Half-day Seminar on "Intervention and Prevention of Students' Self-harm behaviour"

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October 2014

Definition

- Self-injury is the act of deliberately harming your own body, such as cutting or burning yourself. Typically not meant as a suicide attempt.
- Self-injury is an unhealthy way to cope with emotional pain, intense anger and frustration. Bring a momentary sense of calm and a release of tension, usually followed by guilt and shame and the return of painful emotions.
- Self-injury may be linked to a variety of mental disorders, such as Depression, Eating disorders and Borderline Personality Disorder.

Forms of self-injury

- One of the most common forms of self-injury is cutting, which involves making cuts or severe scratches on different parts of body with a sharp object. Other forms of self-harm include:
- Burning (with lit matches, cigarettes or hot sharp objects like knives)
- Carving words or symbols on the skin
- Hitting or punching
- Piercing the skin with sharp objects
- Head banging
- Biting
- Persistently picking at or interfering with wound healing

Warning Signs for NSSI

- Risk-taking behaviors such as playing with knives, sexual acting out, running into traffic, or jumping from high places
- Evidence of eating disorder or substance abuse
- General signs on depression, social isolation, and disconnectedness
- Possession of sharp implement (razor, shards of glass, thumb tacks)

Adapted from: Lieberman, R., Poland, S. (2006). Self-mutilation. In G. G. Bear & K. M. Minke (Eds.), *Children's needs III: Development, prevention, and intervention.* Washington, DC: National Association of School Psychologists. [http://www.nasponline.org]

Other Signs

- Scars, such as from burns or cuts
- Fresh cuts, scratches, bruises or other wounds
- Keeping sharp objects on hand
- Wearing long sleeves or long pants, even in hot weather
- Claiming to have frequent accidents or mishaps
- Spending a great deal of time alone
- Pervasive difficulties in interpersonal relationships
- Persistent questions about personal identity, such as "Who am I?" "What am I doing here?"
- Behavioral and emotional instability, impulsivity and unpredictability
- Statements of helplessness, hopelessness or worthlessness (expressed in verbal, written or through internet social networking device e.g. FB)

Cause

- No one single or simple cause.
- Usually the result of an inability to cope in healthy ways with psychological pain related to issues of personal identity and having difficulty "finding one's place" in family and society.
- Difficulties regulating, expressing or understanding emotions.
- Mixture of emotions.
- For instance, there may be feelings of worthlessness, loneliness, panic, anger, guilt, rejection, self-hatred or confused sexuality.

Through self-injury, the person may be trying to:

- Manage or reduce severe distress or anxiety
- Distraction from painful emotions through physical pain
- Feel a sense of control over his or her body, feelings or life situations
- Feel something when feeling emotionally empty
- Express internal feelings in an external way
- Communicate depression or distressful feelings to others
- Be punished for perceived faults

Risk Factors

- **Female.**
- **Age.** Most people who self-injure are teenagers and young adults, although those in other age groups also self-injure
- **Friend's influence.**
- **Life issues.** Some people who injure themselves were neglected, or sexually, physically or emotionally abused, or experienced other traumatic events. They may have grown up and still remain in an unstable family environment, or they may be young people questioning their personal identity or sexuality.
- **Mental health issues.** People who self-injure are more likely to be impulsive, explosive and highly self-critical, and be poor problem-solvers. In addition, self-injury is commonly associated with certain mental disorders, such as borderline personality disorder, depression, anxiety disorders, post-traumatic stress disorder and eating disorders.

The Story

- Self-injury took seven years of my life; it was seven years of hell. It was a crutch, a burden, an excuse, a drug. I slowly became addicted, moving from injuring once in a while to everyday to more. I was punishing myself. I was hospitalized for a suicide attempt and it was then I realized how addicted, dependent, and desolate I really was.

The Story

- But what I didn't realize was that self-injury was a *choice*. No one forces you to self-injure; other's actions or words might lead you to self-injuring but you alone control your actions. Self-injury is nothing more than a dangerous bandage, covering emotional pain with physical pain. Physical pain is more concrete than emotional pain and that's what's so appealing.

The Story

- Self-injury is nothing to live with: you deserve so much better. Remember, life is what you make of it. I'm not saying you won't have impulses because you will. But, people are there to help, yet it won't do any good unless you're ready. Ready to change, to be free, to live. Ready to ask for help. (Written by K.A., age 17)

Response to Student's Disclosure

- First, the response to student disclosure should show a respectful willingness to listen in a nonjudgmental fashion.
- The practitioner should use similar language to the youth in describing the behavior (e.g., if they describe "cutting", identify the behavior as such in your discussions) and should avoid the use of suicide terminology (Walsh, 2006).

Response to Student's Disclosure

- In the initial response and discussions that follow, one should not express shock, revulsion, or discomfort; nor should the practitioner overreact and show too much concern for the adolescent. These types of reactions could alienate the youth and damage the trust within the working relationship.
- Should not show excessive interest in the behavior as this can be a trigger for further self-injurious behaviors.

Suggestions for Teachers: Helping Youth Who Self-Injure

- It is important for teachers to know the do's and don'ts of how to handle such situations.

Suggestions for Teachers: Helping Youth Who Self-Injure

Do:

- Try to approach the student in a clam and caring way.
- Accept him or her even though you may not accept the behavior.
- Let the student know how much you care about him or her and believe in his or her potential.
- Understand that this is his or her way of coping with the pain he or she feels inside.

Do:

- Refer that student to your school-based professional (e.g., psychologist or counselor).
- Offer to go with that student to see the professional helper.
- Listen! Allow the student to talk to you. Be available.
- Discover what the student's personal strengths are and encourage him or her to use those strengths.
- Help him or her get involved in some area of interest (club, sport, or peer program).

Suggestions for Teachers: Helping Youth Who Self-Injure

Don't

- Say anything to cause the student to feel guilt or shame (e.g., "What did you do to yourself?")
- Act shocked or appalled by his or her behavior.
- Talk about the student's NSSI in front of the class or around his or her peers.
- Try to teach the student what you think he or she should do.

Don't

- Judge the student, even if you do not agree with him or her.
- Tell the student that you won't tell anyone if he or she shares information about self-injuring behaviors with you.
- Use punishment or negative consequences if a student does self-injure.
- Make deals in an effort to get the student stop.
- Make promises to the student that you can't keep.

Adapted from: Bowman, S., & Randall, K. (2004). See my pain: *Creative strategies and activities for helping young people who self-injure.* Chapin, SC: YouthLight. [http://www.youthlightbooks.com]

Different Levels of Treatment for Different Clinical Presentations

- **Careful monitoring**

NSSI has been performed just once or twice, the context of NSSI is social or experimental, medical severity is low, emotion distress is low, suicidal ideation is absent, clinical disorders are absent.

Different Levels of Treatment for Different Clinical Presentations

- **Outpatient therapy**

NSSI has been performed more than once or twice, NSSI is performed for intrapersonal reasons such as affect regulation and self-punishment, multiple methods of NSSI have been utilized, suicidal ideation is present, there is clinically significant emotional distress, NSSI is usually performed alone, there are co-occurring clinically significant conditions such as emotional distress, suicidal ideation, or clinical disorders

Different Levels of Treatment for Different Clinical Presentations

- **Inpatient or partial hospitalizations**
- Medical severity of NSSI is high, thoughts/urges of NSSI are almost constant, frequency of NSSI is high, numerous methods of NSSI have been used, suicidal ideation is high, there is severe impairment due to a co-occurring mental disorders

Sample School Protocol for Non-suicidal Self-Injury

Response to NSSI

- Schools should have assigned school-based professionals (e.g., school psychologist or counselor) for NSSI referral issues. There must be a key referral person if the school-based professional is not regularly available. This person would be responsible for contacting and collaborating with the school psychologist or counselor should any students be referred.
- All staff should have training and information about NSSI so that reactions are consistent, appropriate, and conform to protocol.

Sample School Protocol

Referral

- Any school personnel who learns of a student's NSSI will immediately refer to a school-based mental health professional, maintain the chain of supervision, and remain involved with the school team that is conducting the intervention with this student.

Sample School Protocol

Assessment

- The school-based professional conducts an initial (Level 1) assessment. If it is found that the student is at any risk of suicide (current thoughts, previous attempts, self-harm, or current plan with access to means), then procedures will be followed for suicide risk (parents contacted, referral to community or hospital-based mental health professional for fuller evaluation, or, if urgent, emergency room crisis evaluation).
- If it is found that the student is engaging in NSSI as a maladaptive coping strategy and is not currently suicidal ensure that the student receives a more complete assessment and appropriate school interventions that include parent involvement are implemented.
- The school-based professional should conduct a fuller assessment and determine if more individualized, intensive therapy is required.

Sample School Protocol

Parent Contact

- If it is deemed the outside therapy is required, the school-based professional will make the decision to contact the parent. Although it is best practice to involve parents at all times, not all adolescents who have engaged in NSSI must have parents contacted. Be aware of state or provincial laws regarding the school's obligation to contact parents.

Referral & Risk issues

At any risk for suicide or other mental health issues.

Low - reporting current thoughts that were revealed in something they said (direct or indirect threats) or wrote (journals).

Moderate - in addiction to current thoughts,

Reports previous suicide attempts or evidence of self-injurious behaviors such as fresh or recent wounds.

High - has a plan to kill him – or herself and has access to means.

- At high risk involvement of the appropriate emergency mental health services
- Risk is deemed low to moderate, supervising and handing off the student directly to parents or guardians is recommended.

7 Suggestions for Reducing Contagion of NSSI

- NSSI should not be discussed in detail in school newspapers or other student venues. This can serve as a “trigger” for individuals who engage in NSSI.
- Those who engage in NSSI should be discouraged from revealing their scars because of issues of contagion.
- In general, a designated person should be clear with the student that although the fact of NSSI can be shared, the details of what is done and how should not be shared, as it can be detrimental to the well-being of the student’s friends.

7 Suggestions for Reducing Contagion of NSSI

- Health educators should reconsider the classroom presentation of certain books, popular movies, and music videos that glamorize such behaviors.
- Divide students who are referred for a group rite of passage and have each assessed and responded to individually. When numerous students within a peer group are referred, assessment of every student will often identify an “alpha” student whose behaviors have set the others off. This student should be assessed for more serious emotional disturbance. Although most students participating in a group event will assess at low risk, identifying moderate and high risk students and targeting them for follow up is critical.

7 Suggestions for Reducing Contagion of NSSI

- Educators must refrain from school-wide communications in the form of general assemblies or intercom announcements that address self-injury.
- School mental health professionals should refrain from running specific groups that focus on cutting, rather focusing on themes of empowerment, exercise and tension relief, and grief resolution

Communication Skill-Building

- Communication skill-building develop more adaptive coping strategies to deal with life stressors.
- Role-play practicing how to communicate more effectively are helpful to identify and talk with trusted adults at home or at school about their feelings.
- Vent his or her emotions using written journals or art projects.

Behavioral Interventions

- Finding alternative ways to understand, manage, and express their emotions.
- Techniques such as diaphragmatic and controlled breathing, meditation, and visualization can be effective exercises to reduce tension when these skills are learned and practiced regularly.
- “self-care” to exercise every day or every other day for 3 weeks. (Substitution of aerobic exercise).
- Controversial –

  snap a rubber band around the wrist when the impulse to self-injure overwhelms them.

Questions to Help Identify Different Aspects of Emotions

- **Physiological**

How does this emotion feel in your body?

Where do you feel your emotion in your body?

What physical sensations do you have with this emotion?

- **Behavioral**

What do you want to do when you feel this emotion?

How do you behave when you have this emotion?

What things do you or don't you do when you feel this emotion?

- **Intensity**

How strong is the emotion you're feeling?

Have there been times when you're had a similar emotion but with less/more strength?

What other words could describe the intensity of the emotion you have?

- **Function**

Do people react differently to you when you show this emotion?

What purpose did this emotion serve for you in this situation?

How could you use your emotion to help you figure out how to act?

Cognitive Restructuring

Choice

A. The behavior is acceptable or necessary;
B. The persons are disgusting and deserving of punishment ;
C. This action is needed to reduce unpleasant feelings or to solve immediate crises;
D. This overt action is required to communicate their feelings to others and to have others understand the deep emotional pain they are experiencing.

Challenging Cognitive Beliefs

Step	Sample question
1. Identify & recognize maladaptive beliefs/thoughts	1. What were you telling yourself when that happened?
2. Link thoughts to cognitive distortions	2. Which type of distortion does that though fit under?
3. Evaluate evidence for beliefs/thoughts	3. If you had been successful, would you stop being a failure? What if you made a mistake again in the future? Do successful people ever make mistakes?
4. Create more realistic & adaptive thought	4. What would be a more balanced thought that captures the full picture of things?
5. Behave consistent with new belief/thoughts	5. What would you do, or how would you act, if you told yourself (new belief)?

Family Treatment Targets

1. **Psycho-education**

a. About NSSI, its common functions, and how it differs from suicide

b. What behaviors signal a crisis, and warning signs for suicidal behavior

c. How to respond to NSSI in a non-judgmental fashion

d. What to expect from treatment, treatment process

2. Family processes

a. Improve communication styles, interaction patterns, connectedness
b. Reduce skill deficits in parents (parenting skills, emotion regulation, validation)
c. Limit setting and issues around client autonomy, trust
d. Decrease family stressors or risk factors (pathology, abuse, substance abuse)
e. Enhance and build upon family strengths and protective factors

3. Ways to support client

a. Help client identify triggers and prompt skill use
b. Model skill use, practice skills together
c. Provide positive reinforcement for successes related to treatment goals