

Non-Suicidal Self-Injury (NSSI): What School Counselors Need to Know to

Support their Students

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Abstract

Non-suicidal self-injury (NSSI) is defined as intentional self-inflicted damage to the surface of the body without suicidal intent. Research shows that approximately 15% of adolescents engage in NSSI behaviors, necessitating school counselors with the knowledge and skills to respond systemically and systematically. Five functions of NSSI have been identified, including: (a) affect regulation (anxiety, anger, frustration, depression); (b) change cognitions (distraction from problems, stopping suicidal thoughts); (c) self-punishment; (d) stop dissociation; and (e) interpersonal (secure care and attention, fit in with peers) (Peterson et al., 2008). As educational leaders and mental health professionals, school counselors are in a unique position to educate school personnel, accept referrals, provide responsive services, and provide referrals to address non-suicidal self-injury of students (American School Counselor Association, 2017). This article will describe how school counselors can respond to NSSI, briefly reviewing recent literature in training and education, NSSI protocols, and interventions used in school settings.

Keywords: non-suicidal self-injury, NSSI, self-harm, self-injury

Non-Suicidal Self-Injury (NSSI): What School Counselors Need to Know to Support their Students

Non-suicidal self-injury (NSSI) is an intentional act with the objective to do harm to the body without leading to a result of death. Non-suicidal self-injury is commonly reported as a means to regulate and manage distressing thoughts and emotions. As NSSI behaviors are increasing among students, school counselors are in a unique position to provide early identification, intervention, prevention, and advocacy (Kress et al., 2004).

Definition, Signs, and Symptoms

Non-suicidal self-injury is defined in the DSM-5 (2017) as intentional self-inflicted damage to the surface of the body with no suicidal intent. NSSI is deliberate and intentional, not accidental. Non-suicidal self-injury is commonly reported as a means to obtain relief from a negative feeling or cognitive state, to resolve an interpersonal difficulty, or to induce a positive feeling state. Non-suicidal self-injury may include cutting, burning, stabbing, hitting, or excessive rubbing behaviors which are likely to induce bleeding, bruising, or pain without suicidal intent (DSM-5, 2017). Tattooing, piercing, and religious or cultural rituals are not considered NSSI.

Most students who engage in NSSI tend to cut or burn themselves in areas of their body that may easily be covered up (ie: on their arms, legs, abdomen, or bottoms of their feet). These students may wear pants, long-sleeved shirts, and coats to cover up scars. Students may hide their injuries due to shame and embarrassment or deliberately display scars, cuts, or burn marks to make their emotional pain visible in an effort to seek attention or support (Selekman, 2009). Signs of NSSI include: fresh

wounds; clustered and patterned scars; unseasonal dress; refusal to engage in activities that require less coverage; interpersonal difficulties; and negative thoughts or feelings, such as depression, anxiety, tension, anger, and self-criticism (DSM-5, 2017).

When youth engage in NSSI, their bodies secrete endorphins into the bloodstream to protect them from pain. These endorphins temporarily numb their feelings of emotional distress. Youth who engage in NSSI report feelings of loss of control and compulsion to engage in NSSI as well as increased physical tolerance of pain. They also experience withdrawal symptoms of anxiety and irritability when they abstain from NSSI. Non-suicidal self-injury has become one of the most popular pain killing and sedative drugs for youth today (Selekman, 2009).

A common misconception about non-suicidal self-injury is that it is a suicide attempt, especially if it involves cutting on the arm, near the wrist. Suicide and NSSI are distinct behaviors and not all students who self-injure are suicidal (Walsh & Muehlenkamp, 2013). However, NSSI is a risk factor of suicide as it desensitizes a person to self harm, contrary to the basic human instinct of survival. Students who self-injure require continuous suicide risk assessment, safety planning, and mental health treatment.

Demographics

According to the DSM-5 (2017), non-suicidal self-injury often begins in the early teen years and may continue for many years. The average age of onset is around 12-years-old, though reported in children as young as 7 years of age “with 7.6% of third graders reporting self-harm engagement” (Bem et al., 2017, p. 2). The prevalence of NSSI in adolescents varies depending on source, with a general average of about 15%

and a lifetime prevalence estimated between 20% and 46% (Bem et al., 2017). The DSM-5 (2017) notes that male and female rates of NSSI are closer to each other than in suicidal behavior disorder, in which female-to-male ratio is about 3:1 or 4:1. There are similarities in the demographics for NSSI and suicidality in the sense that they only include people who have disclosed and/or have received treatment. It is safe to suggest that these numbers capture the low-end of how many children and adolescents are engaging in self-injurious behaviors. This makes NSSI a concern for school counselors at every grade level.

Cultural Considerations

School counselors have an ethical obligation to protect students from unforeseeable harm. Further, school counselors have an obligation to deliver a comprehensive school counseling program to all students from diverse populations (ASCA, 2016). This makes it imperative to consider diversity when responding to NSSI as it impacts prevention, assessment, and treatment. To do so, school counselors should assess population characteristics, determine best practices relevant to populations, and gain knowledge on available resources. Diversity considerations when responding to NSSI including racial and ethnic makeup, gender identity and sexual orientation, religion, socioeconomic status, geographic area, and family makeup. Below, we will briefly discuss diversity considerations based on recent literature.

Racial/Ethnic Makeup. The majority of research on NSSI is conducted with Caucasian-majority samples in Western countries such as the US, Canada, Australia, and European countries. Additionally, prevalence rates among ethnic/racial minority

adolescents conducted in Western countries have been inconsistent (Gholamrezaei et al., 2015).

Gender Identity/Orientation. Previous research has found that NSSI is more prevalent amongst adolescent females (Miner et al., 2016). Additionally, females may also be more likely to seek help than males (Berger et al., 2017). Sexual orientation and sexual minority adolescents are found to be at statistically significant higher risk for NSSI (Batejan et al., 2014).

Socioeconomic Status. Several studies report that NSSI appears to be equally prevalent among all SES, however recent research outside of the US shows otherwise. For example, low SES was associated with NSSI in a sample of high school and college students in China (Wan et al., 2011), but in a Hong Kong study no relationship between family economic status and NSSI was found (Shek & Yu, 2012).

Family Makeup. There is limited research on how to approach an adolescent's self-harm within a family context. According to Miner et al. (2016), NSSI focuses primarily on the behavior of the individual but does not include the family as potential cause or in treatment. However, recent research found that families have anxiety around how to respond and manage NSSI (Garisch et al., 2017) and need guidance about removing access to means and asking regularly about NSSI behaviors. By providing psychoeducation of NSSI, families can avoid emotional reactions including not setting boundaries around behavior for fear of triggering the adolescent.

Given that the research in NSSI with diverse populations is inconsistent and minimal, school counselors should consider characteristics of the person and

environment, unique aspects of the population, risk factors and protective factors, and overlapping cultural influences and identities.

Legal and Ethical Considerations

School counselors are ethically obligated to keep student-reported information confidential, unless a student poses a serious and foreseeable risk of harm to self or others (ASCA, 2016). In the case of NSSI, the serious and foreseeable risk of harm is to the student, even if the danger appears relatively remote, parents/guardians must be notified. In addition to the duty to warn parents or guardians of the student's behavior, NSSI is also considered a limit to confidentiality in necessitating a report to Child Protective Services. This often comes as a surprise to mandatory reporters, such as school counselors, but since the behavior poses a serious and foreseeable risk of harm to self, it must be reported within 24 hours of disclosure. It is also at this time that the school counselor will determine who and what they disclose to the school team, which may include administration, the school resource officer, the nurse, and other school staff as appropriate. There are no hard and fast rules that determine the people and the information to share, but the school counselor must always serve as an advocate for the student's privacy and the parent's/guardian's wishes for their child (ASCA, 2016).

While considering the legal and ethical implications of limits of confidentiality, duty to warn, and mandatory reporting, school counselors also have an ethical responsibility to assess whether they have knowledge and skills to provide interventions for a student engaging in NSSI (ASCA, 2016). Practicing within one's professional competence suggests that school counselors may need to seek professional development around NSSI if either they completed a preparation program that did not

address responding to students engaging in NSSI, or if they need additional training as their students' and school's needs require. At any rate, it is always important for school counselors to know when to refer a student to a qualified mental health professional, when the response is either outside of their practice competency and/or if the student requires more intensive treatment in addition to school-based interventions and support.

Functions of NSSI Behaviors

While previously considered to be a morbid form of self-help, five functions of NSSI have been identified, including: (a) affect regulation (anxiety, anger, frustration, depression); (b) change cognitions (distraction from problems, stopping suicidal thoughts); (c) self punishment; (d) stop dissociation; and (e) interpersonal (secure care and attention, fit in with peers) (Peterson et al., 2008). The identification and understanding of these functions is imperative in considering how to respond to student disclosure of NSSI behaviors. While a student's safety is the primary goal of any response, intervention must match the function of the behavior, whether self-harming or otherwise, engaging the student in meeting the same need in a more appropriate, desirable way.

Role of School Counselors in Response and Intervention

School counselors, newly graduated or seasoned, often report lack of knowledge and resources in working with students engaging in non-suicidal self-injury. Considering that an estimated 15% of adolescents engage in NSSI behaviors, there is a clear discrepancy between students requiring prevention and intervention and school counselors prepared to prevent and intervene. A review of the research on practices of working with children and adolescents who engage in NSSI in the school setting

suggest three key themes: training and education, importance of having a protocol in place, and interventions used in school settings.

Training and Education

School counselors are educational leaders and mental health professionals who address non-suicidal self-injury by educating the school community, accepting referrals, providing responsive services, and making referrals for treatment. Roberts et al. (2019) suggests that school counselors must gain more training and knowledge regarding effective interventions that are appropriate to use with adolescents in the school setting. Additionally, school counselors must educate school staff to recognize the signs and symptoms of NSSI and how to respond in a constructive and sensitive manner to youth who self-injure. Nelson and Piccin (2016) emphasize the need for school staff to respond with the interpersonal skills of compassion, empathy, acceptance, and trust rather than more common responses driven by fear and uncertainty.

Training and education should extend beyond staff professional development to include mental health literacy and peer response skills for students, as well as psychoeducation and support for families. By improving families' understanding, NSSI behaviors may be de-mystified and de-stigmatized while decreasing familial conflict and expanding communication skills. Collaboration with family is even more valuable during safety planning and skill development (Peterson et al., 2008).

Importance of Identified Protocol

School counselors should collaborate with administrators to develop a comprehensive school protocol to address NSSI (Bubrick et al., 2010), however there is limited research on whether schools have proper protocols in place to work with

students who exhibit signs of NSSI (Nelson & Piccin, 2016). Research-informed recommendations for managing NSSI in schools, including guidelines for (a) identifying students at elevated risk of self-injury, (b) developing a protocol for school personnel's initial response to student self-injury, (c) first-level assessment of NSSI, and (d) managing critical issues related to NSSI contagion and online activity (De Riggi et al., 2017).

In assessing the immediate behavior, school counselors must complete a self-injury risk assessment to determine the severity of the self-injury. Regardless of the severity, school counselors should always conduct a suicide risk assessment with students who self-injure (Lloyd-Richardson, 2010). Often there are suicide elements within self-injury risk assessments and frequently the assessment tools are synonymous. Although screening for suicide risk is imperative, school counselors should also caution against assuming the student is suicidal (Brown & Kimball, 2013). The intentions of the formal assessments are to document behaviors and other relevant information, evaluate for severity and level of risk, and to guide the school team through appropriate protocols and development of a safety plan and subsequent interventions.

In addition to formal assessment tools, school protocols should also include parent notification and report to Child Protective Services. School counselors are ethically obligated to keep student-reported information confidential unless a student poses a serious and foreseeable risk of harm to self or others (ASCA, 2016). NSSI behaviors clearly pose a serious and foreseeable risk of harm to self for the student, therefore, school counselors have an ethical responsibility to notify parents or

guardians. The parent/guardian notification process is an important step in engaging family in the intervention and safety planning processes.

Interventions in School Settings

School counselors provide early identification, prevention, and advocacy and must be prepared to accurately assess the student's needs, provide responsive services, and make referrals to outside services for treatment (Kress et al., 2004). Additionally, the school counselor will work with the student, and often parents, to develop a written personalized safety plan to share with parents/guardians, appropriate staff members, administration, and mental health professionals (Stargell, et al., 2017). The safety plan may include positive strategies and coping mechanisms in the form of interventions and school-based programming, identified support people at school, emergency resources, referrals to outside providers, and a follow up plan to include continuous monitoring and communication (Nelson & Piccin, 2016). School counselors must establish regular communication and contact with the student, parent/guardian, school staff, and mental health professionals to continuously monitor the student's self-injury and potential suicide risk and provide ongoing support through mental health interventions within the school setting (ASCA, 2016). These interventions may include individual and group counseling to empower students to identify their strengths, build resilience skills, regulate emotions, and manage stress (Selekman, 2009).

Since research has shown that NSSI behaviors have the capacity of serving various functions, it is imperative for the school team to conduct a functional behavior analysis to identify specific antecedents (situations/stressors triggering self-harm), behavior characteristics (frequency, intention, duration), and consequences (i.e the

function of the behavior) (Peterson et al., 2008). This analysis will inform appropriate interventions for the student to minimize antecedents, monitor behaviors, and provide more desirable ways for the student to achieve similar consequences.

Conclusion

Professional school counselors play a crucial role in responding to students engaging in non-suicidal self-injury. Efforts in identification, response, and referral are imperative in keeping students safe. By understanding the signs and symptoms, multicultural considerations, and interventions appropriate for the school setting, school counselors can prepare to effectively meet student needs.

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Biographical Statements

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