Working With Nonsuicidal Self-Injurious Adolescents

Mark D. Nelson
Montana State University

Rian Piccin
Lander, Wyoming

Abstract

Nonsuicidal self-injury (NSSI) has evolved into a serious issue for adolescents, and is encountered in school systems across the United States. The ability of school counselors and other professionals working in the school environment to understand and assist students who exhibit signs of NSSI is critically important. Research remains minimal on the subject and it is unclear whether or not schools across the country have proper protocols in place for working with students who exhibit signs of NSSI. School professionals should be familiar with NSSI, how to identify NSSI behaviors in students, and proper protocols for working with students who exhibit signs of NSSI.

Keywords: nonsuicidal self-injury, school counselors

Working With Nonsuicidal Self-Injurious Behavior Adolescents

Adolescents are faced with a myriad of psychological hurdles as they grow and develop; however, many adolescents develop maladaptive coping mechanisms for dealing with extreme and painful emotions. Nonsuicidal self-injury (NSSI) is one type of the maladaptive coping mechanisms used by adolescents to alleviate negative emotions or as a form of punishment (Berger, Hasking, & Reupert, 2014). The International Society for the Study of Self-Injury (ISSS) defines NSSI as “the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (ISSS, n.d.). According to Kerr, Muehlenkamp, and Turner (2010), self-injurers typically are not thinking about suicide when they engage in NSSI and are, in fact, avoiding suicide by controlling their pain through self-injury.

The most common methods of self-injury in adolescents include “cutting, skin carving, burning, severe abrading/scratching and punching/hitting [and] can also include more severe behaviors, such as bone-breaking and [...] auto-amputation (Kerr et al., 2010, p. 240). According to Rosston (2014), self-injury is becoming much more frequent and young people are finding creative ways to conceal the injury, including inserting razor blades between their toes and burning themselves with erasers on less obvious parts of the body. Young people self-injure for a multitude of reasons, including to “regulate unwanted affective experiences [...] that are perceived to be intolerable, punish oneself, reduce feelings of numbness or dissociation, to generate a feeling when feeling emotionally empty, and to avert suicidal impulses or urges” (Lewis & Heath, 2015, p. 527). Self-injurious behavior is prevalent in the school environment and, as such, it is important for school professionals to understand what self-injurious behavior

is, how it can be identified, and how best to assist an adolescent if he or she is engaging in self-injurious behavior (Fernandez, 2013).

In this review, we will briefly summarize the current demographics and detection related to self-injury and describe the need for more professional training. In addition, we will provide a protocol and tools that school counselors can use during informal assessment and action planning responses to reported or suspected self-injurious behavior.

Definition and Demographics

Self-injury is categorized as an impulse disorder, much like substance abuse, shoplifting, and eating disorders (Lieberman, 2004). The impulse disorder has been given several names, including “self-mutilation, self-harm, parasuicidal behavior, self-inflicted violence, and nonsuicidal self-injury” (Hall, 2013, p.1). Self-injury exists in a wide range of injurious behaviors, including less serious, light scratching to self-injury with much higher severity and consequence, such as limb amputation (Hall, 2013). NSSI has evolved as a serious issue for adolescents and young adults and is currently considered a high-risk factor for attempted suicide (Lloyd-Richardson, Lewis, Whitlock, Rodham, & Schatten, 2015). Additionally, NSSI “is associated with a number of psychiatric issues and confers risk for varying degrees of physical injury” (Lloyd-Richardson et al., 2015, p. 1). NSSI is not listed as a distinct disorder in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, American Psychiatric Association [APA], 2013). However, the DSM-5 includes NSSI in a chapter titled “Conditions for Further Study” with proposed criteria that could qualify NSSI as an

identifiable disorder in the next published edition (DSM-5, American Psychiatric Association [APA], 2013).

According to Hamza & Willoughby (2013), “NSSI tends to have its onset in adolescence [and] recent estimates indicate that as many as 12-38% of young adults report lifetime histories of NSSI” (p. 1). Previous research suggested that more than 70% of self-injurers are females, many of whom have suffered from past victimization or abuse (Lieberman, 2004); however, more recent aggregated research has found similar incidence rates for males and females (Kerr et al., 2010). Typically, there is comorbidity between self-injury and other mental health issues (Hall, 2013). Self-injury is “associated with a host of psychological difficulties and disorders, which include, but are not limited to: mood and anxiety disorders, borderline personality disorder, substance abuse, difficulties with negative affect (e.g., anxiety, frustration), hopelessness, self-criticism, poor body image, and low self-esteem” (Lloyd-Richardson et al., 2015, p. 1). Self-injurers can also have a contagious effect among their peer groups, although there is little research regarding NSSI contagion in school settings (Lieberman, 2004).

Detecting Self-Injurious Behavior

The age of onset for those people exhibiting self-injurious behavior tends to occur during early adolescence (Favazza, 1998; Lewis & Heath, 2015; Lieberman, 2004; Ross & Heath, 2002). Young people spend much of their time during these formative years in some type of school setting (Fernandez, 2013). As such, it is important for school personnel to understand how to detect self-injurious behaviors in students. According to Lieberman (2004), school personnel must be aware of the various indicators when evaluating the possibility of self-injury among adolescents.

Lieberman (2004) asserts that adolescents who self-injure may have frequent or unexplained scars, bruises, cuts, burns (often on the arms, thighs, and abdomen) or broken bones in their fingers, hands, wrists, and toes. Adolescents who self-injure may also exhibit consistent clothing choices designed for covering up scars that might be inappropriate for the weather, environment, or situation. Another sign of self-injury in adolescents may involve secretive behavior, including spending unusual amounts of time in isolated areas or restrooms at school (Lieberman, 2004). As mentioned previously, adolescent self-injury is often related to general signs of depression and social or emotional isolation and disconnectedness. In addition, Lieberman found that young people who self-injure often refuse to be involved in activities where they might have to change their clothing, including dressing out for physical education in the school environment. Other signs include substance abuse, possession of sharp objects like razor blades and thumb tacks, indications of extreme anger, sadness, or images of physical harm in class work, evidence of self-injury in creative writing pieces, journals, or art projects, and extreme risk taking behaviors that could result in a possible injury (Lieberman, 2004).

According to Toste and Heath (2010), “one of the most significant hurdles to effective identification of NSSI in schools is a lack of awareness and knowledge about the issue [as] the majority of school personnel underestimate the prevalence of NSSI” (p. 14). Along with teachers and administrators, it is vital that school mental health professionals (school counselors, psychologists) recognize how high the rate of occurrence for NSSI is for young people and that the behavior is not attributable to a specific type of student or group of students. School counselors are in a unique position

in the school setting as they have the opportunity to develop connections with students that allow them to be seen as a trusted confidant, particularly in critical situations (Toste & Heath, 2010). Whitlock and Rodham (2013) assert that:

> A fully engaged school will:
>
> - Raise awareness about the sources of help available to young people who are engaging in NSSI
> - 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
> - Promote resilience and thriving among all youth (p. 9).

In addition, Toste and Heath suggest that professional development within schools will familiarize school staff with NSSI behavior, the function that it serves, and thereby increasing staff understanding of behavior that might otherwise be alarming or frightening.

Established Need

Adolescent self-injury appears to be increasingly more common, while research on the subject remains low (Whitlock, Powers, & Eckenrode, 2006; Whitlock & Rodham, 2013). Also, there is mounting concern surrounding adolescent internet use and access to other individuals who self-injure (Whitlock et al., 2006). According to Fernandez (2013), studies have found that online forums provide social support for isolated adolescents but also encourage and normalize self-injurious behavior. Fernandez asserts that “there is concern that internet sites may promote lethal behaviors and cause adolescents to further engage in [self-injurious behavior] or elicit the behavior in adolescents who are trying to explore their identities” (p. 21).

Toste and Heath (2010) explain that while self-injurious behavior is common, there are no evidence-based prevention programs for NSSI, making its prevalence all the more serious. Additionally, it remains unclear if schools across the nation have proper protocols in place for documenting, reporting, and responding to self-injurious behavior. Consequently, it is becoming increasingly apparent that there is a need for more research on the subject, training opportunities for professionals working with adolescents, and formalized protocols for schools to follow once students who self-injure have been identified. Following a school-approved protocol helps to insure that students receive appropriate care and support.

Protocol

Once a concern has been expressed to a school faculty member, an assessment and action plan should be implemented to ensure the safety and well-being of the student. The following elements may be included in the design of school protocol for working with NSSI students. A school counselor “should meet with the student for a primary assessment that focuses on determining immediate risk, as well as intervention planning and/or referral” (Toste & Heath, 2010, p. 14).

Based upon the research of Lewis & Heath (2015) and Toste and Heath (2010), we provide an outline for a checklist of behaviors and factors that may assist school counselors as they provide an initial and informal assessment summary of NSSI behaviors (Table1). While Table 1 is not a formal or comprehensive assessment, it may provide counselors with a means to assess levels of concern or risk.

Table 1

Nonsuicidal Self-Injury Risk/Concern Summary

	Low risk/concern	Medium risk/concern	High risk/concern
Risk/concern factors			
Frequency	☐ <2 lifetime incidents	☐ 2-10 lifetime incidents	☐ >10 lifetime incidents
Forms of injury	☐ 1 form of self-injury	☐ 2 forms of self-injury	☐ 3 or more
Tissue damage	☐ Superficial	☐ Light to moderate	☐ Severe
Type of injury	☐ Scratching	☐ Punching or banging self or objects	☐ Cutting, carving, burning on the body
	☐ Pinching	☐ Self-bruising	☐ Ingesting caustic substances
	☐ Preventing wounds from healing	☐ Sticking objects into skin	☐ Breaking bones
Other risk factors	☐ No history of abuse or trauma	☐ History of moderate abuse or trauma	☐ History of or current experience of severe, chronic abuse or trauma
	☐ Identifies appropriate alternative coping strategies	☐ Identifies limited and/or ineffective coping strategies	☐ Unable to identify alternative coping strategies and/or identifies inappropriate or dangerous coping strategies
	☐ Pain is minimal/manageable	☐ Pain is increasing	☐ Pain is overwhelming
	☐ No history of risky or dangerous behaviors	☐ History of risky or dangerous behaviors	☐ Currently engaging in risky or dangerous behaviors
	☐ No reported substance use or addictive behaviors	☐ History or substance use or addictive behaviors	☐ Currently using or abusing substances and/or addictive behaviors
Mental health	☐ History of mental disorder, but currently considered healthy	☐ Diagnosed with mental disorder, but currently receiving treatment	☐ Diagnosed with mental disorder and not currently receiving treatment
Depression	☐ Mild, feels sad with a somewhat depressed mood	☐ Moderate, some moodiness, sadness, irritability, lonely, and decrease in energy	☐ Overwhelmed with sadness, hopelessness, and feelings of helplessness
Stress	☐ No significant stress	☐ Moderate reaction to loss and/or environmental changes	☐ Severe reaction to loss and/or environmental changes
Resources	☐ Support is available; student acknowledges that significant others are concerned and supportive	☐ Family and friends are available, but are not perceived by the student to be supportive	☐ Family and friends are not available and/or are hostile, injurious, exhausted
Total number of checked boxes in each column			

School counselors can use Table 1 to check observed or reported behaviors in a low, medium, or high risk/concern column. Identifying the frequency, forms, and types of injuries creates a frame of reference and context for the overall set of NSSI behaviors. Other risk, mental health, depression, stress, and resource factors provide additional factors useful in understanding overall risk/concern. Counselors provide a check for each factor in an appropriate column on the form. Once checks have been assigned for each factor, each column is summed and a numerical value is indicated in the last row.

An overall level of risk or concern may be evident as a result of completing the assessment. In such a case, it may become clear how to document and plan actions going forward. In other cases, counselors may find that two adjacent columns are similar in magnitude, which may lead a counselor to conclude that the level of risk or concern is low-medium or medium-high. The assessment is meant to help guide a school counselor's actions with the student and their parents. While the assessment may not be unequivocal, it helps to create framework of understanding for the variety of NSSI and related behaviors.

Once a risk/concern assessment has been completed, counselors can compile information that documents student contact, the assessment, actions, and safety plan (see Appendix). Confidential documentation should be utilized during this assessment that includes the date, the student's name, the school he or she attends, his or her grade, date of birth, gender, and who completed the form. Additionally, the form should include how the student was referred to counseling (e.g., self-referred, friend or other student, parent, or staff member, etc.) and also the level of risk/concern for the behavior (low, medium, or high).

Toste and Heath (2010) promote the need to conduct an informal risk assessment and explain that “it is important to acknowledge that there is no simple formula for differentiating whether a youth is high or low risk” (p. 15). School counselors must make an effort to assess and refer when necessary. It must be clearly noted that if a student appears to be at an increased risk for suicide, further severe self-injury, or if the student appears to exhibit symptoms that are comorbid with other significant mental health concerns, the level or risk for the student increases. In such cases, students would be assessed for suicide risk, parents would be contacted, and referrals would be provided.

While there is no consensus in the NSSI literature regarding a formalized assessment for determining low, medium, and high risk or concern, an informal assessment tool may be useful to school counselors as they work with NSSI students. If a student is considered low to medium risk/concern, the counselor “may elect to continue with a more complete assessment and intervention planning, if circumstances permit” (Toste & Heath, 2010, p. 15). The school counselor should provide alternate coping mechanisms that can be used to replace NSSI behaviors in situations of distress. The school counselor may also develop a student safety plan that coordinates with the student, school, and family members. The safety plan identifies positive strategies and coping mechanisms, a school-based programs, supportive individuals at school, emergency resources (if outside school hours), and participation in a community-based program. Some school districts may have policies regarding parent notification as it relates to counseling students who exhibit NSSI behaviors. When school districts do not have specific parent notification policies in place, school

counselors should contact a parent or guardian and notify them of their conversation with the student. Students who are considered low risk can typically return to class following the assessment, planning, and a parent phone call.

If a student is considered high risk, a parent or guardian should be notified and "an immediate referral should be made to the appropriate emergency mental health services through community or hospital resources" (Toste & Heath, 2010, p. 15). A student safety plan should be filled out by the school counselor in coordination with the student and his or her parent or guardian to be kept in the student's file. It is critical that school counselors provide supervision for the student until they are released as well as document who the student is released to outside the school setting, the time of release, where the student is going, and who is transporting the student. School counselors must give parents appropriate referrals for community-based assistance, discuss the value of a home safety plan with parents, and notify the student's outside counselor or other family members if applicable. The information gathered during this time should be recorded thoroughly and included in the student's permanent file.

Research suggests that "even though there are a number of notable differences between NSSI and suicide, all youth that present with NSSI should be assessed for suicide risk" (Lewis & Heath, 2015). If a school counselor finds that a student's NSSI behaviors include suicidal ideation, a re-evaluation of the student must be conducted adhering to district protocols for suicide assessment. In the event that student behaviors escalate to include suicidal ideation and/or attempts, then a re-evaluation of the student as a suicidal risk must be undertaken and this would no longer be considered NSSI.

School Staff Response and Training

According to Toste and Heath (2010), “initial response to disclosure [of NSSI] will play a critical role in an adolescent’s future help-seeking behavior” (p. 14). It is essential that school personnel respond with compassion when interacting with an adolescent who may be engaging in self-injurious behavior. School personnel can “approach the student in a calm and caring way, accept the [student] even though they might not accept their behavior, let the student know they care, understand that this is a way of coping [for the student], use the student’s language for NSSI, show respectful willingness to listen, show non-judgmental compassion for their experience, and let them have choices in relation to the self-injurious behavior” (p. 14). In addition, Toste and Heath warn that school personnel should not “overreact, respond with panic or shock, try to stop the behavior with ultimatums, show interest in the actual behavior, permit the student to relive the experience, talk about it in front of the class or peers, and tell the student that [they] will not tell anyone” (p. 14). Establishing a caring and supportive alliance will be invaluable as school counselors and other caring professionals attempt to help students create more adaptive coping strategies.

According to Berger, Hasking, and Reupert (2014), “although […] teachers and school staff respond to students who self-injure, most [report] being ill-equipped and lack the training to effectively and confidently address self-injury in the schools (p. 33). As such, it is important that school staff be engaged in professional development programs or training that will “foster early detection and intervention of self-injury in schools, and will improve the confidence and well-being of school staff as they continue to support the mental health and welfare of students who self-injure” (Berger et al.,

2014, p.33). School counselors and other school personnel should implement specific, board-approved protocols that are intended for use with a student who is engaging in self-injurious behavior (Fernandez, 2013).

Conclusion

Adolescence is a time of maturation and growth; it is also the time when young people develop and hone coping skills to effectively address the stress they experience. Nonsuicidal self-injury is a coping mechanism that is becoming much more frequent in the adolescent population and one that requires more research and attention. School counselors are in a unique position to help students struggling with maladaptive NSSI behavior. School counselors, teachers, and administrators have the opportunity to advocate for students who may be engaging in self-injurious behavior, promote the safety and well-being of students, and work to establish proper training and protocols that can be used in relation to adolescents who self-injure.

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Appendix

Nonsuicidal Self-Injury Documentation

CONFIDENTIAL

Student:

School: Date:

Grade: Female Male Date of birth:

Completed by:

Referral source (check all that apply)?

- ☐ Student self-referred
- ☐ Student was accompanied by friend or other student
- ☐ Parent
- ☐ School Staff
- ☐ Other :

Actions

Assessed level of risk/concern: low medium high

(If medium or high level of risk/concern is present, then additional staff consultation is recommended)

- ☐ School counselor contact with student
- ☐ Returned to class (low risk only)
- ☐ Student was supervised until released
- ☐ Student Released To: Parent/Guardian ER/Hospital Other:
- ☐ Parents notified Time:
  - ✓ Spoke to:
- ☐ Referrals given to parent
- ☐ Discussion of home safety/supervision (access to weapons, drugs, Rx's, etc.)
- ☐ Outpatient counselor/physician notified (if applicable)
- ☐ Other students' families contacted (if applicable)
- ☐ Other
- ☐ Enter in student files

Safety Plan and Supportive Measures

A safety plan was established with: student school family

- ☐ Positive strategies and coping mechanisms:
  1.
  2.
  3.
- ☐ Participate in school-based program:
  1.
  2.
  3.
- ☐ Identified supportive resources at school:
  - ✓ Support person:
  1.
  2.
  3.
- ☐ Emergency resources/supports (if after school hours):
  1.
  2.
  3.
- ☐ Participation in community-based services:
  - ✓ Name and phone number of counselor:
- ☐ Release of information signed? Yes No

Other comments or concerns:

Note. Keep original in a confidential centralized location within your building. Send copy marked confidential to student assistance coordinator.

Biographical Statements

Mark D. Nelson is a professor and program leader for the school counseling program at Montana State University, Bozeman. His teaching and research interests include school counseling programs, guidance curriculum, student well-being, adventure counseling, and student development (academic, career, and personal/social development). Correspondence regarding this article may be sent to Dr. Mark D. Nelson, 121 Herrick Hall, Montana State University, Bozeman, MT. mark@montana.edu

Rian Piccin is a school counselor at Gannett Peak Elementary School in Lander, Wyoming. She is a 2016 graduate of Montana State University. Her research interests include trauma in children and adolescents and, most recently, play therapy.