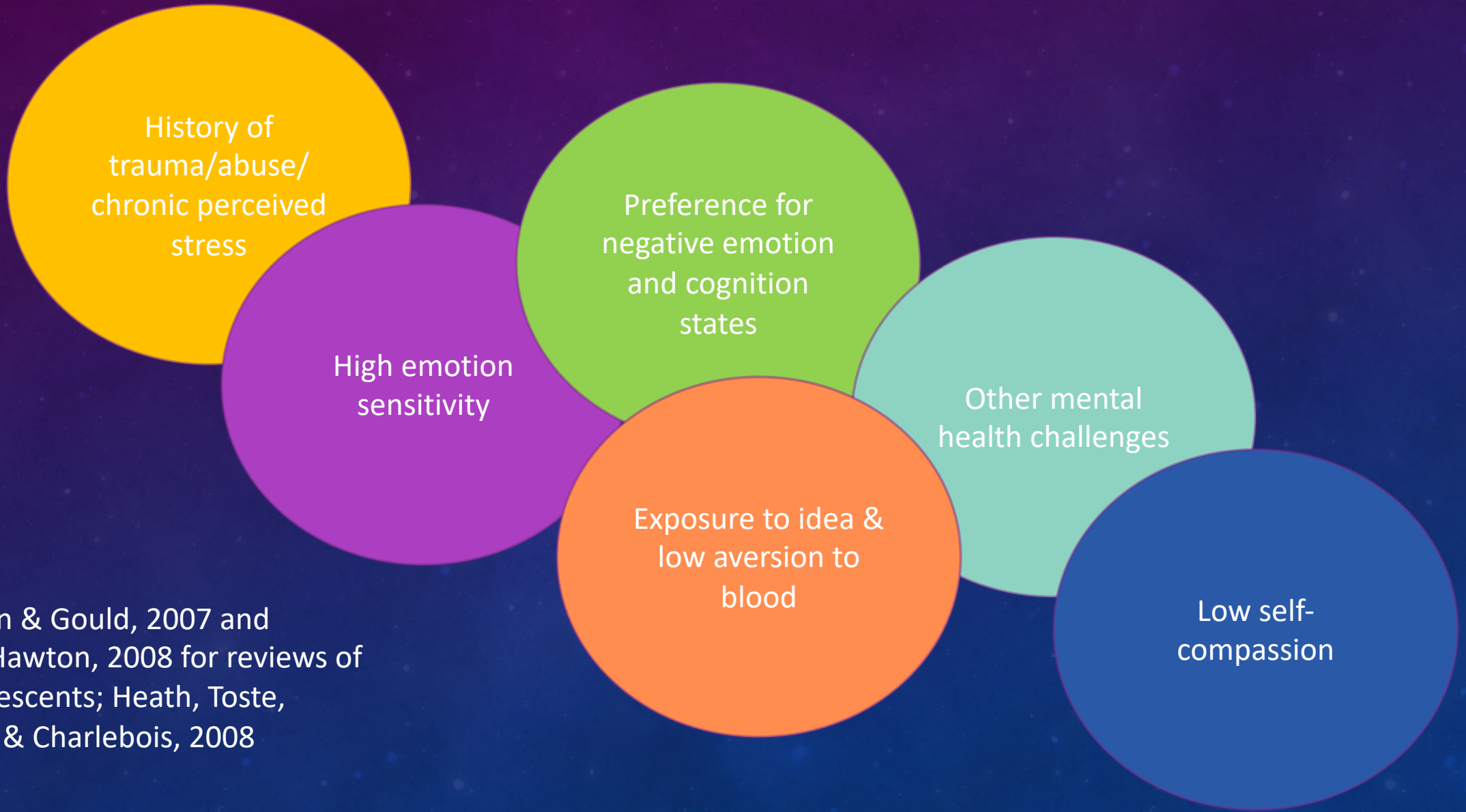
MOST COMMON LOCATIONS

Arms	Wrist	Hands
Thighs	Stomach	Calves
	Ankles	

A FEW OTHER THINGS TO NOTE

Most (68%) report injuring in private but some do injure as part of group membership or ritual	• Assess extent of group engagement
Often episodic; periods of high or low activity	• Do not assume out of risk zone even if long lapse since last injury episode • Assess periodically
Can become habitual or “addictive” for about 1/3 of individuals – most common high prevalence users and those with forms considered high lethality.	• Assess degree of entrenchment and use harm reduction models as needed
About 20% of individuals who SI, report doing so more severely than intended	• Assess for experience with this • Discuss safety measures

RISK FACTORS



see Jacobson & Gould, 2007 and Rodham & Hawton, 2008 for reviews of NSSI in adolescents; Heath, Toste, Nedecheva, & Charlebois, 2008

COMORBIDITY

Associated in clinical samples with:

- PTSD
- Anxiety disorders
- Depression
- Disordered eating
- Obsessive-compulsive disorder
- Substance abuse

Was added to the DSM V as a condition in need of additional research

DOES SELF-INJURY LEADS TO SUICIDE?

No

Self-injury is a way of managing feelings

Self-injury is a risk factor for suicide so suicidal intent should be assessed

A history of self-injury can make it easier to actually take the steps of attempting or ending life by suicide if the individual begins to feel suicidal

WHY?

HOW DOES IT HELP?

Regulate negative affect or no affect (to deal with feelings)

Social communication / belonging

Self-punishment and deterrence

Sensation seeking

Self-distraction

WHAT BIOLOGICAL AND NEUROLOGICAL STUDIES TELL US

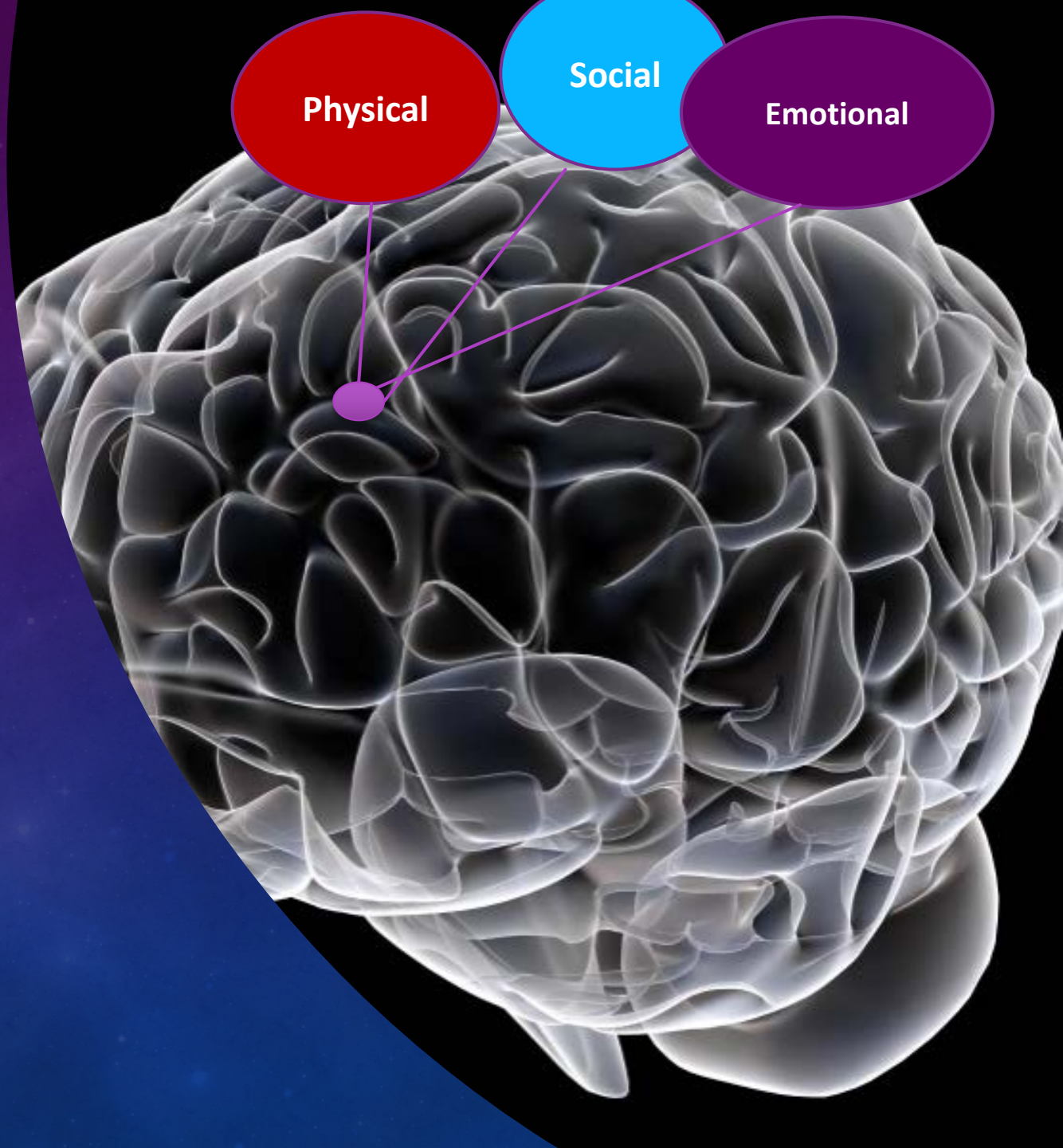
Studies of the biological and neurological basis
of self-injury show that people who self-injure possess:

- Higher physiological reactivity to emotional stimulus
- Difficulty down regulating negative emotions regardless of source / association
- Less physical pain perception when emotionally aroused

PAIN OFFSET

Physical, social and emotional pain use same brain circuitry

The capacity to use physical pain offset to reduce emotional pain is why self-injury is so appealing to some individuals



SO…….

Emotional and physical pain perception are yoked. Physical and emotional pain are processed in the same part of the brain. When one decreases so does the other .

Small decrease in physical pain intensity

=

Big decrease in emotional pain perception

NOTE

- NSSI affects physiological response to stress even when imagined (can be used to arouse or down regulate even when not actively engaged in)
- Downregulation can be trained
- Many individuals who self injure report an immediate sense of calm and or integration

Why is it so hard to stop?

NOTICING AND RESPONDING

DETECTION

- Fresh cuts, bruises, burns or other physical marks of bodily damage
- Unexplained or clustered scars or marks
- Parental reports of blood in the sink/shower/tub
- Frequent bandages
- Odd/unexplained paraphernalia (e.g., razor blades or other cutting implements)
- Constant use of wrist bands or bracelets
- Inappropriate dress for season
- Unwillingness to participate in events that require less body coverage (e.g., swimming)
- Association with “goth” or”emo” subgroups

RESPONDING

Respond non-judgmentally, immediately and directly

Remain calm and dispassionate

Use “respectful curiosity”

- ✓ How does self-injury help you?
- ✓ Who do you feel comfortable talking to about what you are feeling?

Be clear about what has to happen next and provide choices when possible

Sarah, I noticed the cuts on your arms just now. It looks like you may be cutting. Usually people do this to feel better when they have feelings they do not want or like. Is this what is happening for you?

I understand that it may be hard for you to share your feelings, this can be a hard thing to talk about. How about if you and I go talk to the guidance counselor together about what you are feeling? I am sure we can come up with good ways to help.

RESPECTFUL CURIOSITY

"It seems like you may be having strong feelings right now. Can you help me understand what you are feeling?"

"Can you help me understand how self-injury helps you feel better?"

"Can you help me understand what kinds of things trigger a desire to hurt yourself?"

"When you resist the temptation to hurt yourself, what do you tell yourself or do that works?"

DEVELOP PROTOCOLS FOR GUIDING INSTITUTIONAL RESPONSES TO SELF-INJURY

Who is responsible for assessing intention (e.g. suicidal vs non-suicidal), lethality approach to care, and next steps?

What are the approach to care options that best balance institutional protocols and needs re: risk and liability with respectful engagement of the youth and, if applicable, family/guardian?

How will the institution handle general education needs of all staff related to detection & intervention, response, protocols and prevention?

INSTITUTIONAL RESPONSE

Understand that self-injury is most often a statement of perceived disconnection and is associated with shame. Try not to make it worse

Need a specific protocol for managing NSSI separately from suicide

Establish point people on staff equipped to triage difficult cases

Work with clinical staff to determine best response and support approach for each case

Meet with compassion, connectedness, clarity, and resources for support

Cornell Research Program on

Self-Injury and Recovery

KATE BUBRICK, JACLYN GOODMAN & JANIS WHITLOCK

Non-Suicidal Self-Injury in Schools:

Developing & Implementing School Protocol

Who is this for?

School staff and faculty, specifically for school administrators, counselors, nurses nd other support sonnel

included?

Non-suicidal self-injury is an increasingly common behavior among school-aged youth and occurs with regularity in secondary school and college settings. It is uncommon, however, for schools to have well-articulated protocols for detecting, intervening in, and preventing self-injury. Although specific protocols and practices are likely to vary considerably from school to school, this report provides an overview of best practices for detecting and responding to self-injury in secondary school settings.

The information presented here has been adapted from the work of Barent Walsh, Matthew Selekman, Nancy Heath and Mary K. Nixon, in addition to our Program's own research.

WHAT HELPS?

MOST COMMON METHODS FOR RESISTING URGES

Keeping busy (82.4%)

Being around friends (80%)

Talking to someone about how you feel (74.3%)

Writing about how you feel (74.3%)

MOST HELPFUL METHODS FOR RESISTING URGES

Doing sports or exercise (65.2%)

Removing the means/instruments used for self-harm (63.6%)

Finding someone who is understanding (60.9%)

Inward focus on connection to something bigger than oneself (religion/spirituality) (50%)

SOMEWHAT HELPFUL

Writing	Writing poetry (73.3)
Soothing	Taking a hot shower or bath (71.4)
Interacting	Interacting with someone who is nice to you (70.8)
Calming	Closing eyes and thinking calming thoughts (69.2)
Acting	Doing household chores (66.7)

CORE COMPONENTS

- Emotion literacy, acceptance and regulation
- Working with negative cognition and self-regard
- Low aversion to pain, blood
- Tolerating distress / adversity
- Present moment awareness
- Coping repertoires
  - Engages social ecology and contexts
  - Skill practice in untriggered environment

HELPFUL TOOLS

CREATE “COPING KITS”

Possible contents may include:

- Soothing tools for the 5 senses
  - A favorite book, movie, or piece of art
  - A favorite CD, or playlist of favorite songs
  - A favorite snack
  - A favorite scented soap, candle, or lotion
  - A favorite stuffed animal or other soothing tactile item
- Mindfulness reminders and guided exercises
- Puzzles or other tactile, thought-engaging activities
- Compassionate letters to yourself from when you were feeling good, letters from others, lists of good things or reasons not to self-injure, etc.

Do not include anything that could be used to self-injure as it may be reinforcing

TRIGGER LOG

Category	Mon	Tues	Wed	Thu	Fri	Sat	Sun
# of wounds							
Episode Start time							
Episode end time							
Extent of physical damage (length, width, sutures?)							
Body areas							
Pattern to wounds?							
Use of tool (implement)							
Trigger							
Reason (function)							
Pattern to wounds?							
Room or place							
Alone or with others?							

Be sure to a) ask about omissions and b) have clients place a "0" in boxes where no injury occurred – this is good positive reinforcement; see Dr. Barent Walsh's forthcoming book, "Treating Self-Injury"

Date	What I did	My parents / siblings	Friends	Others involved	How it specifically helped

From Matthew Selekman's book, "The Adolescent and Young Adult Self-Harming Treatment Manual" (2009)

Date	My Epiphany	Sparked by	Wisdom Gained	Applied to

From Matthew Selekman's book, "The Adolescent and Young Adult Self-Harming Treatment Manual" (2009)

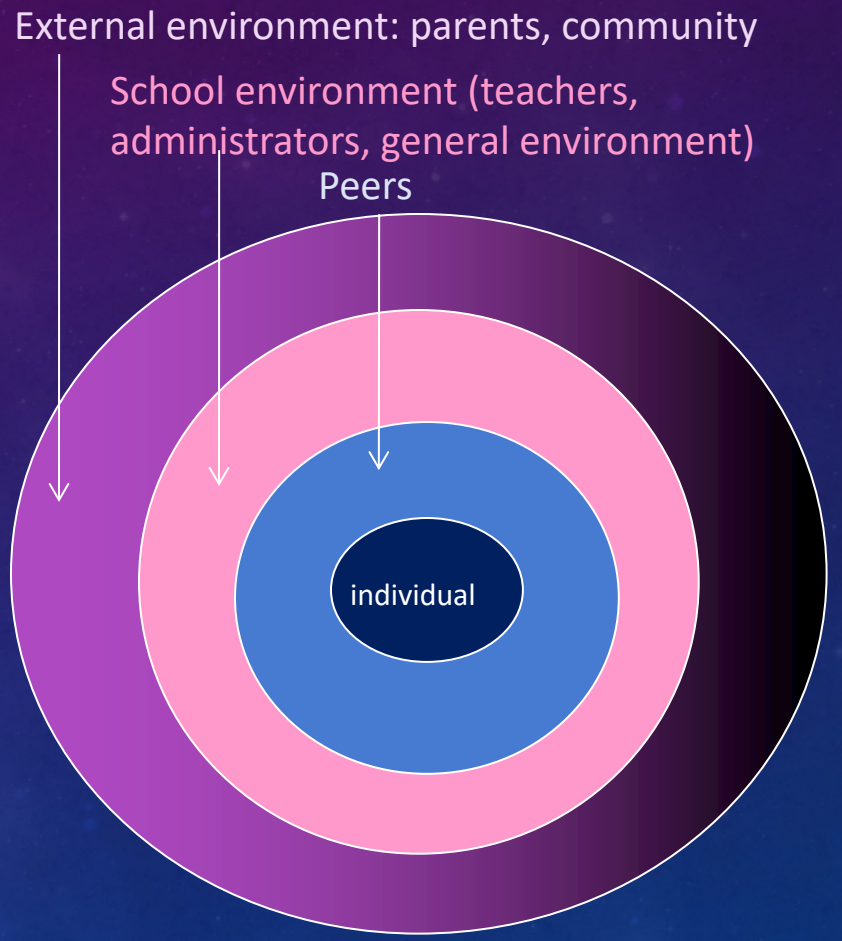
POSITIVE TRIGGER LOG

FOCUS ON PREVENTION

- DO NOT provide broad NSSI education to students; DO provide this to staff

Enhance:

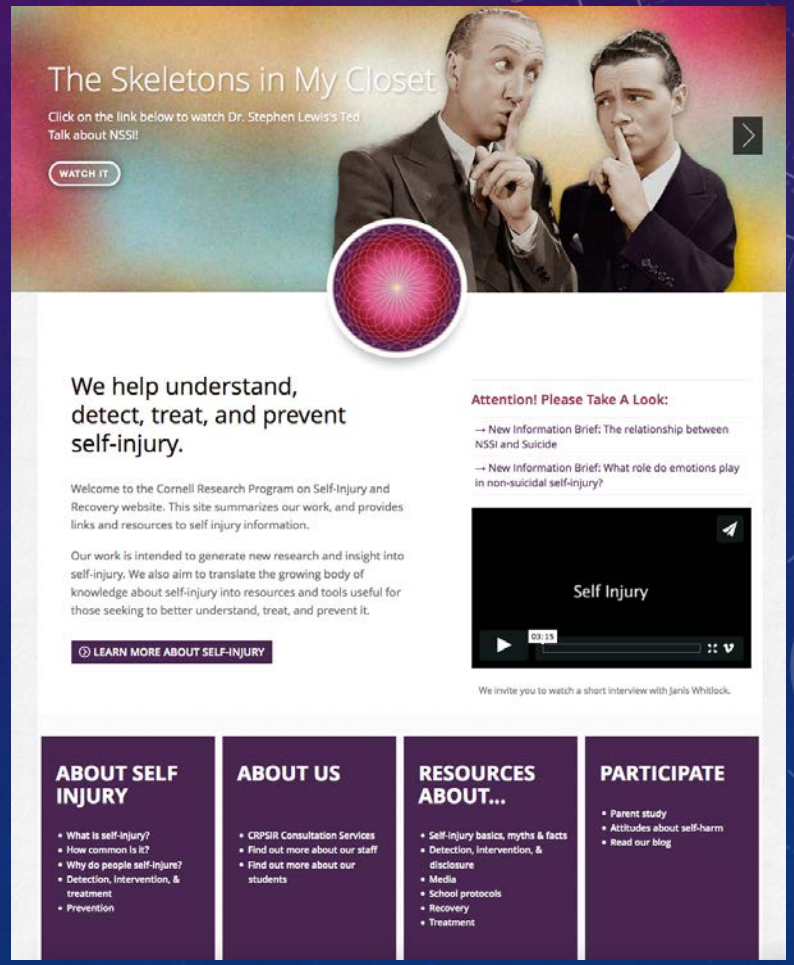
- Awareness of signs of global psychological distress, including but not limited to NSSI among *all* social ecologies (including peers and parents)
- Emotion perception, literacy, tolerance, regulation and transformation
- Social connectedness
- Cognitive reframing: recognizing patterns, questioning and reframing negative thoughts and narratives
- Facilitate development of sense of life purpose and meaning



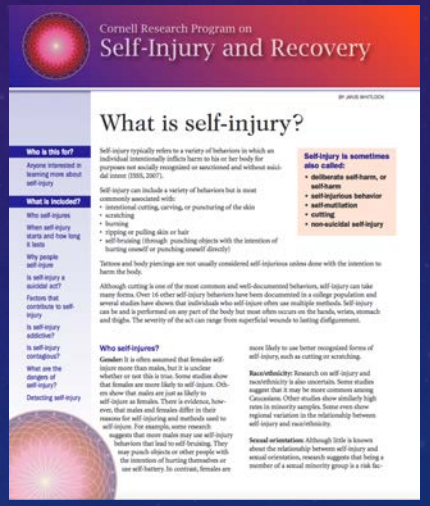
RESOURCES

CRPSIR WEBSITE

www.selfinjury.bctr.cornell.edu



WRITTEN MATERIALS



Cornell Research Program on
Self-Injury and Recovery

What is self-injury?

PRACTICAL MATTERS

The Cornell Research Program on *Self-Injury and Recovery*

Understanding and Using *the* Stages of Change *Model*

by Janis Whitlock & Mandy Purington

Sometimes it can be difficult to understand why your child doesn't *just stop* self-injuring. Keep in mind that self-injury can become a firmly rooted habit that is used in response to a multitude of stressors. This can make change hard and slow to come. Understanding the Stages of Change model (Prochaska et. al., 1994), particularly as it relates to self-injury, can help you better understand where your child is in the pathway to recovery and how to best help along the way.

1. **Precontemplation**: During this stage, the person is not considering change at all and may not see self-injury as a problem. In fact, a self-injurious person in this stage may defend the benefits of self-injuring and ignore the negative outcomes of it.
2. **Contemplation**: In this stage, a person is becoming open to the idea of change, though likely feels ambivalent about it. A self-injurious person may see some of the negative aspects of self-injury, consider some of the benefits of stopping, but wonder if it is worth giving it up.
3. **Preparation**: Once in Preparation, a person has made a commitment to change and begins to consider lifestyle changes that need to be made. During this stage, a person may seek out therapy or other supports.
4. **Action**: During this stage, a person is taking active steps towards change and is becoming more confident that he or she can be successful. However, it is during this stage that slips or backslides can often occur – beginning to practice new coping skills inherently means they have not yet been mastered. Support is critical at this stage.
5. **Maintenance**: In this stage, a person is working to maintain the changes made. A self-injurious person is aware of triggers, has developed other positive coping skills, and is capable of turning to these other methods of coping in times of distress.

How do you determine which Stage of Change your child is in?

If your child is working with a therapist, it is likely that he/she has already put some effort into figuring this out – particularly if self-injury is a primary reason for being in therapy. This may be something you can all talk about in family sessions if the self-injury behavior is a major stressor for the family. Self-injury usually arises as part of a complex set of challenges and it can take time to let it all go. Understanding where your child is in their process can help you figure out what might be the most supportive role to play. To assess overall readiness, for example, you might ask:

- **On a scale from 1-10 where 1 is "not at all" and 10 is "I definitely want this", how much do you want to stop self-injuring?**

Lower numbers on the scale generally indicate less readiness to change. You can ask this

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Who is this for?

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What is included?

- How to develop a protocol
- How to implement a protocol
- Questions and issues that might come up
- Flowchart to aid in decision-making

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The information presented here has been adapted from the work of Barent Walsh, Matthew Selekman, Nancy Heath and Mary K. Nixon, in addition to our Program's own research.

Non-suicidal self-injury (NSSI) is defined as:
the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned.[1]

Why is a self-injury protocol important?

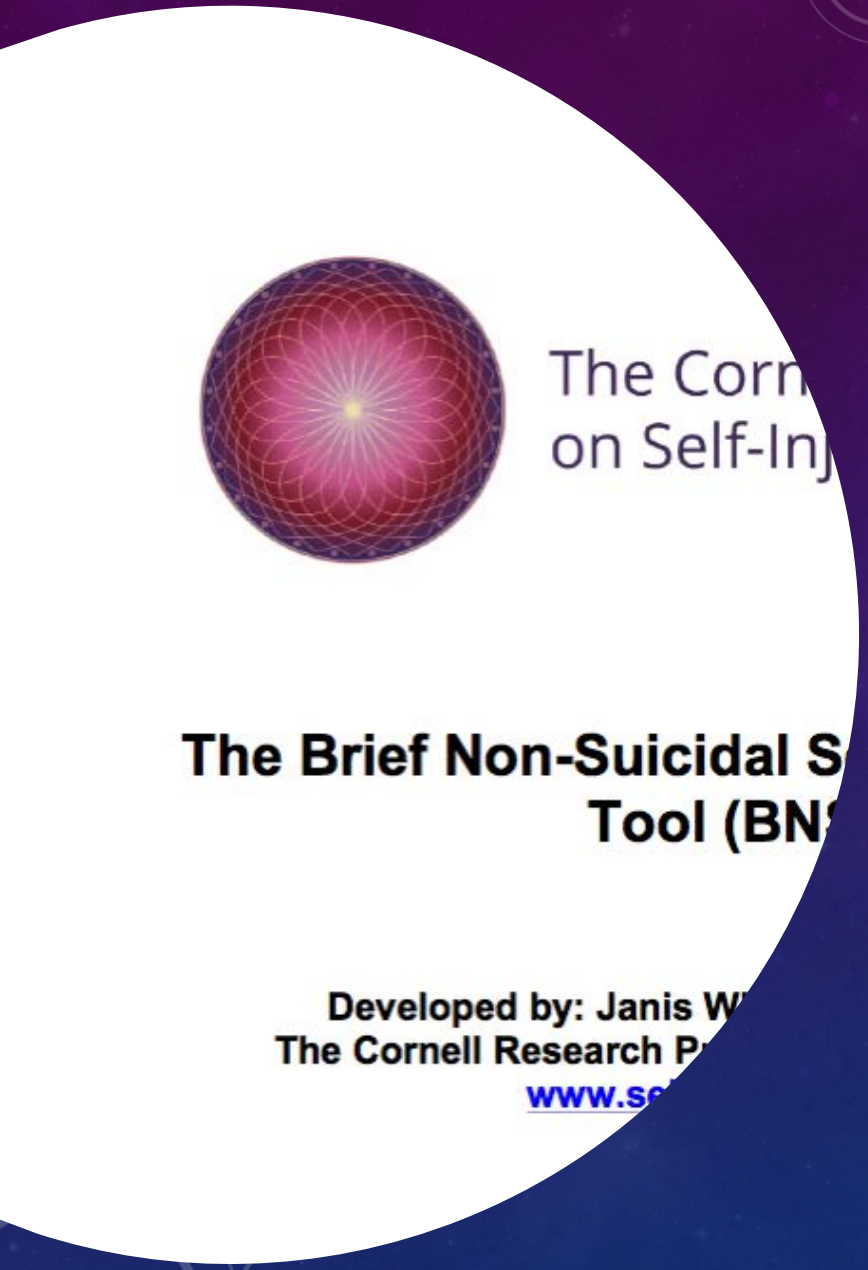
Protocols are useful in guiding school personnel responses to situations that many find uncomfortable or unable to manage. Additionally, they provide a means of assuring that a school's legal responsibilities and liabilities are addressed even in situations where personnel may not have this as their primary concern. In his discussion of self-injury protocols, Walsh (2006) explains that "the advantage of having a written protocol is that staff know how to respond to self-injury systematically and strategically."[2] It is essential to note that although a self-injury protocol may be similar to one used to manage suicide-related behavior, it is not the same. The two types of protocols may, however, share common elements and suicide-related protocols are often a good starting point for development of non-suicidal self-injury protocols.

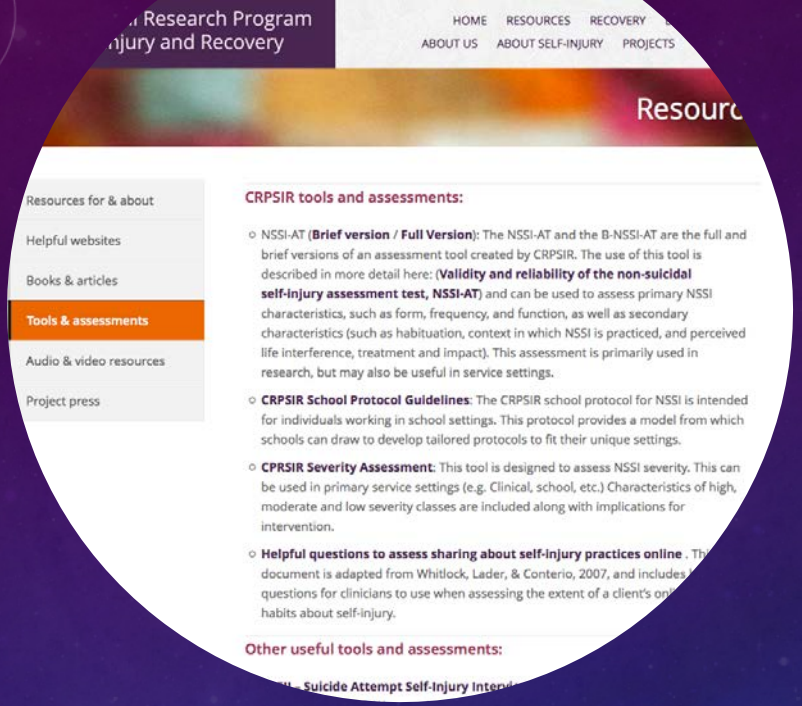
What is included in the school protocol?

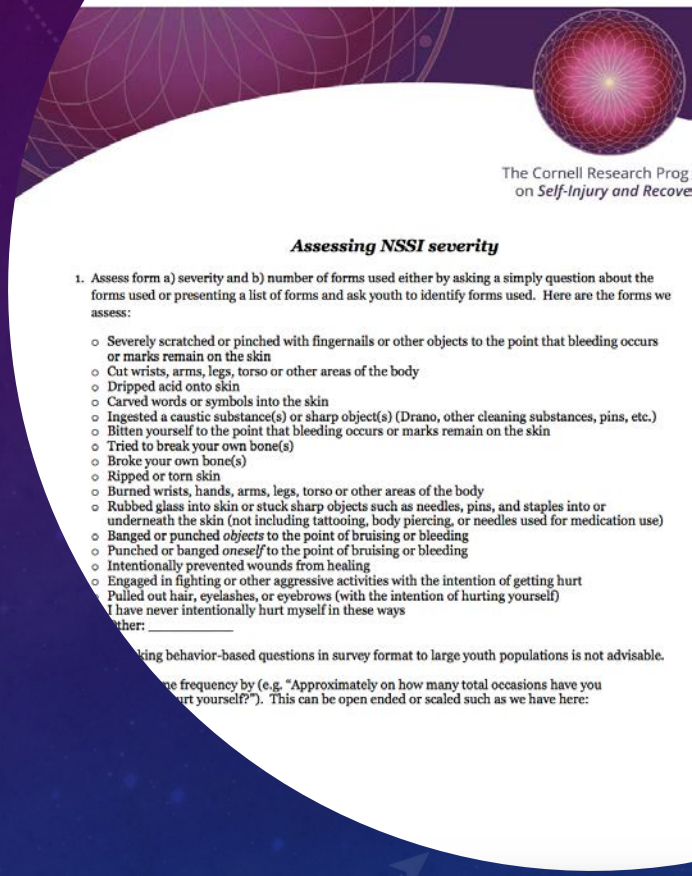
A functional school protocol for addressing self-injury incidents should include steps for the following processes:

- Identifying self-injury
- Assessing self-injury
- Designating individuals to serve as the point person or people at the school for managing self-injury cases and next steps
- Determining under what circumstances parents should be contacted

PROTOCOL

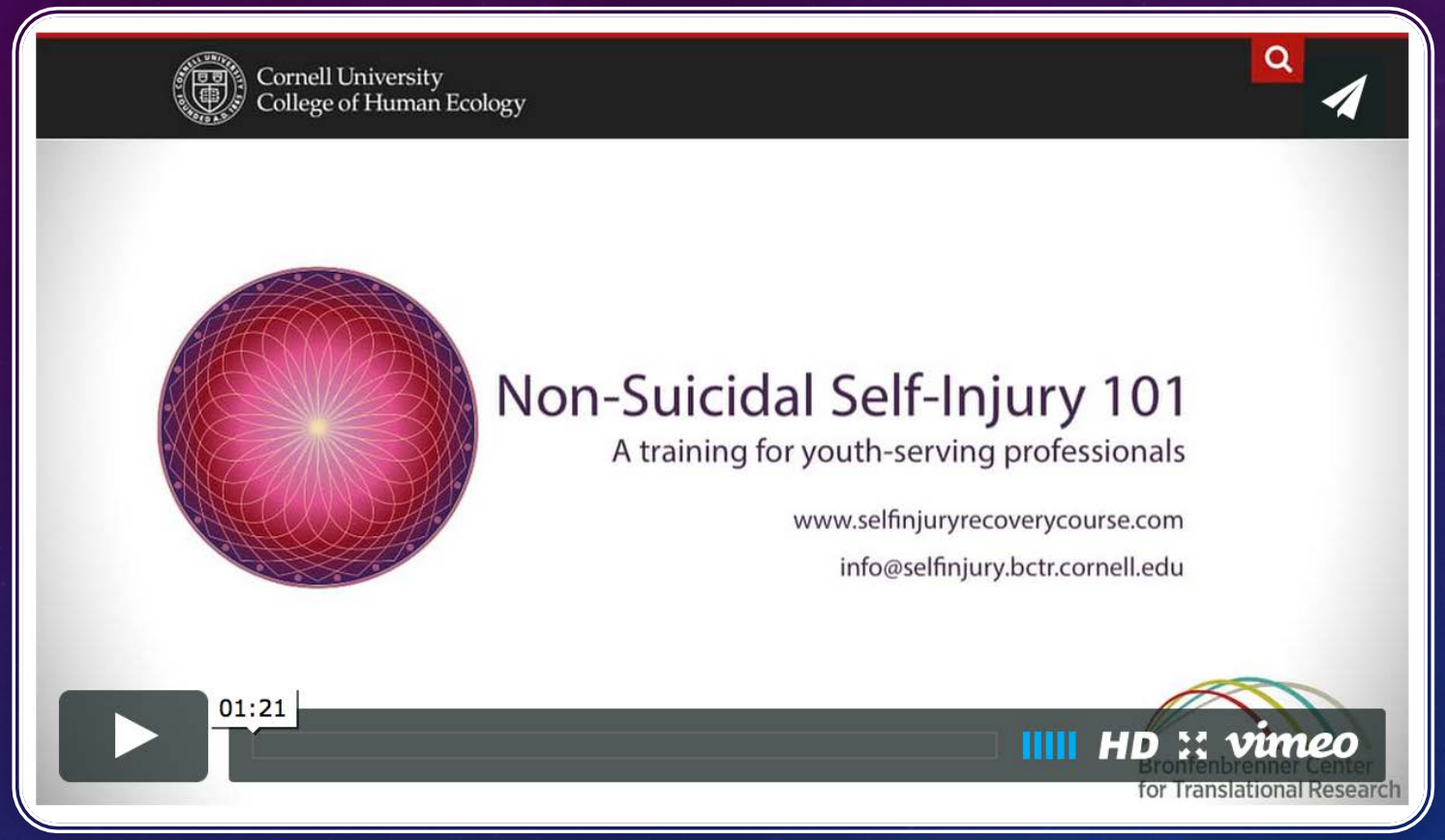






ASSESSMENT TOOLS

WEB-BASED TRAINING



NSSI 101

- 8-9 hour
- Self paced or facilitated
  - Certificate (Cornell certificate &/or NASW CEU, .8)
- Brief primer
- Parent psychoeducatioal workshop

RESOURCES

Websites:

- Cornell Research Program on Self-Injurious Behaviors: www.crpsib.com
- CRPSIR training page: http://www.selfinjury.bctr.cornell.edu/training.html
- S.A.F.E. Alternatives: http://www.selfinjury.com/index.html
- The National Self-Harm Network (UK): http://www.selfharm.org.uk/default.aspa
- The American Self-Harm Information Clearinghouse (ASHIC): http://www.selfinjury.org/indexnet.html
- Resources for addressing mental health issues in schools: http://smhp.psych.ucla.edu/
- Heart math: :http://www.heartmath.org/about-us/overview.html
- Collaborative for academic, social and emotional learning http://www.casel.org

Books & articles:

- All books by Barent Walsh and Matthew Selekman and
- Conterio, K., & Lader, W. (1998). *Bodily harm: The breakthrough treatment program for self-injurers*. New York: Hyperion Press
- Whitlock, J.L., Lader, W., Conterio, K. (2007). The internet and self-injury: What psychotherapists should know. *Journal of Clinical Psychology/In Session 63*: 1135-1143. (available at www.crpsib.com)