

Understanding, Assessing & Treating Nonsuicidal Self-Injury

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Differential Classification of Self-Harm Behaviors

	Direct	Indirect
High Lethality	Suicidal Behavior	Late Phase Anorexia; Serious Addiction
Medium Lethality	Atypical, Severe Self-Injury	High Risk Stunts; Sexual Risk-taking; Acute Intoxication
Low Lethality	Common, Low Lethality Self-Injury	Bulimia; D/C Psychotropic Medications

Differentiating Suicide from NSSI

Suicide

NSSI

	Suicide	NSSI
Prevalence	2010: 12.4 per 100,000 (.012%) in U.S. 2010: 9.9 per 100,000 in Germany	U.S.: 18.0% mean lifetime prevalence NSSI (Taliaferro et al. 2012) Germany: lifetime prevalence - 35.1% (Brunner et al. 2013)
Intent	<i>Permanently</i> end psychological pain; terminate consciousness	<i>Temporarily</i> modify emotional distress; effect change with others
Lethality of Method	High lethality: gunshot, hanging, O.D., jumping, ingesting poison	Low lethality: cutting, self-hitting, burning, picking, abrading

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NSSI

Cutting as a method for suicide vs. NSSI	Almost no one dies by cutting: All ages, .2% of suicides die by cutting; For 15-24 year olds, .6%; For 25-34 year olds, 1.5%	Cutting is the most common NSSI method almost universally in both community & clinical samples
Frequency	Low rate behavior even in severely mentally ill persons	Frequently high rate: scores of episodes per person
Number of methods	Repeat attempters generally employ one method, often overdose	In both community & clinical samples most use multiple methods; e.g. Whitlock (2008) 78%

Differentiating Suicide from NSSI

	Suicide	NSSI
Ideation	Suicidal ideation predominates; less positive Reasons for Living and Attraction to Life (Muehlenkamp 2010)	Suicidal ideation infrequent; concerning when present; more positive RFL and AL
Cognition & Affect	Helplessness and hopeless predominate; poor problem solving	Helplessness and hopelessness less likely as long as NSSI “works”; more intact problem solving
Aftermath	Continued despair; often high lethality	Immediate relief; reduction in negative affect

Differentiating Suicide from NSSI

Suicide

NSSI

Reaction of others	Most others express concern and support, move towards protection	Ongoing NSSI may be condemned, judged negatively; therapy-interfering behaviors (aka counter-transference) are common
Restriction of means ?	Often an important preventive intervention	Often ill-advised, counterproductive

Cautionary Notes: NSSI vs. Suicidal Behavior

While self-injury is generally not about suicide, self-injury is an important risk factor for suicide.

It is important to emphasize that while the behaviors are distinct, both can occur within the same individual.

The Relationship between NSSI and Suicide Attempts

Klonsky et al. (2013) reported on the relationship between NSSI and suicide attempts in four different samples:

- Adolescent high school students (n = 426)
- Adolescent psychiatric inpatients (n = 139)
- University undergraduates (n = 1364)
- Random-digit dialing of sample of U.S. adults (n = 438)

NSSI and Suicide Attempts

In all four samples, NSSI exhibited a robust relationship to attempted suicide (median $\phi = .36$)

Only suicidal ideation yielded a stronger relationship (median $\phi = .47$)

Associations were smaller for:

- Borderline personality disorder (.29)
- Depression (.24)
- Anxiety (.16)
- Impulsivity (.11)

NSSI and Suicide Attempts

Victor & Klonsky (2014) conducted a meta-analysis of 52 studies comparing self-injurers with and without suicide attempts (SA).

Results - Strongest predictors of SA in order:

- Suicidal ideation
- NSSI frequency
- Number of methods
- Hopelessness

Conclusion re: Suicide and NSSI

NSSI is substantially different from
suicide,

yet....

NSSI is a major risk factor for suicide
attempts

NSSI and Suicide Attempts

Good clinical practice suggests:

- Understand, manage, and treat the behaviors differentially
- Carefully cross-monitor; assess interdependently
- Intervene early with NSSI to prevent emergence of suicidality.
- Remember: NSSI can be “double trouble”

Some U.S. Demographics

- Data from the 2009 Massachusetts YRBS indicated that 17% of high school students and 15% of middle school students reported having self-injured during the past year.
- Also, a study from Cornell and Princeton Universities, using a sample of almost 3000 students, found that 17% indicated having self-injured (*Whitlock et al. 2006b*).
- And in a follow up study involving 8 colleges and more than 11,000 students, Whitlock (2008) found that 15.3% reported some NSSI lifetime; 29.4% reported more than 10 episodes

NSSI Internationally

High rates of “deliberate self-harm” (e.g. 2.5 to 11.8% of adolescents) have also been reported in other developed countries:

- UK
- Australia
- Japan
- Ireland
- Belgium
- Norway
- Germany

-- (Rodham & Hawton, 2009)

Clinical Definition of Self-Injury

"Self-Injury is intentional, non-life-threatening, self-effected bodily harm or disfigurement of a socially unacceptable nature, performed to reduce and/or communicate psychological distress."

(Walsh, 2008)

Eight Levels of Care in the Treatment of NSSI

I. The Informal Response

-- The Importance of Language

- > professional language (self-mutilation vs. NSSI)
- > pejorative language
- > idiosyncratic language

-- Interpersonal Demeanor

- > Low key, dispassionate demeanor
- > Respectful Curiosity (Kettlewell, 1999)

Eight Levels of Care for NSSI

II. Crisis Intervention

- Level of Physical Damage, e.g. multiple sutures or other medical response
- Bodily Location, i.e. face, eyes, breasts, genitals
- Foreign body ingestion

III. Assessing Nonsuicidal Self-Injury

1. Antecedents (events in environment)
2. Antecedents (biological elements)
3. Antecedents (thoughts, feelings, behaviors)
4. Strength of urges
5. # Wounds
6. Start and end time of SI episode
7. Physical pain?
8. Extent of physical damage (length, width; sutures obtained? If yes, how many?)
9. Body Area(s)

III. Assessing Self-Injury, continued

9. Use of words, symbols?

10. Use of tool- (Yes/No-If Yes, Type)

11. Room or place of SI

12. Alone or with others during SI

13. Aftermath of SI (thoughts, feelings, behaviors)

14. Aftermath of SI (biological elements; self-care?)

15. Aftermath of SI (events in environment)

16. Motivation to stop? Rebound responses?

17. Other idiosyncratic details (standard)

Eight Levels of Care in the Treatment of NSSI

IV. Replacement Skills Training

- Negative Replacement Behaviors
- Mindful Breathing
- Visualization
- Non-Competitive Physical Exercise
- Writing - Playing/Listening to Music - Artistic Expression
- Diversion Techniques

Basic Features of a School Protocol to Manage NSSI

Staff Training

1. This protocol can only be implemented with adequate advance training of school staff.
2. Staff is trained regarding the forms of direct and indirect self-harm and how to provide a thorough assessment.
3. Staff is trained to understand how self-injury and suicidal behavior are markedly different in terms of 9 characteristics.

Basic Features of a School Protocol to Manage NSSI

Responding to Self-Injury in Individuals

1. School Administration identifies point persons to be contacted when self-destructive behavior surfaces within the school. Point persons are usually guidance counselors, social workers and/or school nurses.

Basic Features of a School Protocol to Manage NSSI

Responding to Self-Injury in Individuals

2. Staff refers all students with self-destructive behavior or plans to the designated point persons. Point persons assess:
 - Suicidal behavior
 - Other life-threatening behavior
 - Atypical, severe self-injury

Basic Features of a School Protocol to Manage NSSI

Responding to Self-Injury in Individuals

3. If the behavior or plan is deemed to be suicidal or otherwise life-threatening, emergency procedures are followed.

Basic Features of a School Protocol to Manage NSSI

Responding to Self-Injury in Individuals

4. If the behavior is deemed to be **common low lethality self-injury**, the point person calls the student's parent while the student is present.
5. The point person explains that he/ she has learned the child has self-injured and explains that the behavior is cause for concern but not usually about suicide.

Basic Features of a School Protocol to Manage NSSI

Responding to Self-Injury in Individuals

6. The point person requests that the parent follow up immediately with outpatient counseling for the child and family.
7. The point person requests that the parent call back to confirm that the outpatient appointment has been made.

Basic Features of a School Protocol to Manage NSSI

Responding to Self-Injury in Individuals

8. If the parent does not call back, the point person re-contacts the parent and requests that the outpatient referral be pursued.
9. If after repeated requests the parent fails to act, mandated reporting for neglect or abuse must be considered

Basic Features of a School Protocol to Manage NSSI

Responding to Self-Injury in Individuals

10. The point person generally stays in periodic contact with the parent to monitor progress.
11. In some cases, the point person obtains consent from parent and child to communicate with the outpatient clinician.

Basic Features of a School Protocol to Manage NSSI

Responding to Self-Injury Among Groups

1. Point persons should assess if multiple students are triggering the behavior in each other.

Basic Features of a School Protocol to Manage NSSI

Responding to Self-Injury Among Groups

2. Contagion may be due to the following influences:
 - a. Limited communication skills
 - b. Desire to change the behavior of others
 - c. Response to caregivers, family members
 - Competition for caregiver resources
 - Anticipation of aversive consequences

Basic Features of a School Protocol to Manage NSSI

Responding to Self-Injury Among Groups

2. Contagion may be due to the following influences:

- d. Other peer group influences
 - Direct modeling influences
 - Disinhibition
 - Competition
 - The role of peer hierarchies
 - Desire for group cohesiveness

Basic Features of a School Protocol to Manage NSSI

Managing & Preventing Contagion

1. Point persons identify the primary high status peer models.
2. These high status models are approached strategically.

Basic Features of a School Protocol to Manage NSSI

Managing & Preventing Contagion

3. Point persons explain to peer models that they are hurting their peers by communicating about SI to others.

Self-injurers are encouraged to talk with the point persons, family, therapists, but not to peers about SI as such talk is “triggering.”

Basic Features of a School Protocol to Manage NSSI

Managing & Preventing Contagion

4. Students are asked not to appear in school with visible wounds or scars
5. Point persons involve parents when necessary
6. Some students may need to have extra sets of clothing in school to cover wounds or scars.
7. In rare cases, students may have to be dealt with disciplinarily

For more info:

- On the High School Self-Injury Prevention Program:
- www.mentalhealthscreening.org
- Click on 2009/2010 SOS Signs of Suicide and Self-Injury Programs

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