NON-SUICIDAL SELF INJURY

Cutting Through The Pain

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1. Only females self-injure. Studies show that 30-40% of people who self-injure are male.

2. Self-injury is a suicide attempt or failed suicide attempt. Most studies find that self-injury is often undertaken as a means of avoiding suicide. It is most often undertaken as a means of self-soothing.

3. Only teenagers self-injure.
While it is true that the majority of those who self-injure do so during their adolescent years, people of all ages practice self-injury. Cases of self-injury have been documented in children 7 years or younger well into adulthood.

4. Self-injury is just attention seeking.

For some, self-injury is clearly an attention-seeking act. In this case, it is very important to honor the intent. That is, a person is injuring himself or herself for attention, then that person clearly needs attention and is asking for help. The majority of people who engage in self-injury, however, go to great extremes to hide their cuts, scars, or burns.
Although not overtly attention seeking, hidden self-injury is still a symptom of underlying distress and it merits attention from others who are in a position to help. As one individual who self-injured advised, “A lot of the time, the people [who] do this do it for attention, so just give it to them...Instead of scolding or looking down on someone for doing this, just let him or her know that one day it’ll be okay.”

5. People who self-injure are manipulative.
Self-injury is more about relieving tension and distress than it is about manipulating others. Although some individuals report starting the practice as a means of getting attention from someone, very few report this as a primary reason for continuing the practice.
6. People who self-injure only cut themselves.
Although a common method of self-injury is cutting, there are many methods of self-injury. Studies also show that individuals who report repeat self-injury often report using multiple methods. Examples of other methods include burning, scratching the skin, and hair pulling.

7. Anyone who self-injures is part of the Goth or emo subgroup or are simply wanting adult attention.
Self-injury excludes no one. People who self-injure come from all types of groups, ethnicities, and economic backgrounds. People who self-injure may be male or female, rich or poor, gay, straight, bisexual or questioning, be very well or less well educated, and live in any part of the world.
Some people who self-injure manage to function effectively in demanding jobs. They can be teachers, therapists, medical professionals, lawyers, professors, or engineers. It is impossible to classify someone as a person who self-injures (or not) based on what he or she looks like, the type of music he or she listens to, or who the friends are.

8. Someone who self-injures can stop if he or she really wants to.

This is true for some people but for others self-injury can be an addiction. There is emerging evidence that self-injury releases endorphins in the brain, a process that increases the possibility of becoming addicted to self-injury.
9. There is nothing anybody can do to help.

There are many ways to help. For instance, in school, the easiest way to help is by being honest with the student about concerns and by being supportive and understanding. Most importantly, just do not give up.
DEFINITION

- Non-Suicidal Self-Injury is referred to as deliberate and direct harm of one’s own body tissue, causing injury, without suicidal intent (Claes, Islam, Fagundo, Murcia, Granero, Aguera, Rossi, Menchon, & Aranda, 2015).

- This presentation will encompass any form of non-suicidal self-injury to include scratching, cutting, hitting, scabbing, embedding, bruising, bone breaking, and burning oneself, among others (Claes, et al., 2015).
DIFFERENCES BETWEEN NSSI AND SSI

- Literature on self-injury indicates a disagreement among experts on how self-injury behavior should be classified (Orlando, Broman-Fulks, Whitlock, Curtin, & Michael, 2015).

- Some experts believe that they are related. Others believe that there are two distinct groups of those with self-injury behaviors. The two forms include:
  - Non-Suicidal Self Injury which does not have an intent to die (Orlando, et al., 2015).
  - Suicidal Self Injury which is the intent to end one’s life at some point (Orlando, et al., 2015).
DIFFERENCES BETWEEN NSSI AND SSI

- 59%-79% of those that participate in SIB do not report suicidal thoughts (Orlando, et al., 2015).
- Those that report Suicidal self-injury, at times, present with more frequent SIB and a greater number of methods of SIB (Orlando, et al., 2015).
- Research suggests a positive correlation between the number of lifetime suicide attempts and the number of methods used to self-injure (Orlando, et al., 2015).
DIFFERENCES BETWEEN NSSI AND SSI

• Some research shows that SIB can lead to suicide when the SIB increases in severity over time (Orlando, et al., 2015).

• Some studies indicate that suicidal thoughts either precede or co-occur with SIB, in 61% of college students. This makes some believe that it is a “gateway” to suicide attempts (Orlando, et al., 2015).
Prevalence

• Self-injury is addressed daily by many school counselors.

• Currently, it is very common and accepted within the adolescent population.

• “Roughly 1 in 6 teenagers has tried self-harm at least once” (Muehlenkamp, Claes, Havertape, & Plener, 2012).

• “In community samples, up to 17% of adolescents and 4% of adults report a history of NSSI” (Muehlenkamp, Claes, Havertape, & Plener, 2012).
“NSSI age of onset is typically between 13 and 15 years” (Heath, Schaub, Holly, & Nixon, 2009).

However, “25% of youth have started to engage in deliberate self-injury before the age of 12” (Nixon, Cloutier, & Jannson, 2008).

“Studies also suggest that of all youth reporting any NSSI, more than three quarters report repeat NSSI (>1 episode), about half report between 2 and 10 lifetime incidents, and 20-25% report more than 10 lifetime incidents” (Whitlock & Rodham, 2013).
“Overall, about a quarter of all adolescents and young adults with NSSI history report engaging in NSSI only once in their lives” (Heath, Toste, Nedecheva, & Charlebois, 2008; Whitlock et al., 2006).

“Although NSSI is, for many youth, a phase that does not endure well into adulthood, for some youth (about 20%) NSSI is the beginning of just that, a behavioral habit that becomes increasingly more intractable and difficult to stop” (Whitlock & Rodham, 2013).

More than one in five report injuring themselves more severely than they had expected to, some while under the influence of drugs and alcohol” (Whitlock & Rodham, 2013).
PREVALENCE

• “Identity issues have been hypothesized to play an important role in the emergence and maintenance of NSSI” (Breen et al., 2013).

• Identity confusion or a lack of identity synthesis
TYPES OF NON-SUICIDAL SELF-INJURY

(SOMER, BİLDIK, KABUKCU- BASAY, GÜNGÖR, BASAY, & FARMER, 2015)

• Cutting
• Banging/hitting
• Bruising
• Pinching
• Hair pulling
• Biting
• Scratching
• Rubbing Skin
• Buming
• Needle Sticking
• Carving
• Wound Picking
• Swallowing objects, chemicals, or other substances.
ARM LACERATIONS
LEG AND THIGH LACERATIONS
WOUND PICKING OR SCABBING
MINOR CUTS
REPEATED SCRAPING
BRUISING
Conditions for Further Study

• Non-Suicidal Self Injury

• A. In the last 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, 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 (i.e., there is not suicidal intent).

Note: The absence of suicidal intent has either been stated by the individual or can be inferred by the 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:

1. To obtain relief from a negative feeling or cognitive state.
2. To resolve an interpersonal difficulty.
3. To induce a positive feeling state.

Note: The desired relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behavior suggesting dependence on repeatedly engaging in it.
• **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 a religious or cultural ritual) and is not restricting to picking a scab or nail biting.
• E. The behavior or its consequences cause clinically significant distress or interference in the interpersonal, academic, or other important areas of functioning.
• **F.** The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypes. The behavior is not better explained by another mental disorder or medical condition (e.g. psychotic disorder, autism spectrum disorder, intellectual disability, Lesch-Nyhan syndrome, stereotypic movement disorder, trichotillomania [hair-pulling], excoriatio[n] [skin-picking] disorder.
• Repeated shallow, yet painful injuries to the surface of the body.
• Inflicted to reduce negative emotions.
• Associated with a sense of urgency and craving that resembles addiction.
• Injury is most often inflicted with a knife, needle, razor, sharp objects.
• Patterned scars.
• Injury most commonly occurs on frontal thighs and dorsal side of forearm.
• Other methods include: stabbing with needle or sharp point, inflicting burns with lit cigarette, repeated rubbing with pencil eraser.
• Engaging in multiple methods is associated with more severe pathology, including suicide attempts.
• Most do not seek clinical attention because it is often seen as stigmatizing.
DEVELOPMENT OF NSSI ACCORDING TO DSM V

(AMERICAN PSYCHIATRIC ASSOCIATION, 2013)

• Begins in early teens and continues for many years.
• Peaks between the ages of 20-29.
• Often, individuals learn the behavior on the recommendation or observation of another.
• Patients admitted to inpatient units with others that engage in non-suicidal behavior may begin to engage in the behavior.
• Thought to be a form of self-punishment by behavior theorists.
Permanent scarring
Risk of blood-borne disease transmission
**Borderline Personality Disorder**
- Non-suicidal self-injury has long been regarded as a symptom of BPD. Although, comprehensive clinical evaluation has found that most individuals with NSSI meet the criteria for another diagnosis, such as eating disorders, and substance abuse disorders.
• **Suicidal Behavior Disorder**
  - Differentiation between NSSI and SBD are based on the stated goal of the behavior. Individuals with frequent history of NSSI episodes learn that it is largely benign. Likelihood of suicidal intent has been associated with multiple methods of self-harm.
• **Trichotillomania** (hair-pulling disorder)
  - injurious behavior confined to pulling one’s hair, most commonly from the scalp, eyebrows, and eyelashes.

• **Stereotypic Self-Injury**
  - Includes head banging, self-biting, self-hitting associated with intense concentration or under conditions of low external stimulation associated with developmental delays.

• **Excoriation** (skin-picking) disorder
  - Occurs in females and is directed to picking an area of the skin that they feel is a blemish, usually the face or scalp.
• Unexplained frequent injury
• Wearing long sleeves or other long clothing during the warm weather months
• Low self-esteem
• Difficulty managing emotions
• Relationship issues
• Poor functioning at school, work, and home
• Long periods of wanting to be alone in their bedroom or bathroom
“Adolescence is, in and of itself, a risk factor for NSSI” (Whitlock & Rodham, 2013).

“No one profile for an individual who self-injures” (Whitlock & Rodham, 2013).

All kinds of youth: high achievers, shy youth, boys and girls, popular kids, athletes” (Whitlock & Rodham, 2013).

Found in “the best neighborhoods and private schools, in colleges and in the workplace” and are “often bright, talented and creative achievers – perfectionists who push themselves beyond all human bounds, people-pleasers who cover their pain with a happy face” (Strong, 1998).
RISK FACTORS

• “High levels of depression and anxiety and comparatively few coping mechanisms” (Haines & Williams, 2003).

• “With certain subgroup cultures (e.g. emo, punk, or Goth)” (Whitlock & Rodham, 2013).

• Abuse and neglect histories (Miller, Rathus, & Linnehan, 2007).

• “Substance abuse, obsessive-compulsive-disorder, and depression are the most frequently correlated psychiatric conditions of NSSI” (Lofthouse, Muehlenkamp, & Adler, 2009).
RISK FACTORS

• “The prevalence of NSSI in eating disorder patients is high ranging between 25.4% and 55.2%” (Claus & Muehlenkamp, 2014; Svirko & Hawton, 2007).

• “Deficits in impulse control, particularly in response to distress” (Peterson, 2012).
DIFFERENCES ACCORDING TO SEX
(BAKKEN & GUNTER, 2012)

Males Reported
- More Impulsive
- More burning
- More pain experience
- Identify as a Sexual Minority
- Use of hard substances (crack, cocaine, inhalants, etc.)
- More likely to have corresponding suicidal thoughts

Females Reported
- More cutting
- Eating Disorders
- Early onset
- Use of substances such as alcohol and marijuana
- Sexual abuse victimization
- More likely to report behavior
CULTURAL DIFFERENCES

- Caucasians and Multi-racial individuals have much higher rates of NSSI (Borrill, Fox, & Roger, 2011).
- Caucasian students report five or more incidents of NSSI (Borrill, Fox, & Roger, 2011).
- African Americans are least likely to report repeated NSSI (Borrill, Fox, & Roger, 2011).
- Hispanics are more likely to participate in burning skin, wound picking, and scraping until skin bleeds (Bakken & Gunter, 2012).
- Individuals that define themselves as a part of a religious group (Christian, Muslim, Hindu, etc.) have a low occurrence of NSSI (around 6%) (Whitlock & Rodham, 2013).
- Individuals who identify as atheist or agnostic have a much higher rate of NSSI (over 33%) (Whitlock & Rodham, 2013).
CYCLE OF SELF-INJURY

- Negative Thoughts
- Tension building
- Guilt
- Shame
- Urge to Act
- Relief
- Action
ETHICAL AND LEGAL CONSIDERATIONS

• To avoid ethical and legal dilemmas, the following guidelines are recommended:
  • 1. Check your school's policies, and be sure that you are following the school's policies in terms of cutting, etc.
  • 2. Check regarding safety issues (welfare of the student).
  • A. Obtain information regarding whether the student shares cutting instruments with others as the student could be exposed to life-threatening diseases (HIV, Hepatitis C, Infection).
• B. Document that you (counselor) have discussed safety risks with regard to sharing instruments that can lead to disease.

• 3. Assess whether the SI (self-injury) has escalated since the student began cutting.

• As in the cycle of drug and alcohol addiction, those who develop a tolerance for pain from cutting may engage in more damaging self-injury in order to receive the same benefits before tolerance began.
• 4. The student and counselor should draft a plan for the disclosure to the parent.
• Contact the parent(s) or legal guardian regarding the SI (Self Injury).
• First, try to have the student talk to his/her parents (guardian) about the self-injury.
• If the student prefers, the counselor and the student could meet with the parents (guardian) together.
• If the student prefers to meet alone with the parent, obtain permission for you (counselor) to talk with the parents.
• Remember that historically, the courts have protected parental rights and give the parents ready access to information about their child.

• 5. Assess for other risks.
• For example, risks regarding whether the student is at risk for suicide, injury (physical) and co-occurring conditions.
• If the counselor determines the student is at high-risk, then the counselor should consider whether referral to an emergency mental health facility is warranted.
• If the assessment indicates the risk is low, then the counselor should assess the risk of suicide frequently. Make sure and follow up.

• 6. Remember that the law does not address the duty to protect the student who engages in self-injury as directly as the law addresses suicide.

• However, the counselor must address safety issues such as self-injury that could be related to suicide ideation.
7. Remember that for counselors, the ethical principle of nonmaleficence (do no harm) must be followed.

8. Remember that for counselors, confidentiality is an important principle.

However, in instances of self-injury that may be life-threatening, confidentiality can be breached based on the student's reported self-injury incidents and intentions that are life-threatening. The intent here is to protect the student from harm.
9. Manage and monitor your (counselor) personal reactions to cutting.

10. Consult, consult, consult!
IMPLICATIONS FOR SCHOOL COUNSELORS

- “50% of adolescents “were more likely to turn to a friend than a parent or school psychologist” (Hennig, Craig, & Crabtree, 1998).

- “Adolescents rated having close friends as one of the most important sources of help when feeling suicidal or in a crisis” (Evans, Smith, Hill, Albers, & Neufeld, 1996).

- Most adolescents engage in NSSI impulsively (Whitlock & Rodham, 2013). “50% of those who cut themselves said that they had thought about harming themselves for less than an hour beforehand” (Hawton et al., 2002).
Schools should:

• “Raise awareness about the sources of help available to young people who are engaging in NSSI” (Whitlock & Rodham, 2013).

• “Support, prepare, and equip peers who may be the first person a friend turns to when he or she is thinking of or has already carried out an act of NSSI” (Whitlock & Rodham, 2013).

• “Promote resilience and thriving among all youth” (Whitlock & Rodham, 2013).
“School staff needs:

• Current and accurate information about NSSI (Whitlock & Rodham, 2013).

• A willingness to directly address NSSI cases (Whitlock & Rodham, 2013).

• Protocols or other guidelines for assuring the first two above” (Whitlock & Rodham, 2013).

School counselors should provide:

• Stress/Anxiety Group Counseling – helping adolescents learn how to deal with stress, which will hopefully prevent them from turning to NSSI; support group
- Dialectical Behavior Therapy (DBT)
  - A combination of individual and group therapy that utilizes emotional regulation, interpersonal effectiveness, distress tolerance, mindfulness, and self management.

  - Expectation is that the therapist is on call, at all times, for the patient and parents of the patient.

Example of DBT Exercise: Next Slide
# The Wise Mind

Your mind has three states: the reasonable mind, the emotional mind, and the wise mind. Everyone possesses each of these states, but most people gravitate toward a specific one most of the time.

![Venn Diagram](image-url)

- **Emotional Mind**
  - A person uses their **reasonable mind** when they approach a situation intellectually. They plan and make decisions based off of fact.

- **Wise Mind**
  - The **wise mind** refers to a balance between the reasonable and emotional halves. They are able to recognize and respect their feelings, while responding to them in a rational manner.

- **Reasonable Mind**
  - The **emotional mind** is used when feelings control a person’s thoughts and behavior. They might act impulsively with little regard for consequences.

Describe an experience you’ve had with each of the three states of mind.

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<tr>
<th>Reasonable</th>
<th>Emotional</th>
<th>Wise</th>
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Therapistaid., 2015
TREATMENTS

- Use of deep breathing exercises
- Progressive Muscle Relaxation
- Meditation Techniques
- Use of Art/Music
- The Ice Cube Method
- The Butterfly Project

Many Techniques on DBT can be found on Therapistaid.com.
VIDEO AND ACTIVITY

- https://www.youtube.com/watch?v=nVQ51yjQSGI
REFERENCES


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