Table 1. Myths and Facts About Self-Injury

Myth	Fact
All youth who self-injure are suicidal.	• Self-injuring youth are attempting to manage emotions; suicidal youth want to end all feelings. • Self-injurers do not typically express a desire to die. • Due to increased risk of suicide, lethality of thinking must be evaluated.
Self-decoration is self-injury.	• The purpose of self-decoration is to fit in or find acceptance with a particular cultural or peer group. • The purpose of self-injury includes the management of emotions or expression of feelings.
All youth who self-injure have been sexually or physically abused.	• Research is limited in generalizability and scope, as it typically comes from adult or clinical populations. The connection with trauma in youth is not clear. • Youth should be encouraged to tell their own histories, as perceived trauma may also play a role.
All youth who self-injure have borderline personality disorder (BPD).	• This diagnosis should be discussed with great caution in school-age populations as it requires a pervasive pattern of behavior. • The relationship between BPD and self-injury is likely exaggerated because self-injury is one of the BPD diagnostic criteria. • Self-injury exists separate from BPD.
All youth who self-injure need to be hospitalized.	• Barring life-threatening injuries, accompanying suicidal intent/behavior, or another serious, comorbid disorder, a student is more likely to benefit from remaining in his or her normal routine with access to support for healthy coping skills.

Sources: American Psychiatric Association (2000); Best (2005b); Conterio et al. (1998); Gratz & Chapman (2007); Heath & Beettam (2005); Heath et al. (2005); McVey-Noble et al. (2006); Muehlenkamp (2005); Nock & Prinstein (2004); Purington & Whitlock (2004); Wester & Trepal (2005); Whitlock & Knox (2007); Whitlock, Powers, et al.(2006); Yates (2004).

Kanan, L., Finger, J. & Plog, A. (2008, Winter). Self-injury and youth: Best practices for school intervention. *School Psychology Forum: Research in Practice, 2(2), 67-79*.

Table 2. Responding to Self-Injury: Best Practice Recommendations for Schools

1. Provide awareness and knowledge to school personnel.	• Physical signs • Emotional signs • Obligation to report behavior to parents • Understanding self-injury as a coping attempt
2. Educate students about the need to report.	• Large awareness campaigns are not recommended • Educate students to report *all* dangerous behavior and early warning signs
3. Use a team approach to responding to students.	• Collaborate with school nurse when needed • Consultation is encouraged
4. Provide appropriate school support for students.	• Listen and acknowledge feelings • Individualized support is recommended
5. Screen for comorbid disorders and suicidal ideation.	• Determine indicators of comorbid disorders • Behavior should be differentiated from suicidal behavior unless screening indicates otherwise
6. Notify and provide resources to parents.	• Gather additional relevant history • Document contact • Refer to knowledgeable community therapists
7. Develop short-term plans for safety.	• Identify possible triggers and physical cues • Identify alternative behaviors to try to interrupt cycle of self-injury • Identify at least one supportive adult at school if impulse to self-injure returns • Plans should not require a promise to "no-harm" until replacement behaviors are in place • Introduce healthy coping techniques, stress management, anger management skills
8. Collaborate with community support.	• Communicate with treatment providers • Reinforce treatment goals and techniques in the school environment
9. Control the contagion effect, as needed.	• Identify the leader of peer group engaging in self-injury • Identify interventions for that student • Set limits on behavior at school when needed

Sources: Alderman (1997); Conterio et al. (1998); Heath & Beettam (2005); Heath, et al. (2005); Kanan & Finger (2006); Lieberman (2004); Nock & Prinstein (2005); Onacki (2005); Purington & Whitlock (2004); Simeon & Favazza (2001); Walsh (2006); White Kreiss et al. (2004); Whitlock & Knox (2007); Whitlock, Powers, et al. (2006).

Kanan, L., Finger, J. & Plog, A. (2008, Winter). Self-injury and youth: Best practices for school intervention. *School Psychology Forum: Research in Practice, 2(2), 67-79*.

Linda M. Kanan, Ph.D.
Ohio School Psychologists Association
November 9, 2017

Responding to Teens at School – Non-Suicidal Self-Injury

1. Address any medical needs, insure physical safety
2. Screen for suicidal ideation and/or assess for other co-morbidity
    - Plan, preparation, access to means, past attempts, other significant history
    - Be direct with questioning about topics involving danger to self or others
3. Use a team approach and/or consultation with colleagues
4. Develop short-term plans for safety
5. Notify and collaborate with parents; help link them with appropriate resources and community support
    - Reactions may vary depending upon the severity of behavior
6. Control for the contagion effect - be proactive
    - Assess factors that may contribute
    - Direct modeling influence or competition with others
    - Disinhibition
    - Peer or group hierarchies or desire for group cohesiveness
    - Pseudo-contagion episodes

Do:

- Acknowledge the behavior as something you are familiar with
- Forge and alliance with the teen
- Listen and acknowledge feelings
- Take the child's concerns seriously
- Respond without being directive or judgmental
- Create a safe and caring place for student to talk, cry, or rant without criticism about feelings
- Provide hope
- Help them to see consequences of behavior/choices
- Help to think through choices
- Help to tolerate/accept feelings
- Help to separate anger from violence
- Utilize what the person has access to
- Try to understand the meaning and them help to communicate more directly

Don't:

- React with horror or discomfort to the disclosure
- Ask abrupt and rapid questions
- Threaten or get angry
- Engage in power struggles & demand that they just stop
- Accuse them of attention-seeking
- Get frustrated if behavior continues after treatment has begun
- Ignore other warning signs
- Engage in power struggles

- Try to rescue the student
- Focus on the showing of scars
- Use cathartic methods
- Use substitute behaviors
- Use hypnotherapy for memory recovery
- Minimize the behavior

Developing Short Term Plans for Safety

1. Short term plan serves to help ***stabilize*** student until community support can begin
2. Do not over-emphasize expectation that student is not to self-injure or stop behavior
3. Help students to identify the ***triggers*** for the behavior and possible ***physical cues***
4. Help them to understand the ***function of the behavior***
5. Encourage student to talk to someone and use an identified strategy from their toolbox before injuring (give help line phone numbers)
6. Remove objects when appropriate