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Non-Suicidal Self-Injury

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CERTIFICATE OF APPROVAL

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Abstract

Thirteen to forty percent of middle and high school students engage in non-suicidal self-injury (NSSI) behaviors. Of the adolescents who engage in NSSI, most use the maladaptive coping skill to regulate overwhelming negative emotions or feelings. Due to the amount of time adolescents spend in schools, school staff are usually the first adults to potentially identify signs of NSSI in students. However, most school staff do not notice signs, symptoms, or causes of NSSI and do not feel comfortable addressing students who engage in NSSI because they lack knowledge and understanding. Schools should provide training for all staff and students in order to better serve the student population, allowing students with mental health concerns to receive interventions and the treatment they need.

Contents

Introduction

When life gets tough, all individuals in the world have ways of coping with their stress or other difficulties that are presented to them (Gratz & Chapman, 2009). Sometimes healthy coping strategies are used including talking with friends, going to therapy, practicing mindfullness, or practicing breathing exercises. Other times maladaptive coping strategies, like drinking, using drugs, or engaging in non-suicidal self-injury (NSSI), are used to relieve the stress or pain an individual feels (Gratz & Chapman, 2009). While it is perplexing to many (Selekman, 2010; Toste & Heath, 2010), NSSI is just as addicting as drugs and alcohol (Gratz & Chapman, 2009). For some, they try it and it takes the pain away, making it hard to break the habit (Gratz & Chapman, 2009).

Studies show a range of 13-40% of middle and high school students engage in NSSI (Toste & Heath, 2010; Klonsky & Muehlenkamp, 2007; Ballard, Bosk, & Pao, 2010; Klonsky, Glenn, Styer, Olino, & Washburn, 2015; Noble, Sornberger, Toste, Heath, & Mclouth, 2011; Klonsky, 2007; Dickstein, Puzia, Cushman, Weissman, Wegbreit, Kim, Nock, & Spirito, 2015); while approximately 4% of adults engage in this unhealthy coping behavior (Selby, Gordon, Joiner, Bender, & Nock, 2012). NSSI is a common maladaptive coping skill for individuals ranging in age from 15-35, with the behavior becoming less common after the age of 35 (Gratz & Chapman, 2009). In 2005, 25% percent of individuals between the ages of 7-24 were treated in emergency rooms for the most common form of NSSI, which is cutting, (Dickstein et al., 2015). Individuals engaging in NSSI, report an age of onset anywhere from 12 to 14 years, which falls around the time of being in middle or high school (Noble et al., 2001; Lloyd-Richardson, 2010). Of the adolescents who use NSSI to cope, 80% of them are not involved in formal mental health treatment (Trepal, Wester, & Merchant, 2015). Most of the time, individuals engaging in NSSI will talk to their friends about using this coping skill, but the

ability to seek help for healthier ways to cope with stress is not something adolescents usually do (Muehlenkamp, Walsh, & McDade, 2010; Berger, Hasking, & Martin, 2013).

Since the rate of using NSSI is higher during adolescent years and these individuals spend most of their day in school, there is a need for all school staff to understand the behavior of NSSI so students have access to help, appropriate interventions and treatment (Trepal et al., 2015; Muehlenkamp et al., 2010). Unfortunately, many staff members are uncomfortable talking to students when they recognize cuts or other forms of NSSI on their bodies (Toste & Heath, 2010). Staff members may also be confused by the behavior or may sometimes react in a negative way towards students who are seeking help. This turns students away from the help provided in schools (Toste & Heath, 2010).

Taking time to teach all school staff members about mental health, including NSSI behaviors, will increase knowledge so staff members can learn appropriate ways to respond to students who may be struggling with their mental health (Toste & Heath, 2010; Selekman, 2010; Berger et al., 2013). Schools may also invest in prevention programs, which are developed to increase knowledge of staff and students, provide skills for reacting and referring students who are engaging in NSSI and teach healthy coping skills (Muehlenkamp & Walsh, 2010). School staff need knowledge, a common understanding, and a plan in place in order for students to access the help that is available to them daily (Toste & Heath, 2010).

Review of Literature

What is NSSI?

Researchers will find variations within definitions of NSSI and the terminology that goes with it. Most definitions describe NSSI as intentionally damaging or harming one's body tissue in a specific moment without intentions of suicide. (Noble et. al., 2011; Toste & Heath, 2010;

Gratz & Chapman 2009; Klonsky et al., 2015; Lloyd-Richardson, Lewis, Whitlock, Rodham, & Schatten, 2015; Lloyd-Richardson, 2010; Klonsky, 2007; Klonsky & Muehlenkamp, 2007). The definition is followed by more specific examples of harming body tissue like: cutting, burning, scratching, biting, self-tattooing, picking at skin, hitting oneself to see bruising, or inserting objects under the skin (Gratz & Chapman, 2009; Noble et al., 2011; Ballard et al., 2010; Lloyd-Richardson, 2010). The most common method of NSSI is cutting of the skin; with approximately 70% of individuals who report using NSSI use this method (Klonsky & Muehlenkamp, 2007; Ballard et al., 2010). Individuals engaging in NSSI most commonly harm their body tissue on their arms, hands, wrists, thighs, and stomachs (Klonsky & Muehlenkamp, 2007). There could be other parts of the body that are used for NSSI but those listed previously are the most common (Klonsky & Muehlenkamp, 2007). Definitions also make it clear to exclude other types of body modification like tattooing and piercings from any NSSI descriptions mostly because these behaviors are socially acceptable (Noble et al., 2011). Other words or phrases used to describe NSSI include: self-injury, self-injurious behavior, self-mutilation, and deliberate self-harm (Lloyd-Richardson, 2010; Klonsky, 2007).

Individuals engaging in NSSI often report difficulties with emotion regulation and coping with overwhelming negative feelings (Noble et al., 2011; Ballard et al., 2010; Klonsky & Muehlenkamp, 2007). In some cases, individuals may report not feeling anything (Noble et al., 2011). When individuals report feeling nothing or feeling numb they may use NSSI to help them feel something, even if it is pain (Noble et al., 2011).

Coping techniques are used to get through difficult situations or work through negative emotions. Individuals use NSSI as a coping technique to deal with intense negative feelings (Noble et al., 2011). Sometimes NSSI is used to cope with numb or empty feelings or daunting

events that cause emotions to overpower thoughts (Hollander, 2008). Instead of managing feelings with healthy coping techniques, individuals who use NSSI have insufficient skills to regulate their feelings, and instead use this maladaptive coping technique to resume back to a normal emotional state. Individuals who cannot regulate their negative emotions will explain feeling "out of control" and NSSI helps them regain these unmanageable feelings (Hollander, 2008, p.8). While in the moment of negative emotions, feelings of frustration or sadness are reported to be common (Ballard et al., 2010). Individuals using NSSI to regulate these emotions, report feeling a release from their pain, relaxed, or sometimes a separation from their feelings (Ballard et al., 2010).

Some individuals may be willing to consider using NSSI to help regulate or cope with their negative emotions due to social contagion (Gratz &Chapman, 2009). Social contagion is said to cause the spread of NSSI because once individuals see their friends, family, or popular individuals in the media use NSSI to cope, others are more likely to try it as well (Gratz & Chapman, 2009). When individuals see or hear of others they know using NSSI to cope the maladaptive skill may seem like a possible option for stopping the negative emotions (Gratz & Chapman, 2009).

History of NSSI. In the 1980's NSSI was added to the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) as a symptom of borderline personality disorder (BPD) (Lloyd-Richardson, 2010; Klonksky, 2007). Thirty years later, NSSI was still connected to BPD in *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV-R) (Klonsky, 2007). Klonsky and Muehlenkamp (2007) state that pairing NSSI to BPD makes sense because negative emotions and the inability to regulate emotions are common in both diagnoses. In *The Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V-R) NSSI

is now a separate diagnosis as long as information is collected on the individual engaging in NSSI before the diagnosis is given (Lloyd-Richardson et al., 2015). The first step in considering a diagnosis is to figure out if the individual engaged in NSSI behaviors on five or more days within the last year. The diagnosis also requires knowing the function of NSSI looking for reasons why the individual is using NSSI (Lloyd-Richardson et al., 2015).

The DSM-V-R acknowledges that NSSI is not only diagnosable with BPD, but could also occur in an individual experiencing depressive or anxiety disorders, substance abuse, eating disorders, and conduct or oppositional disorders (Lloyd-Richardson, 2010; Selby et al., 2012; Klonsky & Muehlenkamp, 2007). Some of these disorders can start from negative emotions or the inability to regulate emotions (Klonsky & Muehlenkamp, 2007). Sometimes, NSSI is found in connection with depression, eating disorders, and anxiety; but it is important to note that individuals using NSSI to cope do not always show signs of mental health concerns or have any psychiatric disorders (Noble et al., 2011; Lloyd-Richardson, 2010). However, these individuals frequently report problems regulating emotions and coping with negative feelings (Noble et al., 2011).

Functions of NSSI. Ninety percent of individuals who engage in NSSI describe doing it to ease deep negative emotions (Klonsky et al 2015; Noble et al., 2011). This function or reason of the behavior is called affect regulation (Klonsky et al 2015). Self-punishment is another function of NSSI with approximately 50% of individuals explaining this is why they engage in NSSI (Klonsky et al 2015; Noble et al., 2011; Lloyd-Richardson, 2010). Another function, which is reported less by individuals engaging in NSSI, is anti-dissociation. Individuals who report anti-dissociation as a function of NSSI are producing pain to stop feeling numb (Klonsky et al

2015). Others report functions of NSSI like anti-suicide to stop suicidal thoughts, peer-bonding to fit in with their friends, and sensation seeking to create excitement (Klonsky et al 2015).

In most cases, there are several functions for one individual engaging in NSSI (Lloyd-Richardson, 2010; Klonsky et al., 2015). Klonsky et al. (2015) describe the functions of NSSI as overlapping each other. In their example, an individual may be using NSSI to control affect regulation, reducing negative feelings, which may also help lower suicidal thoughts and bring out the function of anti-dissociation to help an individual feel something (Klonsky et al., 2015).

NSSI in Adolescents

Research shows that approximately 13-40% of adolescents report using NSSI to cope with negative emotions, with the most prevalent age group of users being around the ages of 12-14 (Toste & Heath, 2010; Klonsky & Muehlenkamp, 2007; Ballard et al., 2010; Klonsky et al., 2015; Noble et al., 2011; Klonsky, 2007; Dickstein et al., 2015; Gratz & Chapman, 2009; Lloyd-Richardson, 2010). “Adolescence is defined as the period of physical and psychological development from the onset of puberty to maturity and is characterized by intense emotions and impulsive and risky behaviors that can lead to serious harm to oneself and others” (Ballard et al., 2010, p. 329). Due to the developmental changes in the body and brain, adolescents are vulnerable to their emotions and the emotions of others, which can lead to distorted decision making (Ballard et al., 2010). Around the age of thirteen or fourteen, adolescents begin to develop deep emotions which is also around the same time when most individuals report using NSSI to cope for the first time (Gratz & Chapman, 2009).

During adolescence, some individuals discover the skills previously used to manage their emotions may not work anymore or that the emotions are more intense than in the past (Gratz & Chapman, 2009). Gratz & Chapman (2009) share that adolescents become more willing to try

new ways of coping when their old methods fail. In some cases, these desperate individuals may try NSSI in order to relieve their deep negative emotions (Gratz & Chapman, 2009). Adolescents engaging in NSSI are completing the act without thinking about it, while free from drugs or alcohol and share that they feel "little to no pain" when they are using NSSI (Lloyd-Richardson, 2010).

NSSI in Schools

Due to the high percentage of adolescents using NSSI to cope with their negative emotions and the amount of time they spend in school, it is important for schools to understand the behavior of NSSI so students are supported (Noble et al., 2011). Berger, Hasking, and Martin (2013) also suggest schools are an ideal place for students to be identified and receive interventions for NSSI behaviors. However, professionals in schools have reported a lack of confidence and knowledge about NSSI, therefore, they have difficulty identifying students engaging in the behavior (Noble et al., 2011; Lloyd-Richardson, 2010; Berger et al., 2013). A lack of training for staff members in schools is common for any area of mental health, especially in identifying NSSI or explaining how the school is providing prevention and treatment (Lloyd-Richardson, 2010). School staff may also have a hard time identifying their own biases, which can lead to negative feedback when addressing a student using NSSI to cope (Toste & Heath, 2010). When students receive negative feedback from school staff about their coping behavior, they do not feel supported (Toste & Heath, 2010). This may be the reason why adolescents share more with their friends than anyone else (Berger et al., 2013).

Berger et al. (2013) state adolescents seek more help from their friends than adults. This is believed to be true because adolescents do not feel adults understand them when they share they are engaging in NSSI (Berger et al., 2013; Muehlenkamp et al., 2010). The support given

from friends is usually more accepting, showing the reason why it is used more frequently (Muehlenkamp et al., 2010). What is unknown is how peers actually feel towards their friend's engagement in NSSI and if peers have the skills to help their friends get help if it is needed (Muehlenkamp et al., 2010). If school staff cannot identify and do not feel comfortable addressing students engaging in NSSI and some peer groups do not feel comfortable helping their friends get support, no support is given to the students who need it the most. This shows the importance of schools using prevention programs to addresses the needs of school staff, parents, and students (Toste & Heath, 2010; Muehlenkamp et al., 2010).

Training for school staff. Berger et al. (2013) review adolescents' thoughts on helping prevent NSSI. Adolescents are looking for "non-judgmental parents and teachers to talk to and education for parents and teachers" so they can understand the behavior (Berger et al., 2013 p. 936). Staff development opportunities can help create a common understanding of the behavior of NSSI (Toste & Heath, 2010). Staff and students should be trained on common causes, signs, and symptoms of NSSI (Selekman, 2010). Along with knowing what NSSI is, it is important for school staff to know what is not considered NSSI, like tattoos or piercings (Bubrick, Goodman, & Whitlock, 2010). Staff and students also need to understand myths of NSSI including the difference between self-harming behavior and suicidal behavior or that NSSI is not specific to certain groups of people (Selekman, 2010; Bubrick et al., 2010). It is important for all school staff and students to learn ways to appropriately respond to a student whom they are concerned about or who is reaching out for help (Selekman, 2010). Staff and students need to be aware of the systems in place within the school like protocols for referring a student to a school counselor and prevention programs that are taught to all students (Toste & Heath, 2010; Muehlenkamp et al., 2010).

Myths of NSSI. Common myths of NSSI include: NSSI is the same as a suicide attempt, it is not dangerous, it is manipulative or done for attention, only "goths" or "emos" do it, if you use NSSI you have BPD, it is a female problem, or NSSI is crazy, sick and irrational (Gratz & Chapman, 2009; Hollander, 2008; Bubrick et al., 2010). The three most common myths are linking NSSI to a suicide attempts, believing the behavior is manipulative, and believing NSSI is only a problem with females (Gratz & Chapman, 2009). It is important for school staff and students to understand these myths so they learn more about the behavior of NSSI (Lloyd-Richardson, 2010).

Typically when someone hears an individual is engaging in NSSI, they automatically believe the individual is trying to commit suicide (Gratz & Chapman, 2009). When an individual has signs of suicidal ideation they want to end their lives, which is different with an individual engaging in NSSI (Beer, 2013). It is more common that an individual uses NSSI to cope with or change negative feelings or a negative experience, not that they want to end their life (Beer, 2013; Lloyd-Richardson, 2010). Suicidal behaviors and NSSI can be confused because they can look similar (Gratz & Chapman, 2009). For example, sometimes people commit suicide by cutting their wrists and cutting is the most common form of NSSI. When they look similar it is hard to differentiate between the two (Gratz & Chapman, 2009).

Individuals who engage in NSSI usually do it to work through negative emotions, but sometimes it is assumed that they are doing it to control others (Gratz & Chapman, 2009). If school staff believe NSSI is done to manipulate others or to get attention, they are going to turn students away from getting help (Gratz & Chapman, 2009). Hollander (2008) states the number of adolescents who use NSSI for attention or manipulation is less than four percent. Before making assumptions on the reasoning behind using NSSI, it is important to use respectful

conversations with students to learn their thoughts and reasoning behind using this technique to cope (Gratz & Chapman, 2009.)

In the past, research has shown higher rates of NSSI in females than males, but current research shows an occurrence of NSSI to be similar in both genders (Lloyd-Richardson, 2010). Gratz & Chapman (2009) state that males are engaging in NSSI just as much as females. Both groups are using NSSI as a maladaptive coping skill to overcome negative feelings and emotions. It is believed that this myth started due to the stigma around getting help for mental health concerns. Since it is believed that females engage in NSSI more than males, males may think they are alone. This causes males to try to cope with their negative emotions themselves keeping their behavior of NSSI to themselves (Gratz & Chapman, 2009).

Warning signs. It is important for school staff gain more knowledge about NSSI, including how to identify signs of it (Toste & Heath, 2010). Some warning signs might include observing physical evidence of unexplained bruises, scars, fresh cuts, or burns. Other signs school staff can look for include students who wear long sleeves or bulky clothing when not appropriate with the weather (i.e. long sleeves on a 90 degree day), do not want to participate in activities where their skin would be exposed (i.e. swimming, changing for physical education), include descriptions of NSSI or emotional stress in a art project, journal, or essay, the use of many wristbands/bracelets to cover wrists/forearms, the student has razor blades or other paraphernalia with them, or amplified sense of depression or anxiety (Toste & Heath, 2010; Bubrick et al., 2010). Sometimes a student may openly reveal to a teacher about his/her use of NSSI or a friend may also come to a staff member in the school to report concern for a friend (Bubrick et al., 2010).

Ways to respond. All staff should feel comfortable to respectfully and appropriately respond to students who are reaching out for help or who a teacher may be concerned about (Bubrick et al., 2010). Bubrick et al., (2010) reference the term "respectful curiosity" as a skill school staff should be able to use to appropriately ask students questions but leave room for open communication if a student does not want to respond to the teacher (p.2). Frequently, students who are asked about marks on their arms and are in fact engaging in NSSI will make up stories that seem realistic to hide that they are using this maladaptive coping skill (Bubrick et al., 2010). It is important to for school staff to remember not to push the student to try again with their answer, but leave room for the student to come and talk to them if they ever need to share anything (Budrick et al., 2010).

School protocol for NSSI. Once school staff have a better understanding of NSSI, they will be able to better identify and report a student who may be engaging in NSSI (Toste & Heath, 2010). In order for teachers to know where they should report a student of concern, the school should have a protocol in place to help with the process (Toste & Heath, 2010; Beer, 2013; Bubrick et al., 2010). Most schools have a protocol in place for addressing students who express suicide ideation, but they usually do not have a protocol for students engaging in NSSI (Beer, 2013). Having a protocol in place for NSSI behaviors ensures the use of education for staff, students, and families, referrals, and a safe place for students (Beer, 2013). School protocols also provide a process for school counselors or other trained staff to follow specific interventions and treatment for students seeking help with NSSI (Toste & Heath, 2010).

Protocols from school to school will look different, but all should include a process for reporting NSSI and whom the report should be made to (Toste & Heath, 2010). The roles of each team member should be defined so that all staff knows who handles each task within the team.

Important people to have on this team would be an administrator, school counselor, school nurse, and school social worker. The protocol should also include who will assess students of concern, the process for referring a student to outside mental health services, and when to notify parents (Toste & Heath, 2010).

School-wide prevention programs. Wide ranges of interventions are known to reduce NSSI behaviors in adolescents like communication skill building, behavior interventions, and cognitive therapy (Noble et al., 2011). Other interventions that could be used on a larger scale are school-wide prevention programs, which provide schools the opportunity to reach all staff and students. Using school-wide prevention programs may be helpful in reaching all students so all can build coping skills (Noble et al, 2011). Unfortunately, evidence-based school wide prevention programs for NSSI are lacking and of the two known programs (Signs of Self-Injury and S.A.F.E. Alternatives) little research exists on their effectiveness (Toste & Heath, 2010).

Toste and Heath (2010) suggest creating system wide awareness among school staff along with prevention programs that include support and training for adolescents. These programs should focus on emotion regulation and stress management. They also mention mindfulness, distress tolerance, and developing emotional intelligence are effect ways to teach students engaging in NSSI healthy was to cope with challenging emotions (Toste & Heath, 2010).

The first school-wide prevention program mentioned by Toste and Heath (2010) is the Signs of Self-Injury (SOSI) program. Screening for Mental Health Inc. created this program to target NSSI, using one of their existing, successful programs (Signs of Suicide) (Muehlenkamp et al., 2010). One main goal of SOSI is to increase knowledge of NSSI behaviors so warning signs and symptoms can be detected. The program was also designed to increase the ability of

school staff or peers to refer students who engage in NSSI and decrease NSSI behaviors among adolescents (Muehlenkamp et al., 2010).

The program has a module for school staff members and a separate one for students (Muehlenkamp et al., 2010). Five schools out of twenty-one who were contacted agreed to participate in the pilot study of the SOSI program. A total of 274 students took part in the SOSI program. About half of them were female students and the average age of the students was 16.07. The pre/post tests were split into four subscales: knowledge, NSSI thoughts and behaviors, attitudes, and help seeking. There was also a component where qualitative data was collected through phone interviews to get perspectives from the school counselor or psychologist who taught the program. ANOVAs were used to evaluate the subscales of knowledge, attitudes, and help seeking. These statistical measures found small changes from pre to post tests; however, improvements were made showing students increased the amount of accurate knowledge they had about NSSI along with students feeling less uneasiness of peers engaging in NSSI. These results indicted that students had increased their abilities to be able to help a friend(s) who engage in NSSI. Unfortunately, the results did not report significant findings in the area of help seeking behaviors like a self-report. School counselors and psychologists who taught the program felt that it was easy to use but may be best used with freshmen and sophomores. The authors of this article encourage the use of NSSI prevention programs so staff and students are educated, aware, and have skills to successfully help students who are in need (Muehlenkamp et al., 2010).

The second program mentioned by Toste & Heath (2010), is S.A.F.E. Alternatives. The idea behind this company started in the 1980's after the founder, Karen Conterio, read a newspaper advertisement about a Chicago hospital that provided treatment for individuals

engaging in self-mutilation (Conterio, 2012). The name S.A.F.E. Alternatives stands for Self Abuse Finally Ends. At first Conterio (2012) worked with her group within a hospital setting, but soon created a program for the large amount of adolescents being referred for NSSI. Conterio (2012) and her team, now have several programs that address the groundwork for starting to recover from NSSI for adolescents and adults. Their S.A.F.E. Alternatives Program is located in St. Louis, Missouri but hopes to be in all states so all individuals wanting to overcome NSSI have the resources to do so (Conterio).

The S.A.F.E. Alternatives program recognizes that in most cases school staff are usually the first to encounter an individual who is struggling to cope with negative feelings and using NSSI (S.A.F.E. Alternatives, 2012). To help with this awareness, S.A.F.E. Alternatives (2012) created *Self-Injury: A Manual for School Professionals*. Schools can order this product, which includes a manual for school professionals and five student workbooks for $125.00. The manual covers information on identifying NSSI behaviors and reasons why adolescents may use this maladaptive coping skill. It also covers appropriate ways to address students who are seeking help, assess students for NSSI and suicide, how to talk with parents, how to refer students for appropriate treatment outside of school, and how to help them transition back into school after a hospitalization. The manual covers intervention techniques and tools schools can use to help support individuals engaging in NSSI (S.A.F.E. Alternatives). Other than what is provided on S.A.F.E. Alternatives website, published research on the effectiveness of the program cannot be found.

Discussion

The number of adolescents engaging in NSSI behaviors is alarming. It is also startling to read that students are not reaching out to trained school professionals, like school counselors, to

seek help. It is easy to understand that students feel more comfortable discussing their deep, dark feelings with their friends, but it is disheartening to hear the friends also keep these feelings secret. The cycle of not getting help keeps going around and around, where adolescents continue maladaptive practices of getting help.

School administration or other school professionals need to realize the importance of creating safe environments where students feel comfortable coming forward for help. School staff need to request formal training in mental health, specifically NSSI so they are better equipped with skills and strategies of helping identify students who may be struggling with NSSI.

In the future, a common language should be created, making it easier to access research on NSSI. It is common to find many different terms for NSSI, meaning the definitions may also vary. This makes it difficult to find research on interventions, school-wide programs, and other important research around the topic of NSSI. Another key piece for the future of NSSI is creating school-wide programs that have been researched to show effectiveness in schools. Of the articles that have discussed NSSI, authors share that programs and interventions are starting to form, but research needs to be conducted to determine effectiveness.

School counselors need to remember the importance of continuing to research NSSI and other mental health concerns for effective research-based interventions that can be used within the schools. Many resources emphasized how important it is to have school-wide knowledge about NSSI so staff and students are more aware. Having knowledge develops a system of support for individuals in need, which is the first step to successfully creating a warm school climate to address concerns of NSSI.

Author's Note

I have been a teacher for eight years and every year the need for mental health training for the school staff has increased. Through observations within my school, I noticed confusion from teachers who saw cuts on a student's arm. Confusion and sometimes frustration as to how to talk to the student or where to report what they had seen. Most times, my colleagues would share the information with our school counselor, which is the best option for sharing this kind of information. Even after sharing the information, most teachers were appalled and confused as to why a student would do this.

Through all of this, it became clear to me that all staff in schools must be trained on how to talk to students who are in need of mental health treatment. They should also be trained to develop a level of understanding, to begin to think about the negative feelings the student must be trying to handle. There should also be a framework, which shows the process of handling the concerns for students so that all staff and students know what to expect. The research shows small changes like having staff be able to talk to students with some level of knowledge can make the world of a difference to a student. I'm excited to take these ideas to my future school counseling job and train school staff and students on NSSI.

References

Ballard, E., Bosk, A., & Pao, M. (2010). Invited commentary: Understanding brain mechanisms of pain processing in adolescents' non-suicidal self-injury. *J Youth Adolescents, 39,* 327-334.

Beer, M. (2013). Helping student's deal with self-injury. *Principal Leadership, 14*(3), 12-16.

Berger, E., Hasking, P., & Martin, G. (2013). 'Listen to them': Adolescents' views on helping young people who self-injure. *Journal of Adolescence, 36,* 935-945.

Bubrick, K., Goodman, J., & Whitlock, J. (2010). Non-suicidal self-injury in schools: Developing and implementing school protocol. [Fact sheet] Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults. Retrieved from: http://www.selfinjury.bctr.cornell.edu/documents/schools.pdf

Conterio, K. (2012). The genesis of S.A.F.E. alternatives. S.A.F.E. Alternatives. Retrieved from: http://www.selfinjury.com/history/

Dickstein, D. P., Puzia, M. E., Cushman, G. K., Weissman, A. B., Wegbreit, E., Kim, K. L., Nick, M. K., & Spirito, A. (2015). Self-injurious implicit attitudes among adolescent suicide attempters versus those engaged in nonsuicidal self-injury. *The Journal of Child Psychology and Psychiatry, 56*(10), 1127-1136.

Gratz, K. & Chapman, A. (2009). Freedom from self-harm: Overcoming self-injury with skills from DBT and other treatments. Oakland, CA: New Harbinger Publications, Inc.

Hollander, M. (2008). Helping teens who cut. New York, NY: The Guilford Press.

Klonsky, E. D. (2007). Non-suicidal self-injury: An introduction. *Journal of Clinical Psychology, 63*(11), 1039-1043.

Klonsky, E. D., Glenn, C. R., Styer, D. M., Olino, T. M., & Washburn, J. J. (2015). The functions of nonsuicidal self-injury: Converging evidence for a two-factor structure. *Child & Adolescent Psychiatry & Mental Health, 9*(44), 1-9.

Klonsky, E. D. & Meuhlenkamp, J. J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology, 63*(11), 1045-1056.

Lloyd-Richardson, E. E. (2010). Non-suicidal self-injury in adolescents. *The Prevention Researcher, 17*(1), 3-7.

Lloyd-Richardson, E. E., Lewis, S. P., Whitlock, J. L., Rodham, K., & Schatten, H. T. (2015). Research with adolescents who engage in non-suicidal self-injury: ethical considerations and challenges. *Child & Adolescent Psychiatry & Mental Health, 9*(37), 1-14.

Muehlenkamp, J. J., Walsh, B. W., & McDade, M. (2010). Preventing non-suicidal self-injury in adolescents: The signs of self-injury program. *Journal of Youth Adolescence, 39*, 306-314.

Noble, R. N., Sornberger, M. J., Toste, J. R., Heath, N. L., & Mclouth, R. (2011). Safety first: The role of trust and school safety in non-suicidal self-injury. *McGill Journal of Education, 46*(3), 423-441.

S.A.F.E. Alternatives. (2012). Schools. S.A.F.E. Alternatives. Retrieved from: http://www.selfinjury.com/schools/

Selby, E. A., Gordon, K. H., Bender, T. W., Nock, M. K., & Joiner, T. E. (2011). Non-suicidal self-injury (NSSI) disorder: A preliminary study. *Personality Disorders: Theory, Research, and Treatment, 2*, 167-175.

Selekman, M. (2010). Helping self-harming students. *Health & Learning, 67*(4), 48-53.

Toste, J. R. & Heath, N. L. (2010). School response to non-suicidal self-injury. *The Prevention Researcher*, *17*(1), 14-17.

Trepal, H. C., Wester, K. L., & Mercaht, E. (2015). A cross-sectional matched sample study of nonsuicidal self-injury among young adults: Support for interpersonal and intrapersonal factors, with implications for coping strategies. *Child & Adolescent Psychiatry & Mental Health*, *9*(36), 1-10.