

SELF-INJURY IN OUR SCHOOLS: WHAT WE NEED TO KNOW

Nancy Heath, Ph.D.

Educational and Counselling Psychology
McGill University

February 2007

SELF-INJURY IN OUR SCHOOLS: WHAT WE NEED TO KNOW

Session Objectives

To answer the following questions:

How common is SI?
Who engages in SI?
Why do students SI?

How do I identify a student who SI?
What to do and not do with students who SI?
What are my legal responsibilities?
How does a school handle this behaviour?
- school protocols

What are the treatment guidelines for schools?

Overview

- I. Introduction
 - SI defined
- II. SI Essentials / General Information
 - Background information
 - How common is SI?
 - Who engages in SI?
 - Why do students SI?
- III. Practice Recommendations
 - How do I identify a student who SI?
 - What to do and not do with students who SI?
 - What are my legal responsibilities?
 - What does a school do to handle this behaviour? (protocol)
 - Treatment guidelines in schools
- IV. Concluding Discussion

I. Introduction

Self-injury (SI) defined: Self-injury is involves the deliberate destruction or alteration of body tissue that is non-suicidal not for display and not socially sanctioned. Self-injurious acts include skin cutting (which is most common), skin burning, self-hitting, pinching, scratching, biting, and hair pulling (Gratz, 2003; Ross & Heath, 2002).

SI and not-SI



II. SI Essentials

◆ Background Information:

- Historically understood as being largely or exclusively associated with Borderline Personality Disorder or Intellectual Disability (e.g., Dulit et al., 1994; Griffin et al., 1985)
- In the late 1980s Favazza (1987, 1988) explored the full range of this behaviour and suggested it was not limited to psychiatric populations
- In the 1990s it was noted that SI was increasing in hospital settings AND in the community (Conterio & Lader, 1998; Favazza, 1998; Pipher, 1994)

II. SI Essentials

How common is SI?

- ◆ In regular high schools it has reliably been found that between 14-20% of all students admit to having self-injured at least once (Ross & Heath, 2002; Laye-Gindhu & Schonert-Reichl, 2005; Nixon et al., 2006; Zoroglu, 2002)
- ◆ Reliably approx. 10% of first year university students at McGill admit to engaging in SI (Heath et al., 2005, 2006).

How common is SI?

- ◆ Currently, in adolescence SI peaks and then decreases into adulthood, when by about age 25 fewer and fewer individuals are engaging in SI. Although some continue.
- ◆ However, there is a lot of information suggesting that this behaviour is increasing. Thus students in high school now are far more likely to engage in SI than 20 years ago, or even five years ago.
- ◆ The reason for this is unclear although media attention and the awareness of this behaviour is thought to contribute to the increase.

How did they start?

- ◆ *First thought of the idea of self-injury:*
 - Knew someone else who self-injured (33.9%)
 - Books/ Movies (17.9%)
 - Internet (7.1%)
 - Health Class (10.7%)
 - Didn't know (21.4%)
 - Someone else said that it was effective (1.8%)
 - Escapism (1.8%)
 - Frustration (3.6%)
 - Talking about self-injury (1.8%)

II. SI Essentials

Who engages in SI?

- ◆ SI is beginning earlier and earlier, students in **elementary schools** are engaging in SI.
- ◆ **Females and males** engage in SI but different forms BUT males do not seek help (Best, 2004; Laye-Gindhu & Schonert-Reichl, 2005; Ross & Heath, 2002)
- ◆ In clinical samples it has been found that those who SI were far more likely to have childhood **sexual abuse or trauma**, this is not as clear in school samples.
- ◆ Adolescents in the schools who SI may or MAY NOT have a poor family history/**attachment**! Although they have difficulty "connecting"
- ◆ Those youth struggling with their **sexuality** are more at risk.
- ◆ Individuals who cannot deal with their **emotions**!

II. SI Essentials

Why do students SI?

Maladaptive coping:

4 categories

- ◆ To stop or start an internal thought/feeling (autonomic)
 - e.g., stop anxiety, tension; start feeling relaxation
- ◆ To stop or start a social consequence (social)
 - e.g., stop parent nagging; start getting help

Statements by individuals' who SI

- ◆ As soon as I cut, it was like all the anger was let out and I felt so much better.
- ◆ After cutting arms or legs, all the tension leaves my body and I can go to sleep.
- ◆ People who self-injure are human beings. We aren't abnormal, we aren't freaks, we don't corrupt people and try to turn them to self-injury. We just have a different way of handling things because we've never learned another way.
- ◆ I hurt myself to cope with the overwhelming stress and frustration I feel because of my inability to express myself outwardly in an effective manner. I am afraid that if I let the pain out, I will hurt others. For now, this is the only way I can cope with this feeling. If there is one thing you can do to help me, it would be to understand this, to listen when I do try to express myself, and to gently encourage me to express my feelings in a healthy manner so that one day I will no longer rely on self-injury to cope with my feelings.
- ◆ Self-injury is NOT a suicide attempt. It is a way of making emotional pain into something physical that you can see and control. To show my pain.
- ◆ That it is not attention seeking behavior and how shameful it feels. Most of the people I am aware of who self-injure hide their behavior and are afraid to talk about it. There are even some who are afraid to seek medical care because of the shame involved.

III. Practice Recommendations

◆ How do I identify a student who SI?

- Students will frequently “tell” on another student.
- 66% tell a friend, 43% a romantic partner, less than 30% tell doctor, psychologist, counsellor or teacher
- Students will sometimes write something about someone who SI.
- You may see the cuts on the arm or leg.

III. Practice Recommendations

How to identify SI

◆ When is it SI and when is it a suicide attempt?

- Individuals who cut to attempt suicide do not feel better after the cutting.
- Certain methods suggest suicide attempt: Firearm, suffocation (hanging), poisoning (overdose, carbon monoxide), fall/jump, drowning
- In adolescents only .4% of suicides occur due to cutting and 99.9% of those .4% are from cutting the neck
- So cutting arm and legs RARELY means suicide.

III. Practice Recommendations

What to do and not to do with students who SI

- ◆ **Do not** minimize or say it is “for attention” or “it’s a fad”. SI is a sign of a serious difficulty in coping.
- ◆ **Do not** permit discussion of exactly what they do.
- ◆ **Do not** *assume* that it is an indication of childhood abuse or psychiatric illness.
- ◆ **Do not** allow a non-monitored or uncontrolled class/school discussion of SI; SI is contagious. EX. The Globe and Mail
- ◆ **Do** be very calm and matter of fact when a student is telling you about it.
- ◆ **Do** have discussions in private
- ◆ **Do** limit any material or discussion to understanding that it suggests an inability to cope and a need to seek help.
- ◆ **Do** refer to the designated mental health professional in your school (guidance or social worker or psychologist).

III. Practice Recommendations

What are my legal responsibilities?

1. Ultimately this is a mental health issue and needs to be referred... but how fast?
2. When the SI first becomes apparent you should try to determine the degree of distress (suicide risk?). Talk to them, does the SI help reduce tension? Have they thought of killing themselves? Do they have a plan/ is it feasible? (Suicide risk assessment essential)
3. Usually with SI you will NOT find a suicide risk, in which case you can refer at leisure with the student’s knowledge if not consent.
4. If suicide risk is present then you cannot refer at leisure but immediate. In the event that your mental health professional is not on site you must personally ensure through another designated person or yourself that this student is evaluated by a mental health professional- if need be you take them to emergency.
5. Is it your responsibility to contact parents concerning non-suicidal SI? Unclear at this time. Discuss within your board.

III. Practice Recommendations

What should my school do to handle SI?

◆ School protocol

Sample School Protocol for Self-Injury (SI)

Heath Research Team, McGill University 2006
www.education.mcgill.ca/heathresearchteam

1. Schools should have a “designated” mental health person for SI and suicidal issues for referral. There MUST be a back up if the designated person cannot always be reached. Designated person might be counsellor, psychologist, social worker, nurse, or even VP or Principal if they have had some training.

2. All staff should have minimal information about SI so that reactions are consistent, appropriate and conform to protocol. (Availability of professional development workshops as needed).

3. Teachers who learn of a student’s SI will :

a. Speak to the student to assess level of distress and possible suicide risk IF teachers agree

OR

b. If teacher is unable/ unwilling to do so s/he will ensure that student is immediately seen by the designated person for a level of distress evaluation

Sample School Protocol for Self-Injury (SI)

Heath Research Team, McGill University 2006
www.education.mcgill.ca/heathresearchteam

4.If designated person finds the student is experiencing severe distress and clearly is thinking of suicide and has a feasible plan, then procedure will be followed for suicide risk. (Parents contacted; referral to mental health professional for fuller evaluation; if urgent, then emergency room crisis evaluation). If the distress evaluator was a teacher, designated person is immediately involved and repeats the evaluation.

5.If distress evaluator finds student is engaging in SI as a maladaptive coping strategy and is not currently suicidal they will ensure that the student is seen by the designated person within a week or two.

6.The designated mental health person will do a fuller evaluation and determine if longer term therapy is required and make the decision to contact the parent as needed (not all adolescents who SI must have parents contacted).

Sample School Protocol for Self-Injury (SI)

Heath Research Team, McGill University 2006
www.education.mcgill.ca/heathresearchteam

7.If the mental health person feels that the student requires long term therapy and parents are contacted, but do NOT follow through, the school mental health person will insist as non-compliance in obtaining needed therapeutic intervention can constitute neglect (DYP).

8.Feedback to the initial teacher will be conducted within the constraints of confidentiality (designated person cannot reveal any details of what occurs subsequently with the student, only that it has been dealt with).

OTHER SCHOOL ISSUES FOR PROTOCOL

- ◆ Schools need to have a policy about communication concerning self-injurious behaviour.
- ◆ SI cannot be discussed in detail in school newspapers or other student venues (plays etc). Similarly, curriculum materials should not do this. Explain if this is questioned, that this can "trigger" individuals to SI.
- ◆ Those who SI should be discouraged from revealing their scars because of issues of contagion. This should be discussed and explained and enforced.
- ◆ In general, designated person should be clear with the student that although the fact of SI 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.

School Protocols

- ◆ Teacher and administration training and preparation is needed for protocols to work.
- ◆ It requires an agreement between administration, counselors, and teachers as to what will happen in the case of a self-injuring student. Everyone must reach a level of comfort around procedures and questions of liability

Treatment Guidelines : Initial responses

- ◆ Do:
 - Avoid the use of suicide terminology
 - Use your client's language for self-injury
 - Show a low-key *dispassionate demeanor*, an interest in understanding and *non-judgmental compassion* for their experience
- ◆ Don't:
 - Respond with revulsion, shock, aversive gaze, or fear
 - Try to stop the behavior through threats or "contracts"
 - Show excessive concern or support for the behaviour

Treatment Guidelines for Schools: The Evidence

Muehlenkamp (2006):

- ◆ Empirically supported treatments and therapy guidelines for NSSI.
- ◆ PST: Problem-Solving Therapy; CBT: Cognitive Behavioural Therapy; DBT: Dialectical Behaviour Therapy.

Common elements that work?

What works?

- A. Functional Behaviour Analysis of the SI (triggers, Reinforcers) to determine skill deficit
- B. Behavioural Interventions
 - ◆ Alter the Reinforcers and highlight negative consequences
 - ◆ Skill based: Teach the specific skill e.g. emotion regulation, mindfulness, self-soothing, distress tolerance; interpersonal communication; problem solving; coping strategies
- C. Cognitive restructuring around the perception of the self and emotions (distress tolerance)
- D. Alliance: supportive and collaborative therapeutic alliance

IV. Concluding Discussion

- ◆ Self-injury in adolescents is increasing.
- ◆ Frequently no adult knows - it is secretive.
- ◆ BUT they are in need of help to learn more adaptive coping skills.
- ◆ Understanding and help can make a huge difference, we need to be more open to this increasing behaviour.
- ◆ Current knowledge is constantly changing as it is such a new field.

Self-Injury Myth & Reality Check

1. Self-injurious behaviours are often used as a form of coping by adolescents.
2. We should talk openly about self-injurious behaviour in our schools so that we can open the lines of communication with students.
3. Usually self-injury is an early sign of underlying mental illness.
4. Almost all adolescents who self-injure are female.
5. A self-injury support group would be very effective in our high schools.

Self-Injury Myth & Reality Check

6. Most adolescents who self-injure are suicidal on some level.
7. Almost all adolescents who self-injure have an eating disorder as well.
8. Adolescents who SI are trying to get attention.
9. It is often the case that adolescents who cut their arm frequently are really working themselves up to suicide.
10. Adolescents who self-injure usually have a history of sexual abuse.
11. SI amongst high school students occurs mostly within certain "groups" (i.e. Goths).

What do you think most people need to know about SI?

Rachael: Well, I suppose any book that would portray an intelligent background into self-injury would help take away the "stigma" that people often feel towards any issue that they do not fully understand. To be more specific, I guess I have often wished in the material that I have read that they had gone more into detail in to the productive lives that many self-injurers lead; to make it clear that many self-injurers have very productive lives and yet have coping skills such as self-injury to make it through the day.



Resources/Websites

- Heath Research Team: <http://www.education.mcgill.ca/heathresearchteam>
- The S.A.F.E. program : <http://selfinjury.com/index.html>
- Self-injury and related issues: <http://www.siari.co.uk>
- Young people and self-harm: <http://www.selfharm.org.uk>
- Individuals who Self Harm work to support others who are trying to cope: <http://www.selfinjury.org>

QUESTIONS?

