Nonsuicidal Self-Injury: Prevention, Intervention, and Postvention

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Workshop Goals

- Participants will increase knowledge of...
  1. "non-suicidal" (NSSI) and "suicidal" self-directed violence (SDV) definitions.
  2. the statistics and demographics of non-suicidal SDV.
  3. The similarities and differences between NSSI and suicide
  4. how to assess for risk.
  5. primary prevention, intervention, and postvention strategies for NSSI
  6. resources to respond to the aftermath of a completed suicide.

Workshop Outline

1. Definitions
2. Statistics and Demographics
3. Prevention/Mitigation
4. Risk Assessment
5. Intervention
6. Postvention

Part 1

What is “suicide” and “NSSI”
GOAL:
Understand the term “suicide” and be able to differentiate it from other forms of self-injury

Definitions

- **Self-Directed Violence (SDV)**
  - "Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself."
  - Includes Non-Suicidal and Suicidal behaviors

- **Non-Suicidal SDV** (AKA self-mutilation, cutting, self-injury)
  - "Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent."

- **Suicidal SDV**
  - "Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent."

Crosby, Ortega, & Melanson (2011, p. 21)
NSSI & Suicide: Differences

<table>
<thead>
<tr>
<th>NSSI</th>
<th>Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expressed Intent</strong></td>
<td>relieve pain (feel better)</td>
</tr>
<tr>
<td><strong>Method</strong></td>
<td>damage to body</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>more frequent</td>
</tr>
<tr>
<td><strong>Level of psychological pain</strong></td>
<td>psychological distress is lower</td>
</tr>
<tr>
<td><strong>Cognitive Constriction</strong></td>
<td>less severe</td>
</tr>
<tr>
<td><strong>Aftermath</strong></td>
<td>short-term improvement (death is rare)</td>
</tr>
</tbody>
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Part 2

Statistics and Demographics

**GOAL:**
Have a better understanding NSSI and suicide statistics and demographics, and appreciate how these data can inform risk assessments.

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Definitions

- **Magnitude of the problem (U.S.A)**
  - Non-Suicidal SDV¹
    - 4 to 47% of the population
    - 17 to 35% of the population
    - 12-37.2 % in secondary schools³
    - 12-20% in late adolescents³
  - Suicidal SDV²
    - 10-14 yr olds = 3rd leading cause of death
    - 15-19 yr olds = 2nd leading cause of death
    - Across age groups = 10th leading cause of death

  - Felt sad or hopeless¹
    - 29.9%
  - Suicidal SDV among high school students in 2015¹
    - 17.7% seriously considered suicide
    - 14.6% made a suicide plan
    - 8.6% attempted suicide
    - 2.8% attempt required medical attention
    - 100 to 200 attempts for each completed suicide.²

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Part 3

Prevention/Mitigation

**GOAL:**
Considered a variety of primary prevention strategies.

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Social Emotional Learning

- Positive self identity (vs. self-esteem)
- Emotional regulation
- Delay of gratification
- Impulse control
- Problem solving
- Positive/healthy relationships
- Conflict resolution
- Adaptive coping
- Self-soothing
- Affect tolerance
School Based: NSSI Protocol

1. **Identification**
2. **Assessment**
3. Designated individuals to help manage NSSI cases
4. Determine when parents should be contacted
5. Manage active NSSI student
6. Determine when and how to refer
7. Identify external resources
8. Educate students and staff about NSSI

NSSI Myths

- Only females and/or teen-agers self-injure
- Self-injury is a suicide attempt
- Those who self-injure are crazy
- Just seeking attention
- Manipulative
- Only cut themselves
- NSSI is untreatable
- There’s nothing I can do to help
- Anyone who self-injures: has Borderline PD
- Is part of a “Gothic” or “Emo” subgroup
- Enjoys the pain or can’t feel it
- Are a danger to others
- Have been abused and can stop if really want to

NSSI: Risk Factors

- Variables that Increase the Odds of **Non-Suicidal SDV**
  - Demographics
  - Child Abuse
  - Self Directed Violence History
  - Family Dynamics
  - Peer Modeling
  - Mental Disorder
  - Psychological

Part 4

**Risk Assessment**

**GOAL:**
Increase your knowledge of NSSI & suicide risk assessment.

Cycle of Self-Injury

1. Trigger
2. High emotion intensity
3. Poor distress tolerance
4. Urge to avoid the emotional response
5. Guilt and Shame
6. Difficulty Regulating Emotions
7. Temporary Relief
8. Self-Injury (self-harm)

NSSI: Risk Factors

- Variables that Increase the Odds of **Non-Suicidal SDV**
  - **Personality Traits**
    - Negative affect
    - Low impulse control
    - Hostility
    - Anxiousness
  - **Interpersonal Conflict**
    - Rejection, isolation, criticism
  - **Biological/Genetic**
    - Serotonin imbalances
    - Puberty: typical age of onset
      - Neurodevelopmental vulnerability increases emotional stability
      - Risk-taking behaviors
      - Impulsivity
      - More susceptible to negative social cues and respond poorly to emotional distress
      - Problem solving skills still developing/limited coping skills

References

- Bubrick, Goodman, Whitlock (2016)
- Caicedo & Whitlock (2016)
How adolescents self-injure

- cutting
- punching
- biting
- burning one’s skin
- picking at skin
- hair pulling
- even deliberately breaking a bone

NSSI: Warning Signs

Variables Signal the Presence of Non-Suicidal SDV

- Behavioral
  - Other forms of self-destructive behavior (e.g., substance abuse)
  - Running into traffic
  - Jumping from high places
  - Possession of objects that could be used for cutting (e.g., razors, broken glass, thumb tacks)
  - Sudden change in peer group and/or withdrawal from prior relationships (or social isolation)
  - Secretive behaviors (e.g., spending atypical amounts of time in the restroom or isolated areas in school)
  - Males: tend to engage in self-battery
  - Females: tend to cut, burn, skin-pick
  - Many learn from a recommendation or observation of others

NSSI: Physical

- Cuts, scratches or burns that do not appear to be accidental
- Reports of frequent “accidents” that have caused physical injury
- Frequently bandaged wrists and/or arms
- Reluctance to take part in activities (e.g., physical exercise) that require a change of clothing
- Constant wearing of pants and long sleeved shirts, even in hot weather
- Direct observation of self-injurious behaviors (e.g., self-punching or scratching, needle sticking, head banging, eye pressing, finger or arm biting, pulling out hair, or picking at skin).

NSSI Exclusively

Problems more related to:

- Self
  - Significantly lower: ego clarity
  - self-esteem
  - self-perception
- Negative affect/emotional regulation
- Disengagement coping

NSSI with Other Behavior Problems

Problems more:

- “socially related”
- involve strong peer pressure

NSSI & Suicide: Common Risk Factors

- History trauma, abuse, chronic stress
- High emotional perception and sensitivity
- Few effective mechanisms for dealing with emotional stress
- Feeling of isolation (consider their perception)
- History alcohol/substance abuse
- Depression or anxiety
- Feelings of worthlessness

*Thus presence of NSSI can be a risk factor for suicide
*No evidence NSSI causes suicidal thoughts/behaviors but it lowers inhibition to suicidal behaviors

NSSI: Protective Factors

- Healthy emotion regulation skills
- Ability to self soothe
- A strong support network
- Positive body image
- Positive thoughts and beliefs
- Self-compassion
- Quality attachment with parent/caregiver
Non-Suicidal SDV Risk Assessment

- Assess the behavior, self-esteem, self-clarity, emotional regulation
  - *How I Deal With Stress* (Heath & Nixon, 2009)
  - *Self-Harm Behavior Questionnaire* (Gutierrez et al., 2001)
  - *Nonsuicidal Self-Injury Assessment Tool* (NSSI-AT; Whitlock 2014)
  - *Self-Injurious Thoughts & Behaviors Interview* (SITBI; Nock, Holtberg & Michels, 2007)
  - *Rosenberg Self-Esteem Scale* (1965)
  - *Self-Rating Scale* (Hooley, Ho, Slater, & Lockshin, 2002)
  - *Self-Concept Clarity Scale* (Campbell, Katz, Lavallee, & Trapnell, 1996)
  - *Perceptions of Parents Scale* (POPS; Grolnick, Ryan, & Deci, 1991)

Non-Suicidal SDV: Transactional Relationship

- React to negative stress
  - Actively select and contribute to negative stress (view minor events as having major impact)
    - Can then lead to
      - Psychological distress
      - Self-injurious behaviors

Non-Suicidal SDV: Negative Reinforcement

- Experience a temporary relief and reduction of unpleasant emotions
  - Reinforces act
  - Can make it highly psychologically addicting
    - Opioids released during self-injury mediate affect and decrease negative emotions

Non-Suicidal SDV: Positive Reinforcement

- Gain attention and concern from peers
  - Social rewards
- Use to influence social relationships (get attention, thus decreases isolation)
- Learn about it via social media/online forums
  - Encourages behavior, describes relief, shapes norms

The HIRE Model: A Tool for the Informal Assessment of Nonsuicidal Self-Injury

<table>
<thead>
<tr>
<th>Domain</th>
<th>Specific Field</th>
<th>Some Sample Screening Questions</th>
</tr>
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</table>
| "H" = History | Frequency and methods | *Tell me about the experience of cutting. What is it like for you?*  
*What kinds of wounds does it leave on your skin?*  
*Where on your body do you cut yourself?*  
*What do you use?*  
*What do you feel like when you cut yourself?*  
*What others worry about hurtling yourself, besides cutting, have you used this year?* |
| "I" = Interest in change | Motivation to reduce self-injury; negative outcomes | *What would you like to be different about your use of cutting?*  
*How has cutting affected your relationships?*  
*What do you perceive as the downsides of cutting?*  
*Tell me about a time when you were able to reduce your use of cutting.* |
| "R" = Reasons behind behavior | Interpersonal and/or intrapersonal functions of self-injury | *What kinds of thoughts go through your mind before cutting?*  
*Where do you engage in cutting?*  
*Are you always alone when you cut?*  
*Who else knows about your cutting?* |
| "E" = Exposure to risk | Severity; addictive features; sense of control/ability to avoid repetitive self-injury | *Have you ever harmed yourself so badly that you could have used medical attention, such as stitches?*  
*Have you ever injured yourself more than you expected?*  
*Have you ever used alcohol or drugs while cutting?*  
*Have you ever had an out-of-body experience while cutting?*  
*Have you ever used cutting as a way to avoid thoughts of suicide?* |

References:

- Dr. Melissa Reeves
**Part 5**

School-Based NSSI Intervention

**GOAL:**
Increase your knowledge of how schools should intervene with the student at risk for suicidal behavior.

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**School Based: NSSI Interventions**

- Development of school policy
  - Conducting risk assessment
  - Contacting parents if moderate to high risk
  - Requirement to share resources
- Increased staff development and training
- Provide consultation and supervision
- Increased attention to parent-school collaboration
- Increased parent education

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**Interventions: Skill Development**

- Change underlying problem
- Develop skills for:
  - self-soothing
  - appropriate frustration tolerance
  - delay of gratification
  - tolerance for feelings (affect tolerance)
  - language for expression of feelings and needs
  - solution-focused problem solving
    - Teach them to label the behavior
    - self regulation = self-management

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**School Based: NSSI Interventions**

- Tier 1
  - School wide strategies to recognize warning signs
  - Fostering non-judgmental interpersonal relationships to encourage trust
  - School-wide screening measures
- Tier 2
  - Prevention strategies, individual counseling in school setting to work on interpersonal stressors/social contributors
  - Increasing family and peer support
- Tier 3
  - Intensive interventions, crisis response team, referral to outside MH professional

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**School-Based NSSI: Intervention**

- **Low Risk**
  - Little history of NSSI
  - Generally manageable amounts of stress
  - Some positive coping
  - External supports
  - May need to contact parents
  - Manage through observation, teacher reports, periodic check-ins

- **High Risk**
  - Frequent or long-standing NSSI
  - High lethality methods
  - Chronic internal and external stress
  - Few positive supports or coping skills
  - Need more aggressive intervention and management
  - Must involve parents
School-Based NSSI: Intervention

- Opportunities for increased engagement and positive peer relationships
- Enhancing level of self-compassion
- Increase "self" (self-criticism, self-esteem, ego clarity)
- Improve affect regulation and coping mechanisms
- Enhance opportunities/resources for students and parents to improve relationships

**Mindfulness Self-Compassion Program**
- MSC for Adolescents: Making Friends with Yourself
- [https://centerformsc.org/msc-teens-adults/](https://centerformsc.org/msc-teens-adults/)

NSSI Distraction Techniques & Coping Strategies

**If angry**
- Slash plastic bottle, cut cardboard
- Squeeze ice
- Use "dammit doll"
- Flatten aluminum cans
- Hit punching bag, pans
- Use a stick to hit a tree
- Use pillow, rolled up paper to hit wall
- Dance
- Clean
- Exercise, sports

**Sad/depressed**
- Something slow or soothing
- Hot bath with minerals
- Hot cocoa and good book
- Hug loved one/stuffed animal
- Play with pet
- Make list of things that make you happy
- Soothing music
- Smooth body lotion
- Call/visit friend
- Cook

**Kilburn & Whitlock (2009)**

NSSI: Therapeutic Interventions

- **Dialectical Behavior Therapy**
  - Mindfulness and regulating emotions
  - How to recognize triggers and emotions
  - Teach alternative methods for regulating emotions, anxiety
  - Lessens impulsivity
  - Teaches to chose alternative coping method
- **CBT**
  - Focusing on cognitive distortions
  - Challenges negative thoughts and recognize NSSI patterns
  - Changing negative thought into positive narrative
- **SSRI medication**
  - Target neurotransmitters that contribute to NSSI
- **Attachment Based Family Therapies**
  - Increase trust, communication, and attachment with parents/caregivers

**Kilburn & Whitlock (2009)**

School-Based Suicide Intervention

- **General Staff Procedures for Responding to a Suicide Threat**
  - The actions all school staff members are responsible for knowing and taking whenever suicide warning signs are displayed.
- **Mental Health Professional Risk Assessment and Referral Procedures**
  - The actions taken by school staff members trained in suicide risk assessment and intervention.

School-Based Suicide Intervention

- Mental Health Professional Risk Assessment and Referral Procedures
  - Whenever a student judged to have some risk of engaging in self-directed violence or suicide, a school-based mental health professional should conduct a risk assessment and make the appropriate referrals.

School-Based Suicide Intervention

A Risk Assessment and Referral Resource


Part 6

School-Based NSSI & Suicide Postvention

GOAL: Increase your knowledge of how to respond to the aftermath of a completed suicide.

NSSI and Social Media

Negatives
- Social media/media can enhance contagion
- Online videos
- Message boards
- Images/sounds help to evoke emotions and serve as trigger
- Unhealthy discussions negative impact behavior and recovery

Positives
- Increased support in recovery
- Online emotional support/therapy
- Reduced social stigma as can share
- Inspirational sayings

YouTube, Tumblr, Instagram, Twitter all have guidelines around harmful, dangerous, glorifying behaviors and will take down and/or reach out (Twitter)

Bubrick, Goodman, Whitlock (2016)

School-Based NSSI: Social Contagion

- Reduce communication around self-injury
- Do not encourage student to talk to other students
  - Do not give explicit details
  - Do NOT do a school-wide assembly
- Treat on individual basis
- Educate on signs of distress in selves and others and positive coping skills
- Visible signs of scars, wounds, cuts should be discouraged

Reddy, Rokito, Whitlock (2016)

American Foundation for Suicide Prevention (2018)
https://afsp.org/our-work/education/after-a-suicide-a-toolkit-for-schools/
School-Based Suicide Postvention

Key Terms and Statistics
- Both survivors and exposed persons need support.
  - Survivors need:
    - support groups.
    - support from outside of the family.
    - to be educated about the complicated dynamics of grieving.
    - to be contacted in person (instead of by letter or phone).

Grad et al. (2004)

Suicide Contagion

- 12 to 13 year olds
  - 5 x’s times more likely to have suicidal thoughts (suicide ideation) after exposure to a schoolmate’s suicide
  - 7.5% attempted suicide after a schoolmate’s suicide vs. 1.7% without exposure
- Exposed to suicide have suicidal thoughts
  - 14 to 15 year olds 3x’s more likely
  - 16 to 17 year olds 2x’s more likely
- 16–17 year olds
  - 24% of teens had a schoolmate die by suicide
  - 20% personally knew someone who died by suicide

* Critical we invest in school and/or community-wide interventions following a suicide!!

http://www.cmaj.ca/site/misc/pr/21may13_pr.xhtml - study in Canada (2013)
School Protocol Process
The flowchart below can help school staff decide what action(s) to take after discovering that a student may be engaging in self-injury.

Student shows signs & symptoms

Staff suspects student self-injury
Peer disclosure of student self-injury
Self-disclosure

School becomes aware of student self-injury

Nurse treats wounds & assesses lethality
Contacts emergency services if wounds are severe or life-threatening or if student is suicidal

Point person meets with student

Low Risk
Point person meets with student and discusses strategies for using more positive coping mechanisms and makes follow-up plan

Moderate or High Risk
Point person & student contact parents
Point person, student and parents meet
Encourage & help family & student get outside services
Follow-up 2 weeks later