Understanding and responding to self-injury

The Cornell Research Program on Self-Injury and recovery (CRPSIR)

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www.selfinjury.bctr.cornell.edu
Check out the Cornell Research Program on Self-Injury and Recovery at
www.selfinjury.bctr.cornell.edu

If you want the videos I mentioned, please e-mail me: jlw43@cornell.edu and I will secure access.
At the conclusion of this presentation, participants will be able to:

1) Identify key features of self-injury epidemiology and vectors for contagion

2) Describe the core principles and practices in effective self-injury detection and intervention

3) Develop protocols and intervention strategies
NSSI basics
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.

International Society for the Study of Self-Injury (ISSS, 2007)
What’s your experience?

I have worked with students I know are engaged in self-injury

(A) Yes
(B) No
(C) Possibly, but I am not sure
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
Prevalence and who is at risk?

Among adolescents and young adults

- Lifetime NSSI estimates range from 7% – 25.6% (up to 65% in clinical populations).
  - Recent review shows:
    - 17.2% among adolescents (of 25 kids, 4 may SI)
    - 13.4% among young adults
    - 5.5% among adults
  - 75-80% of all report NSSI is repeat (25% single incident)
  - An estimated 6-10% are current and repeat
  - A global phenomenon

Data by race inconclusive.

- Some studies find Caucasian youth to be slightly more likely to injure than other groups, but modest findings and not always present.

No differences by SES

Much more likely to report being bisexual or questioning
Primary risk factors

- History of trauma/abuse/neglect
- Individuals with history of emotion dysregulation or sensitivity (often Individuals high in emotion detection/generation but low in emotion regulation capacity)
- Tendency toward negative cognitive style and rumination
- Presence of other MH conditions, such as depression, anxiety and disordered eating
- Low affective family environments

(see Jacobson & Gould, 2007 and Rodham & Hawton, 2008 for reviews of NSSI in adolescents; Heath, Toste, Nedecheva, & Charlebois, 2008)
Is NSSI a Suicide Attempt?

- No

- NSSI is most often used as a means of self regulation, medication, and preservation not as a means of ending one’s life. A few differences:
  - Expressed intent
  - Acuity of distress
  - Presence of cognitive constriction
  - Level of physical damage
  - Aftermath

- Since NSSI and suicidality do indicate underlying distress it is important to assess whether self-injurious youth are also suicidal
Distress + Inadequate Coping Capacity

Childhood Trauma  Physiological Sensitivity  Exposure and receptivity to NSSI

NSSI does appear to lower suicide inhibition

Risk of moving to suicide is predicted by >20 NSSI incidents, low sense of meaning in life, poor relationship with parents

Why self-injure?
Described function

Regulate negative affect or no affect
- To cope with uncomfortable feelings (50.8%)
- To relieve stress or pressure (43.2%)
- To deal with frustration (36.8%)
- To change emotion into something physical (35.6%)
- To deal with anger (24.8%)
- To help me cry (11.1%)
- To feel something (26.6%)

Social communication / belonging
- In hopes that someone will notice (18.3%)
- To shock or hurt someone (5.9%)
- Because my friends hurt themselves (2.5%)

Self-punishment & deterrence
- To atone for sins (18.2%)
- To express self-hatred (14.4%)
- So I don’t hurt myself in other ways (5.7%)
- To avoid committing suicide (4.5%)

Sensation seeking
- Uncontrollable urge (16.8%)
- Because it feels good (15.7%)
- To get a rush or surge of energy (11.2%)
- Because I like the way it looks (5.0%)

Self distraction
- To distract me from other problems or tasks (20.1%)
- To create an excuse to avoid something else (4.2%)

Why Self-Injure?
Is self-injury spreading?
What’s your experience?

Is self-injury spreading?

(A) Yes, definitely
(B) It was for awhile, but seems to have leveled off
(C) No, I have noticed significant changes
(D) Possibly, but I am not sure
General consensus among college mental health providers, secondary school staff, researchers, and community-based health and youth professionals is yes.
NSSI in school settings

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<th>Lone No Tell</th>
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<tbody>
<tr>
<td>NSSI Rate (%)</td>
<td>76.9</td>
<td>61.9</td>
<td>24.5</td>
<td>18.4</td>
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Vectors for contagion

- Siblings or parent history of NSSI – current or past
- High status peers
  Can be a ritual for group membership
- Media
- Peers / peer culture
  Allows for anonymous / concealed gathering and sharing
- Internet
- Family
So, what do we do?
Points of intervention: Who knows and how helpful was it?
Of those who think someone knows or suspects but who have not had a conversation:

- Friend: 63.8% wish to talk, 23.5% not sure they want to talk, 12.8% do not want to talk
- Partner: 50% wish to talk, 36.8% not sure they want to talk, 13.2% do not want to talk
- Parent: 65.3% wish to talk, 20.8% not sure they want to talk, 13.9% do not want to talk
- Sibling: 68.6% wish to talk, 11.4% not sure they want to talk, 20% do not want to talk
- Teacher: 44% wish to talk, 44% not sure they want to talk, 12% do not want to talk
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
Assessment and intervention: school based settings
What’s your experience?

Our school / district has a self-injury protocol

(A) Yes, we use our suicide protocol for NSSI
(B) Yes, we have a protocol specifically for NSSI
(C) No, we do not have a self-injury protocol
(D) Possibly, but I am not sure
The case for school intervention

Why schools?

Institutional response
- Conscious protocols, education, skills training and expectations

Individual response
- Compassion, support and skills

Common obstacles in school-based intervention
Tripart Model for Guiding Institutional Responses to NSSI
For most individuals NSSI emerges from developmentally normal impulses:

- To feel better
- To emotionally regulate
- To self-integrate
- To exercise agency

Individuals who practice NSSI are often emotionally perceptive but struggle with regulating their perceptions and their responses.

NSSI is symbolically “agentic” – it reflects physically what the injurer wishes to do emotionally – namely to successfully endure and heal pain.

Success in interactions will be enhanced when approached with responsiveness, respect, and collaboration. This should be a goal for individuals and institutions.
A functional 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
- Managing active student self-injury (with self-injurious student, peers, parents, and external referrals)
- Determining when and how to issue an outside referral
- Identifying external referral sources and contact information
- Educating staff about self-injury
Responding

Respond non-judgmentally, immediately and directly
- Low key compassionate demeanor
- Avoid shock or emotional displays
- Clearly state that you are non-judgmental and committed to helping
- Don’t minimize
- Assure rapid attention and assessment (suicide assessment indicated)

Examples of direct and useful questions:
✓ What does it do for you?
✓ Do you notice patterns in what triggers you?
✓ What do you do to care for wounds?
✓ Have you ever injured yourself so badly that you were worried about whether a wound would heal or become infected?

See Walsh, Barent (2008), Treating Self-Injury: A Practical Guide
What’s your opinion?

Schools should always tell a parent when they learn that a student is engaged in self-injury:

(A) Yes, in all cases
(B) Sometimes, it depends on the case
(C) Rarely - only if severe
(D) I am not sure
Intervention:
Respond, Assess, Engage, Educate, Refer

✧ Respond
✓ Use respectful curiosity
✓ Avoid shock or emotional displays
✓ Don’t minimize

✧ Assess
✓ Immediate danger
✓ General severity
✓ Suicide risk
✓ Risk of contagion
✓ NSSI prevalence in student population

✧ Engage
✓ Self-injurious student and supportive peers in directly addressing issue and underlying causes
✓ Point people on staff or in community with expertise or knowledge in this area
✓ Self-injurious student family if NSSI is frequent and/or of high lethality quality or if school protocol warrants parental notification

✧ Educate
✓ Staff regarding signs, symptoms and appropriate response strategies
✓ Yourself (or key staff point people) about local resources – therapeutic and educational
✓ Self-injurious students about risk for contagion and the importance of not inadvertently a behavior that could hurt a friend
✓ All students about symptoms of distress (not just NSSI) in self and others and positive strategies for coping with stress

✧ Refer
✓ Self-injurious student and family to community-based therapist as needed
A conversation with parents..

Choices for self-injurious students

Conversation often goes something like:

It has come to my/our attention that your child is self-injuring. It is important for you to know that self-Injury is not a suicidal act. In fact, it is quite common these days and us usually a way to cope with strong emotion. He/she is safe.
The copycat phenomenon

Is common in schools

Is best managed by appealing to core student’s best self
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
- Mindfulness skills
- Social connectedness
- Cognitive reframing: recognizing patterns, questioning and reframing negative thoughts and narratives
- Facilitate development of sense of life purpose and meaning

External environment: parents, community
School environment (teachers, administrators, general environment)
Signs of Self-Injury Program

- Capitalize on student proximity by teaching them to
  - Ask
  - Care
  - Tell

- DVD with 2 tracks
  - 1 for staff/parents
  - 1 for students

- Implementation Binder

- Student Follow up Cards

For more information, please contact:
youth@mentalhealthscreening.org
Parents, help us understand your experience!

Seeking parents of young people 15-24 years old for an online study:

We are looking for both parents of children who have a history of self-injury and a control group of parents whose children have no known developmental, genetic, and/or mental health issues. If you have a child between the ages of 15-24 with or without a history of self-injury within the past year, we would really love to hear from you about your experience:

https://cornell.qualtrics.com/SE/?SID=SV_d744IOhuB01h1yt

Do you use Facebook? Are you a college student? If so, please help!

We are conducting a study of Facebook and feelings and would love your help! If you participate, you will be asked to share some of your Facebook content and answer a few questions related to this content. You’ll also be asked to answer questions about how you have been feeling in the past three months, and your general Facebook use. To participate:

https://apps.facebook.com/onlinediarystudy/
Thank you! and Resources

Websites and books:

- Cornell Research Program on Self-Injury and Recovery: [www.selfinjury.bctr.cornell.edu](http://www.selfinjury.bctr.cornell.edu)
- Resources for addressing mental health issues in schools: [http://smhp.psych.ucla.edu/](http://smhp.psych.ucla.edu/)
- Collaborative for academic, social and emotional learning [http://www.casel.org](http://www.casel.org)
- All books by Barent Walsh and Matthew Selekman and Conterio, K., & Lader, W.

Tools:

- See [http://www.selfinjury.bctr.cornell.edu/perch/resourcescprsitsseverityassessment.pdf](http://www.selfinjury.bctr.cornell.edu/perch/resourcescprsitsseverityassessment.pdf) for NSSI severity assessment tool
- Look for the upcoming web-based training for youth-serving professionals. It will be advertised on the CRPSIR website; join our listserv if you want to know when this and new resources comes out!