Understanding, Managing, and Treating Non-Suicidal 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

Modified, Pattison & Kahan (1983)

Checklist for Direct Self-Harm

- **Suicide Attempts**
  __ Use of a gun __ Overdose __ Hanging
  __ Self-Poisoning __ Jumping from height
- **Major Self-mutilation**
  __ Self-enucleation __ Autocastration __ Other
- **Atypical, Serious Self-Injury**
  __ Injury to face, eyes, genitals, breasts
  __ Damage involving multiple sutures
  __ Foreign body ingestion
- **Common Forms of Self-Injury**
  __ Wrist, arm, and leg cutting
  __ Self-burning, self-hitting, excoriation

Checklist for Indirect Self-Harm

- **Substance Abuse**
  - __ Alcohol Abuse
  - __ Cocaine Use
  - __ IV Drug Use
  - __ Methamphetamine
  - __ Marijuana Use
  - __ Inhalant Use (glue, gasoline)
  - __ Hallucinogens, Ecstasy
  - __Other (specify)
- **Eating Disordered Behavior**
  - __ Anorexia Nervosa
  - __ Bulimia
  - __ Obesity
  - __ Use of laxatives
  - __ Other (specify)

Checklist for Indirect Self-Harm *(cont…)*

- **Physical Risk-Taking**
  - __ e.g., Walking on high-pitched roof
  - __ Walking in fast traffic
- **Situational Risk-Taking**
  - __ e.g., Getting into strangers' cars
  - __ Walking alone in dangerous areas
- **Sexual Risk-Taking**
  - __ Having sex with strangers, unprotected anal sex
- __ **Unauthorized discontinuance** of psychotropic meds.
- __ **Misuse/Abuse** of prescribed psychotropic meds.

Differentiating Suicide from NSSI

	Suicide	NSSI
Prevalence	2014: 13.4 per 100,000; 10th ranking cause of death, 2nd among youth (ages 15-24) CDC (2015)	7.3% - 12 month U.S prev - alence (Taliaferro et al. 2012) 18.0% mean lifetime prevalence NSSI; (Muehlenkamp et al. 2012)
Intent	*Permanently* end psychological pain; terminate consciousness	*Temporarily* modify emotional distress; effect change with others
Lethality of Method	High lethality: gunshot (50%), hanging (27%), poisoning/ O.D. (16%),	Low lethality: cutting, self-hitting, burning, picking, abrading

Differentiating Suicide from NSSI

	Suicide	NSSI
Cutting as a method for suicide vs. NSSI	Suicide by cutting/ piercing is rare: 1.7% of suicides die by cutting/ piercing; Therefore, 98.3% use other methods.	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%; Green (2013)

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 are common (aka counter-transference)
Restriction of means ?	Often an important preventive intervention	Often ill-advised, counterproductive

Cautionary Notes: Self-Injury vs. Suicidal Behavior

While self-injury is generally not about suicide, NSSI is a risk factor for suicidal behavior.

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

NSSI and Suicide Attempts

Victor and Klonsky (2014) continued…

Moderate predictors of suicide attempts, in order:

- BPD
- Impulsivity
- PTSD
- Cutting as method
- Depression

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"

As We Leave the Topic of Suicide

Please share:

National Suicide Prevention Lifeline

1-800-273-TALK (8255) – English and Spanish

www.suicidepreventionlifeline.org

U.S. NSSI Demographics

- In community samples, a range of 6 to 25 % of youth report self-injuring at least once
- In clinical samples, more females report SI than males; In community samples there is no gender difference
- Age of onset for the majority is 12 to 14; for a minority it can be younger.
- SI may be more common among Caucasians & GLBTQ youth (Nixon & Heath, 2008)
- Females may be more likely to cut or pick; Males may prefer more aggressive methods such as self-hitting, punching walls (Whitlock 2008; Martin et al. 2010; Green 2013)

More U.S. Demographics

- Data from the 2013 Massachusetts YRBS indicated that 14% of high school students (down from 18%) and 14% of middle school students (up from 13%) reported having self-injured during the past year (Mass. DOE, 2014)
- 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
- Netherlands

-- (Rodham & Hawton, 2009; Claes & Muehlenkamp, 2014)

Responding to Self-Injury

Step 1:

1A. The informal response
1B. Assessment for atypical, severe NSSI
1C. Detailed cognitive-behavioral assessment

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 psychological distress and/or effect change in others."

(Walsh, 2016)

Steps in Treating NSSI

Step 1A: 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)

Steps in Treating NSSI

Step 1B: When NSSI is a Crisis -

Atypical, Severe Self-Injury

- Unusual level of physical damage, e.g. multiple sutures or other medical response
- Atypical, alarming body Location, i.e. face, eyes, breasts, genitals
- Foreign body ingestion

Steps in Treating NSSI

Step 1C: Cognitive-Behavioral Assessment

- Environmental
- Biological
- Cognitive
- Affective
- Behavioral Dimensions

Step 1C: Assessing NSSI

1. Antecedents (events in environment)
2. Antecedents (biological elements)
3. Antecedents (thoughts, feelings, behaviors)
4. Strength of urges (0 – 4 scale can be used)
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)

Step 1C: Assessing NSSI (continued)

10. Hidden or exposed?
11. Use of words, symbols?
12. Use of tool- (Yes/No-If Yes, Type)
13. Room or place of SI
14. Alone or with others during SI
15. Aftermath of SI (thoughts, feelings, behaviors)
16. Aftermath of SI (biological elements; self-care?)
17. Aftermath of SI (events in environment)
18. Motivation to stop? Rebound responses?
19. Other idiosyncratic details (standard)

Summary: Comprehensive Assessment of NSSI

Positive Self-Reinforcement e.g. "I get high off SI."	Negative Self-Reinforcement e.g. "SI provides such relief from stress!"
Positive Social Reinforcement e.g. "My boyfriend reengages whenever I self-injure."	Negative Social Reinforcement e.g. "People leave me alone when I self-injure" (Nock & Prinstein, 2004)

Step 2 in Treating NSSI

2A. Replacement skills training
2B. Cognitive-behavioral treatment
2C. Family treatment
2D. Biological mechanisms and medication
2E. School or group setting protocol (where relevant)

Four Steps in Treating NSSI

Step 2A: Replacement Skills Training

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

Basic Technique for Teaching Skills

Teach the client/ student the Subjective Units of Distress Scale (SUDS Scale)…

0 = the most relaxed you've ever been…

100 = the most distressed you've ever been

1) Identify your SUDS before practicing a skill
2) Identify your SUDS immediately after
3) Develop a list of skills that reliably reduce SUDS

Basic Technique for Teaching Skills

One other rule of thumb:

When teaching a client/ student a skill, ask yourself:

What could go wrong with that?

-- in other words, trouble-shooting…

Negative Replacement Behaviors

Some frequently used examples:

- Snapping a rubber band on the wrist
- Holding a frozen orange or picnic cooler freeze pak (not ice!)
- Marking the body with a red felt-tipped marker
- Stroking the body with a soft cosmetic brush or other implement

More Negative Replacement Behaviors

- Writing or journaling about self-injury
- Creating artwork that depicts self-injury
- Other examples from audience?

Some Breathing Techniques

1) "I am here, I am calm."
   (i.e. "I am here in the present moment without judgment…")
2) 1-10 Exhalation Breathing (2500 years old!)
3) Jon Kabat-Zinn:
"Seeing [emotion, e.g. anger] letting be,"
"Seeing [emotion, e.g. anger] letting go…."
4) Apps: "Calm," "Tibetan Singing Bowls"

Visualization

Suggestions:

- Have clients create their own rather than using boilerplate examples
- Suggest that clients use all five senses in creating the visualization
- Have them create several to choose from over time
- Encourage ownership and individualization
- Apps such as “Hypno,” “Koi Pond,” “Calm”

Non-Competitive Exercise

- Matthew Nock (Harvard U.) has shown that vigorous exercise can be an effective strategy for fending off urges to self-injure
- ➢ Help the client identify type of exercise and location
- ➢ Ensure that the circumstances are safe
- ➢ Emphasize that this form of exercise is not about achievement or enhanced conditioning
- ➢ Walking meditation, Yoga, Tai Chi,

Writing, Journaling

- Can be effective coping techniques
- Can be shared with therapist in the moment via text or during therapy sessions
- Should NOT be shared with peers due to potentially triggering content
- Should NOT focus primarily on details of self-injury as this may triggering and a rehearsal
- Emphasis should be on identifying emotions, changing thoughts, using coping behaviors

Music or Sounds as a Coping Skill

Encourage the client to identify and store music that consistently reduces SUDs

- Create a category on one's music device labeled "relaxation" or "soothing"
- Phone apps such as:
  - "Rain, Rain, Sleep Sounds" or
  - "Relax Melodies"
  - "Sleeping Tips" (CBT for insomnia)

Artistic Expression

- Should be a soothing activity
- Depictions of self-injury may be triggering or a rehearsal. Assess for whether the activity is contraindicated. Self-injury themes should not be shared with peers
- Painting, coloring, crocheting, clay work
- Perfectionism is counterproductive
- Apps: "Color Therapy," "Art Therapy," "Colorgram,"

Diversion Techniques

Examples: watch a comedy, cook, surf the net, go shopping, do a puzzle, etc.

Note: these are *distract skills.* They do not teach sitting with emotions; rather they are more avoidance behaviors.

Therefore, clients need more than such skills. They may be useful early in treatment, but are not sufficient.

Step 2D: Understanding Biological Mechanisms for NSSI

Why Does NSSI "Work?" The Pain Offset Relief Hypothesis

Dr. Joe Franklin proposes to explain how NSSI works using "pain offset relief" (i.e. "removal/ reduction;" Franklin, 2016)

He notes that the brain experiences a profound sense of relief when physical pain ends. And when the pain ends, persons experience a more pleasant feeling than the previous baseline, i.e. pleasant relief.

Pain Offset Relief

A key aspect of POR is that it simultaneously reduces bad feelings and increases good feelings.

There is a large degree of "neural overlap" between physical pain and emotional pain in areas of the brain called "anterior cingulate cortex" and the "anterior insula." (Franklin, 2016).

Pain Offset Relief Ho

It can be easy to turn off physical pain (e.g. stop cutting, remove hand from flame) but hard to turn off emotional pain.

"The physical pain relief that follows a self-injury event basically tricks the brain into perceiving relief of emotional pain too!" (Franklin, 2016)

- This may be why NSSI "works!"

Pain Offset Relief Ho

Read Joe Franklin's brief paper re: "pain offset relief" on the website for the Cornell Research Program on Self-Injury and Recovery.

http://www.selfinjury.bctr.cornell.edu/perch/resources/how-does-self-injury-change-feelings.pdf

Step 2E: A Protocol for Responding to Self-Injury in School Settings

Step 2E: 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 *yet linked*.

Step 2E: 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

2. Staff refers all students with self-destructive behavior or plans to the designated point persons. Point persons assess whether the behavior should be considered:

- suicidal behavior
- Atypical, severe self-injury
- other life-threatening behavior, vs.
- "common, low lethality 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, atypical self-injury, 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 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. Ideally, the point person obtains consent from the 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.

A Continuum of Peer Influence on Social Contagion of NSSI

Passive exposure to NSSI in media (e.g. books, movies, websites, YouTube, forums)	Active participation in NSSI forums	Exposure to NSSI in larger groups (e.g. school, group home)	Exposure to NSSI in friends	Exposure to NSSI in best friend	Active encouragement by peers to self-injure (in person or web-based)	Active engagement in NSSI in front of/ or with peers

>>>>>>> Increased Risk of Influence and Contagion >>>>> (Walsh, 2016)

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.

Basic Features of a School Protocol to Manage NSSI

Managing & Preventing Contagion

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

3. 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:
- mentalhealthscreening.org
- Click on Self-Injury Program

(Note: program has been recently revised)

Final Take Home Points - 1

- Re: suicide vs. self-injury, pay close attention to **method**!
- Remember NSSI is a strong predictor of suicide attempts. Assess routinely for both!
- Ideally, assessment should involve standardized questionnaires and a detailed behavioral analysis

Final Take Home Points - 2

- NSSI is primarily about emotion regulation and secondarily about interpersonal influence
- Treatment should emphasize teaching alternative emotion regulation and social skills
- Treatment should not focus on prohibition or confiscation of tools
- Skills-based treatments work!

Final Take Home Points – 3

- Social contagion is a common phenomenon with NSSI
- Avoid discussion of the details of NSSI in groups
- Encourage clients not to share details of NSSI or exhibit wounds with peers

Thank You!

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