

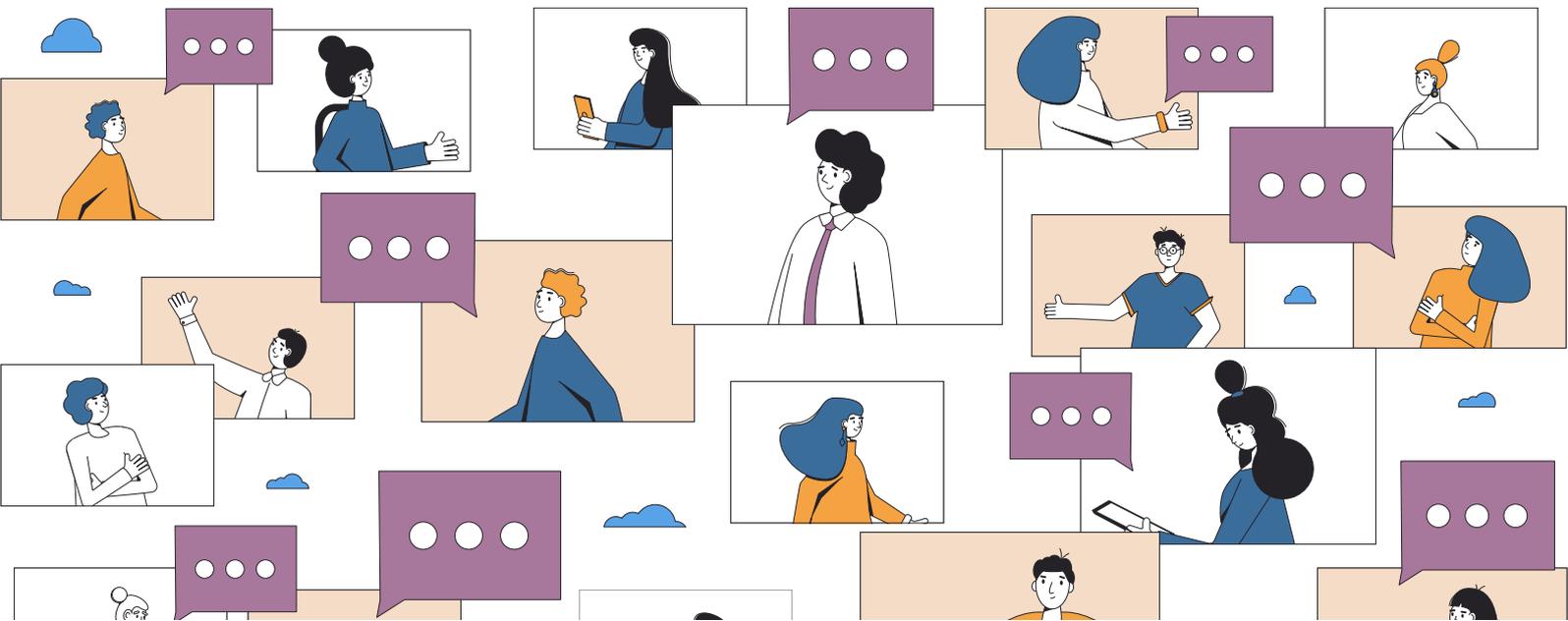


ISSS

International Society for the Study of Self-Injury

17th Annual Conference

Abstract Book



Contents

Extended Abstracts	4
A Comparison of Retrospectively Reported and EMA-Reported Perceived Social Support in Predicting EMA-Reported NSSI	5
Facilitating Post-Trauma Growth in Clients who Self-Injure.....	7
Bisexual-Specific Minority Stress, Perceived Burdensomeness, and Identity Visibility: Models of Risk and Resilience.....	10
Physiological Threat System Differences in Depressed Adolescents with and Without Non-Suicidal Self-Injury	12
Lifetime “Outness” of Self-Injurious Thoughts and Behaviors in Relation to Specific Disclosure Events Reported During Ecological Momentary Assessment.....	14
Non-Suicidal Self-Injury Persistence Patterns, Risk Factors, And Clinical Outcomes During the College Period	16
Trauma-Informed Supervision of NSSI.....	18
Nonsuicidal Self-Injury Amongst Sexual And Gender Minorities: The Role Of Psychological Distress	20
Social Media Use as A Trigger Factor For NSSI: A Study Protocol For An Ecological Momentary Assessment	22
“I Can’t Escape My Scars, Even If I Do Get Better”: A Discourse Analysis Of Adolescent Talk About Their Self-Injury Scars During Therapy.....	24
Suicidality As an Indicator Of DBT-A Treatment Response.....	26
Symposia	28
Empirical Investigations Aimed at Defining and Conceptualizing NSSI as it Relates to NSSI Disorder Diagnostic Criteria.....	29
How Should we Define NSSI? Experiences From the Perspective of Those with Lived Experience	29
Days Versus Acts: Implications for NSSI Assessment.....	29
Operationalizing the Medical Severity of NSSI Behavior	29
Exploring Co-Occurrence of Substance Use & NSSI	29
Online Ethnography and Computational Methods: An Interdisciplinary Approach to NSSI Practices on Social Media.....	30
Communities of Practice as a Performative & Communicative Engagement in NSSI	30
Understanding Online NSSI Communities of Practice through Technology-Assisted Ethnography	30
“Spicy Beans” & “Barcodes”: Understanding the Language Practices of NSSI on Social Media...	30
Network Analysis Methodology for Describing Communities & Connections on Social Media...	30
Oral Presentations	31
Attitudes & Beliefs About NSSI	32
Hungarian School Psychologists’ Knowledge & Attitudes on NSSI: An Explorative Study.....	32
"What do you think about self-injurious behavior?" A Study to Assess Attitudes Towards NSSI	32

The Self-Injury Stigma Questionnaire	32
NSSI & Emotion	32
NSSI: A Systematic Review & Bayesian Meta-Analysis	32
Emotion Regulation in Young Adults with Recent, Distal, or No History of NSSI	32
Amplified Emotional Responding in NSSI? A Systematic Review of Two Decades of Investigation	32
PTSD & Trauma	32
Childhood Abuse & NSSI in Adolescents: The Role of Emotional Dysregulation & Trauma Symptoms	32
Posttraumatic Stress Symptoms and NSSI Engagement Among First Year University Students..	33
Experiential Avoidance, PTSD, & NSSI: A Moderation Analysis in a National Veteran Sample	33
Social Connection & Social Media.....	33
Peer Relationship Closeness and Concordant & Discordant NSSI Dyads.....	33
Social Support and the Impact of COVID-19 on University Students with a History of NSSI.....	33
NSSI and Social Media.....	33
Examining A Linguistic Marker of Emotion Regulation in Online Help-Seeking Communities.....	33
Psychobiology	33
Pain Analgesia or Desensitization? A Longitudinal Lab Study on the Link Between Pain and NSSI	33
The Impact of Childhood Trauma on Plasma Endocannabinoid Levels in Female Adolescents...	34
Neurocognition in Adolescents who Engage in NSSI	34
Individual Differences	34
OFF OR ON TRACK? Positive & Negative Life Experiences Related to Continued Versus Discontinued NSSI	34
Latent Profiles & Profile Correlates of NSSI Functions Among Undergraduates with a History of NSSI	34
BPD Symptom Severity/Features Among Adolescents Engaged In Youth Protection & First-Line MH Services.....	34
NSSI & Other Behaviors	35
NSSI in Undergraduate Students: Eating Habits, Impulsivity, Negative Life Events, & Savoring..	35
Self-Criticism & NSSI, Disordered Eating, & Substance Misuse: Role of Psychological Needs Frustration.....	35
Self-Harm in Treatment Seeking Adults with Gambling Disorder: Prevalence and Clinical Correlates.....	35
Research & Clinical Practices	36
A Comparative Randomized Control Trial: Disseminating Clinical Guidelines for NSSI in Germany	36
Applying a Human Rights-Based Framework in Community-Based Adolescent Self-Harm Research.....	36
Why Do People with Lived Experience Participate in NSSI Research? A Content Analysis	36

Treatment & Help-Seeking.....	36
Efficacy of Psychotherapeutic Interventions for Adolescent NSSI: Systematic Review & Meta-Analysis	36
Help Negation & Suicidal Ideation Among Young Adults Engaging in NSSI: Associations Over Time	36
NSSI, Psychosocial Functioning, & Underutilization of Mental Health Services: A Veteran Cohort	36
Disclosure & Recovery	36
Disclosure of NSSI: Distinctions in Patterns Among Black and Non-Black Individuals.....	36
An Examination of Disclosures in a University Sample with Recent NSSI.....	37
What is Important to the Decision to Disclose NSSI?	37
Understanding the Impact of Involuntary Discoveries of NSSI: A Thematic Analysis.....	37
Views of Self in the Context of Self-Injury Recovery: A Thematic Analysis	37
LGBTQIA+	37
Exploring the Lived Experience of Young Trans People who Self-Injure	37
NSSI Onset Age is Associated with Perceived Burdensomeness & NSSI Among Sexual Minority Young Adults	37

Extended Abstracts

A Comparison of Retrospectively Reported and EMA-Reported Perceived Social Support in Predicting EMA-Reported NSSI

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Keywords: ecological momentary assessment, non-suicidal self-injury, social support

Introduction and Study Aims

Non-suicidal self-injury (NSSI) urges and behaviors are cross-sectionally and longitudinally associated with lower perceived social support, as well as related constructs such as perceived rejection (e.g., Turner et al., 2016). However, no studies have examined concordance of retrospective and ecological momentary assessment (EMA) reports of perceived social support. Traditional measures (retrospective reports) and EMA measures (reporting on an experience in the moment) are often only weakly to moderately correlated (e.g., Trull et al., 2015), and measurement may impact observed associations between variables. The current study examined the correlation between retrospectively reported (baseline/typical) perceived emotional social support and average EMA-reported perceived emotional social support, as well as whether average EMA social support improved estimation of EMA NSSI urges and behaviors above baseline social support alone.

Methods and Measures

Participants were 93 young adults (ages 18-34) with past-month NSSI urges or behaviors residing in the United States. Participants completed a baseline session and two-week EMA protocol. At baseline, past-month perceived emotional social support was assessed with the NIH Toolbox Emotional Support Scale. During EMA, single items were used to assess NSSI urges and NSSI behaviors (separately), and two items were used to assess perceived social support. Ordinal logistic regression models were used to test whether average EMA-reported social support improved estimation of overall frequencies of NSSI urges or behaviors (0, 1, or 2+ behaviors) during EMA above baseline social support alone.

Results and Discussion

Baseline-reported and average EMA-reported social support were strongly positively correlated (Kendall's tau-b = 0.511, Spearman's rho = 0.684). EMA-reported social support was significantly associated with EMA-reported NSSI urges above baseline social support alone ($B = -0.70$, $p = .002$), and model fit was improved when EMA-reported social support was added to the model above baseline social support alone ($\Delta AIC = 8.25$, $\Delta SC = 5.72$; Table 1). Sensitivity analyses showed that key results were consistent across different analytic approaches. EMA-reported social support was also significantly associated with EMA-reported NSSI behaviors above baseline social support alone ($B = -0.45$, $p = .043$), but model fit was not substantially improved by adding EMA-reported social support to the model ($\Delta AIC = 2.46$, $\Delta SC = -0.07$; Table 2). Sensitivity analyses showed that these results varied across different analytic approaches, but together suggested that average EMA-reported social support may have no or minimal incremental utility above baseline social support in estimating EMA-reported NSSI behaviors.

Results indicate that average EMA-reported social support had incremental utility in estimating NSSI urges during EMA, but did not meaningfully improve estimation of NSSI behaviors during EMA, above baseline social support alone. EMA-reported social support may provide further utility in estimation of EMA-reported NSSI urges or behaviors if modeled as a near-term (proximal) predictor of changes in NSSI urges or behaviors, which was beyond the scope of these analyses. Limitations include that baseline- and EMA-reported social support assessed social support over different timeframes, potentially confounding effects of measurement and timeframe, and examining only average levels of social support across all EMA surveys; this study did not examine temporal associations between social support and NSSI urges or behaviors over time.

Table 1. Ordinal Logistic Regression Models Predicting EMA-Reported NSSI Urges

	<i>df</i>	<i>B</i>	OR	95% Wald C.I. for OR	<i>p</i>
Model 1					
Baseline social support	1	-0.04	0.96	0.64, 1.45	.859
Model 1 AIC = 210.31, SC = 217.91					
Model 2					
Baseline social support	1	0.63	1.87	1.02, 3.43	.042
EMA social support	1	-0.70	0.49	0.32, 0.78	.002
Model 2 AIC = 202.06, SC = 212.19					

Table 2. Ordinal Logistic Regression Models Predicting EMA-Reported NSSI Behaviors

	<i>df</i>	<i>B</i>	OR	95% Wald C.I. for OR	<i>p</i>
Model 1					
Baseline social support	1	-0.31	0.74	0.48, 1.12	.155
Model 1 AIC = 201.42, SC = 209.02					
Model 2					
Baseline social support	1	0.10	1.10	0.61, 1.99	.746
EMA social support	1	-0.45	0.64	0.41, 0.99	.043
Model 2 AIC = 198.96, SC = 209.09					

Implications

Results suggest that average EMA-reported social support has differential associations with NSSI urges and NSSI behaviors among young adults, and that timeframe of assessment and/or sampling methodology of social support may impact associations between social support and NSSI urges and behaviors. Further research clarifying these associations is needed.

Acknowledgment: Funding for this study was provided by Texas Tech University.

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Facilitating Post-Trauma Growth in Clients who Self-Injure

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Introduction

Tedeschi and Calhoun (1996) coined the term post-traumatic growth (PTG) to describe the positive psychological growth/changes that some people experience through the recovery from trauma. These changes tend to occur in the domains of “New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life” (Tedeschi & Calhoun, 1996, p. 455). Considering the established link between NSSI and trauma (see de Kloet et al., 2011; Ford & Gomez, 2015; Horowitz & Stermac, 2017; Wan et al., 2015), mental health professionals (MHPs) working with clients who self-injure may consider means through which to facilitate (without imposing expectations of) PTG in clients who self-injure. PTG may provide a pathway through which clients who self-injure can make meaning out of their suffering, enhance their resilience, and support their therapeutic progress.

Discussion

Although the connection between trauma and NSSI is not entirely clear, existing research sheds light on the manner in which trauma and NSSI are related. For instance, Holden et al. (2022) found that “psychache” mediates the relationship between the experience of childhood maltreatment and the development of NSSI. Further, Franzke et al. (2015) found that dissociation mediated the emergence of NSSI for individuals who experienced child maltreatment. And in a highly related vein, Briere and Eadie (2016) found that, although there did not appear to be a direct pathway between the experience of trauma and NSSI, the experience of post-traumatic symptoms and depression created dissociation for some study participants, which was then related to (mediated) the development of NSSI. Looking at the severity of trauma and NSSI, research by Horowitz and Stermac (2018) examined the relationship between trauma and NSSI functions. They found that individuals who reported a “higher trauma severity” endorsed a higher number of NSSI functions, and particularly endorsed the interpersonal boundaries and anti-dissociation functions of NSSI (p. 240). Additionally, research by Peh et al. (2017) suggests that emotion dysregulation may mediate childhood maltreatment and the development of NSSI, wherein NSSI may be a means of managing the emotion dysregulation that happens as a product of childhood maltreatment. Relatedly, Layne et al. (2014) found multiple adverse childhood experiences may be associated with an increased risk of adolescent NSSI. Research continues to emerge, but it is evident that there exists a connection between trauma, particularly interpersonal trauma, and the development of NSSI. To that end, it is prudent for mental health professionals (MHPs) to explore ways in which they may help to facilitate growth through suffering.

Tedeschi and Calhoun (1995) describe the positive psychological changes in intrapersonal and interpersonal function that can occur for some individuals following the experience of trauma. Post-Traumatic Growth (PTG) may include changes in the following dimensions: “perception of self,” interpersonal functioning or relationships, and “philosophy of life” (Tedeschi & Calhoun, 1996, p. 456), which are then reflected in the following five domains: “personal strength, new possibilities, relating to others, appreciation of life, and spiritual change” (Calhoun & Tedeschi, 2014, p. 5). Naturally, the experience of PTG and the related growth individuals may feel as a product of PTG does not nullify the associated costs of the trauma experience (Calhoun & Tedeschi, 2014). However, the thoughtful and careful application of specific interventions that facilitate the development of

PTG may be useful in the treatment of NSSI. Simple availability of support may not be as closely related to growth and change, as the client's ability to positively perceive and access those supports (Tedeschi et al., 2015). To that end, Tedeschi et. al (2015) suggest that the development of new cognitions and emotional regulation processes may be most closely related to positive change and growth.

Implications for Therapeutic Application and Research

Naturally, not all individuals who self-injure have experienced trauma that is implicated in their NSSI. As such, development of PTG may not be an appropriate therapeutic aim with all clients who self-injure. When applicable, MHPs are cautioned to avoid an approach that assumes PTG is attainable for all individuals or that the experience of PTG is inherently positive; PTG should not be considered as a means of eliminating trauma distress (Tedeschi et al., 2015). Although MHPs should remain attuned to themes of PTG throughout the therapeutic process (Tedeschi et al., 2015), MHPs are cautioned to avoid rushing clients towards the development of PTG while minimizing the therapeutic process that must be undertaken to resolve the associated trauma. Early in the post-trauma recovery process is not seen as ideal time to explore possibilities of PTG; rather the MHP should focus on the client's psychological needs (Tedeschi, et. al), aligned with a trauma recovery model, and address NSSI using evidence-based practices. After achieving some level of trauma resolution and stability or progress related to NSSI recovery, MHPs may begin to draw the client's attention to positive psychological changes and explore indicators of PTG (Tedeschi et al., 2015). Receiving feedback from MHPs that recognizes clients' growth and positive changes can be a therapeutic cognitive experience (Tedeschi et al., 2015). Additionally, MHPs may utilize expressive interventions that promote insight (see Whisenhunt & Kress, 2013) and awareness of ways in which NSSI may have been utilized to cope with trauma symptoms, if applicable. Through facilitation of PTG, MHPs may be able to help clients who self-injure find meaning in their trauma, suffering, and NSSI that promotes enhanced psychological functioning.

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Bisexual-Specific Minority Stress, Perceived Burdensomeness, and Identity Visibility: Models of Risk and Resilience

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Keywords: bisexual, minority stress, NSSI, sexual minority

Introduction and Study Aims

Individuals who identify as sexual minorities are three times more likely to engage in non-suicidal self-injury (NSSI) than heterosexual individuals.¹ Bisexual individuals are up to six times more likely to engage in NSSI than heterosexual individuals and are up to four times more likely to engage in NSSI than lesbian/gay (L/G) individuals.² Sexual minority individuals may be at increased risk due to the impact of experiences of discrimination (minority stress; Minority Stress Theory [MST]).³ Furthermore, research has found that Perceived Burdensomeness (PB) mediates the positive relation between sexual minority stress and NSSI.⁴ Bisexual individuals may be at elevated risk for NSSI compared to L/G individuals from bisexual-specific minority stressors (e.g., beliefs that bisexuality is transient, assumptions that bisexual individuals are L/G or heterosexual), which are often perpetrated by both heterosexual and L/G individuals. Davila and colleagues proposed that bisexual individuals may engage in identity visibility strategies (e.g., wearing pride clothing, communicating their bisexuality) to combat these experiences by connecting to their community and reinforcing pride in their identity.⁵ The current study aimed to test two hypotheses: 1) PB would explain the positive relationship between minority stress from both heterosexual and L/G individuals and NSSI, and 2) these mediational effects would be weaker among bisexual individuals who used more identity visibility strategies.

Methods and Measures

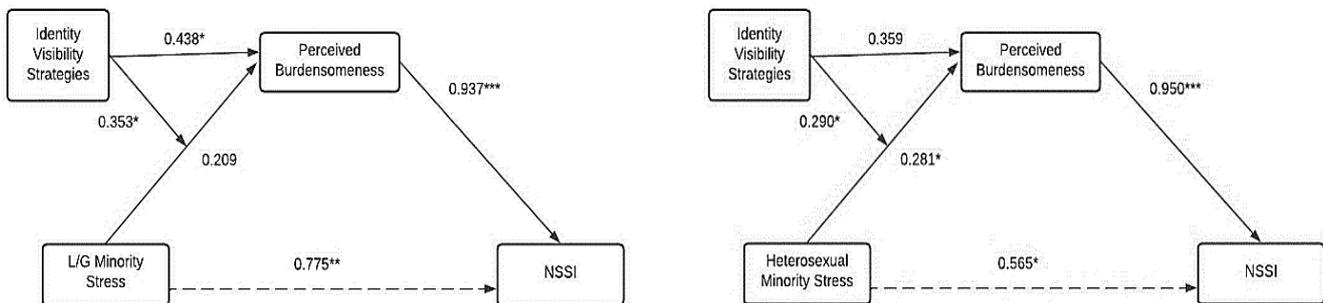
A sample of 166 cisgender, bisexual MTurk workers (76.5% women) completed measures assessing PB,⁶ minority stress,⁷ identity visibility,⁸ and NSSI severity (i.e., number of methods used).⁹ Mediation and moderated mediation analyses were conducted using the PROCESS macro in SPSS.

Results and Discussion

Analyses of the indirect effects of L/G ($ab = 0.35$, $CI = 0.07 - 0.72$) and heterosexual ($ab = 0.37$, $CI = 0.10 - 0.75$) minority stress suggested partial mediating effects of minority stress from both L/G and heterosexual individuals on NSSI through PB. Analyses of conditional indirect effects (Figure 1) revealed that identity visibility strategies significantly moderated the indirect effect of L/G minority stress on NSSI ($CI = 0.001 - 0.68$) but not the indirect effect of heterosexual minority stress ($CI = -0.03 - 0.63$). Specifically, there were statistically meaningful differences between the indirect effects of L/G minority stress on NSSI through PB observed at high levels of identity visibility strategies ($M+1SD = 2.84$; $ab = 0.46$, $CI = 0.14 - 0.78$) and the indirect effects observed at average ($M = 2.13$; $ab = 0.21$, $CI = -0.04 - 0.46$) and low levels ($M-1SD = 1.42$; $ab = -0.04$, $CI = -0.38 - 0.30$). These results suggest that for bisexual individuals, minority stress from both heterosexual and L/G individuals increases NSSI by increasing experiences of PB. Contrary to the hypothesis that identity visibility may foster resilience, bisexual individuals who reported using high levels of identity visibility strategies experienced significantly higher levels of PB when faced with minority stress from L/G individuals.

Figure 1.

Moderated mediation models. Numerical values represent unstandardized beta weights. Dotted lines indicate direct effects. * $p < .05$, ** $p \leq .01$, and *** $p \leq .001$



Implications

These findings establish preliminary evidence that, for bisexual individuals, minority stress from both heterosexual and L/G individuals increases NSSI through PB. Furthermore, using identity visibility strategies to signal bisexuality may confer risk for increased PB when faced with minority stress from L/G individuals. Future research should continue to consider the additive burden of minority stress in risk for NSSI in bisexual individuals and to explore the nuances of potential bisexual-specific resilience variables.

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Physiological Threat System Differences in Depressed Adolescents with and Without Non-Suicidal Self-Injury

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Keywords: adolescent, cortisol, depression, self-injury, stress

Introduction and Study Aims

Major depressive disorder (MDD) is a source of great distress and dysfunction [1]. Individuals with MDD often also engage in non-suicidal self-injury (NSSI), inflicting damage to body tissue without suicidal intent [2]. NSSI is particularly common in adolescents, with prevalence rates up to 60% (12-month) in clinical inpatient samples [3]. Evidence suggests MDD patients with NSSI differ from patients without NSSI in psychosocial factors [4], biological factors [5], and treatment response [6]. More research is needed to understand stress responses that may distinguish them. The hypothalamic-pituitary-adrenal (HPA) axis is a crucial component of the physiological threat system. NSSI is associated with *elevated* cortisol awakening response (CAR) [7] but *attenuated* cortisol response to stress [8]. Few studies have examined cortisol differences in NSSI samples with depression [9]. Thus, the present study examined differences in HPA functioning based on NSSI history for adolescents with MDD. MDD/NSSI patients were expected to have elevated CAR and reduced response to stress.

Methods and Measures

Participants included 24 adolescents (*Mean Age*=14.54, *SD*=1.77; 75% female) with depressive disorders enrolled in a treatment trial. The present study employs pre-treatment data. Half the sample had a history of NSSI (*N*=12), and half did not (*N*=12). Depression diagnosis and NSSI history were assessed using the Kiddie Schedule for Affective Disorders and Schizophrenia-Present and Lifetime Version (KSADS-PL) [10]. Salivary cortisol was collected to capture CAR and reactivity to the Trier Social Stress Test (TSST) [11]. Area under the curve ground (AUCg) and increase (AUCi) were calculated for CAR and TSST [12].

Results and Discussion

Significant group differences were found in CAR AUCg; MDD/NSSI participants had higher CAR AUCg (*M*=1823.34, *SD*=907.30) compared to MDD/NoNSSI participants (*M*=1015.82, *SD*=604.44), $F(1,16)=5.124$, $p=.038$ (see Table 1). This difference was accounted for by a significantly higher CAR in MDD/NSSI at 30 minutes after awakening, $F(1,16)=7.154$, $p=.017$ (see Figure 1). There were no group differences in cortisol during TSST.

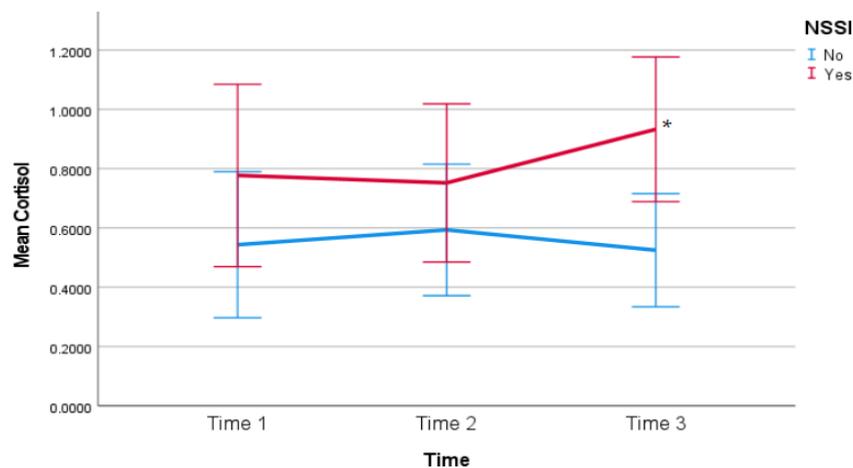
Implications

Despite the limitations of this study, which include a small sample size, single day of assessment, participants who are predominantly white and female, binary NSSI classification, and a cross-sectional design, the findings emphasize the need to study differences in HPA axis functioning based on NSSI history in the context of depression. It also highlights the importance of differentiating between subgroups of MDD patients and points to the need to conduct more work with larger samples.

Table 1. Means, standard deviations, and univariate general linear model results.

Variable	MDD/NSSI Mean (SD)	MDD/NoNSSI Mean (SD)	<i>F</i>	<i>p</i>
Response to Acute Stress (TRIER)				
	<i>N</i> = 12	<i>N</i> = 12	<i>F</i> (1, 22)	
Area under the curve – ground (AUC _g)	1967.43 (1186.08)	1741.68 (1100.19)	0.23	.634
Area under the curve – increase (AUC _i)	155.33(1313.99)	-14.16 (1386.00)	0.10	.761
Time 1 (immediately before test: minute 0)	0.44 (0.42)	0.43 (0.29)	0.001	.974
Time 2 (immediately after test: minute 20)	0.52 (0.34)	0.42 (0.36)	0.48	.496
Time 3 (at minute 35)	0.51 (0.29)	0.48 (0.35)	0.08	.787
Time 4 (at minute 50)	0.43 (0.27)	0.39 (0.32)	0.11	.747
Time 5 (at minute 65)	0.40 (0.22)	0.34 (0.32)	0.31	.584
Cortisol Awakening Response (CAR)				
	<i>N</i> = 8 ^a	<i>N</i> = 10 ^a	<i>F</i> (1, 16)	
Area under the curve – ground (AUC _g)	1823.34 (907.30)	1015.82 (604.44)	5.12	.038*
Area under the curve – increase (AUC _i)	49.08 (484.29)	34.31 (313.11)	0.01	.939
Time 1 (immediately after awakening: minute 0)	0.78 (0.43)	0.54 (0.39)	1.45	.246
Time 2 (at minute 15)	0.75 (0.38)	0.59 (0.35)	0.85	.370
Time 3 (at minute 30)	0.93 (0.35)	0.53 (0.30)	7.15	.017*

Note. ^aCAR data were missing for six participants; SD = standard deviation, MDD/NSSI = major depressive disorder with non-suicidal self-injury, MDD/NoNSSI = major depressive disorder without non-suicidal self-injury; **p*<.05

Figure 1. Mean cortisol awakening response by time of collection and NSSI group.

Note. NSSI = non-suicidal self-injury, error bars indicate standard error; **p*<.05

Acknowledgment: National Institute of Mental Health [grant number K23MH090216] (Gunlicks-Stossel); the University of Minnesota Grant in Aid funds (Klimes-Dougan); and the University of Minnesota Center for Personalized Prevention Research in Children's Mental Health start-up funds (Klimes-Dougan); K23MH090421(Cullen)

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Lifetime “Outness” of Self-Injurious Thoughts and Behaviors in Relation to Specific Disclosure Events Reported During Ecological Momentary Assessment

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Keywords: Disclosure, Non-suicidal self-injury, Outness, Suicidal ideation

Introduction and Study Aims

Rates of self-harm-related disclosure, or communication of self-injurious thoughts/behaviors (SITB) to an external source, are often very low. Only about half of those that make a suicide attempt (SA) and one third of those that engage in non-suicidal self-injury (NSSI) tell someone about their experiences (Armiento et al., 2014; Pompili et al., 2016), contributing to missed opportunities for intervention. For those that do disclose SITB, research suggests that some target recipients, such as family, friends, and intimate partners, are more common than others, likely attributable to the level of trust and closeness experienced with a target person (Calear and Batterham, 2019). Although research has demonstrated differences in disclosure rates for SA and NSSI in distinct populations, to our knowledge, research has yet to examine patterns of disclosure experiences among individuals reporting both NSSI and suicidal ideation (SI). The aims of this study were to 1) examine differences in disclosure experiences that may exist for NSSI and SI within the same individual and 2) to understand if/how an individuals’ self-perceived “outness” of SITB translates to actual disclosure events of SITB assessed in daily life using ecological momentary assessment (EMA).

Methods and Measures

Participants were 110 adults reporting a history of both NSSI and SI. Participants completed a self-report battery including an “Outness Inventory” which assessed how open, or “out” the individual was about their experiences with SI and NSSI (separately) across a variety of categories of people/relationships. This inventory used a one to seven scale where lower numbers indicated less “outness” than higher numbers. Then, participants completed a two-week EMA protocol during which they reported on experiences with SITB. Participants were sent six surveys a day in which they reported on NSSI behaviors and SI. If participants endorsed these experiences, they were asked if they disclosed those experiences to anyone. A paired samples t-test (including 12 pairs) was conducted to determine if self-perceived “outness” across recipient categories varied, within-person, for their experiences with NSSI as compared to SI. Next, using EMA data, bivariate correlations were calculated to examine the relationship between NSSI and SI self-perceived “outness” and the proportion of disclosed NSSI or SI events (relative to total events of each type reported during EMA).

Results and Discussion

Results of the paired samples t-test yielded significant differences in self-perceived outness between NSSI and SI categories for father ($t(105) = 2.046, p = .043$), strangers/new acquaintances ($t(102) = 2.738, p = .007$), and romantic partners ($t(95) = 2.362, p = .020$), where mean outness of NSSI was significantly higher than mean outness of SI for each category (see table 1). No significant differences in self-perceived outness of NSSI and SI were found for the other nine disclosure recipient categories. Bivariate correlations showed that overall mean outness for NSSI and the proportion of disclosure for EMA NSSI events were weakly and non-significantly correlated ($r(84) = .04, p = .71$), as was overall mean outness for SI and the proportion of disclosure for SI events ($r(65) = .07, p = .58$). Further, these correlations were not significantly different from each other ($p = .88$).

Results of the current study suggest that individuals with a history of both NSSI and SI may report higher levels of self-perceived outness for NSSI than SI. The significant differences observed for the father, stranger/new acquaintances, and the romantic partner categories might be explained by the physical nature of NSSI, as engaging in NSSI may result in physical scarring that is visible to others, thus leading to higher self-perceived “outness.” The presence of physical scarring may also

explain why mean outness of NSSI was higher than SI for 11 of the 12 examined categories. Interestingly, overall outness for either NSSI or SI did not translate to actual disclosure events assessed during EMA. This result may be attributable to the outness measure that we used. The “outness inventory” assessed general “outness” across various categories of people and did not assess actual disclosure events. Therefore, disclosure and “outness” might be measuring two distinct constructs.

Table 1. Self-Perceived “Outness” for NSSI and SI Across Relationship Categories

Overall Self-Perceived "Outness" for NSSI Compared to SI Across a Variety of Categories/Relationships

Category	NSSI		SI		N	Paired Differences		
	M	SD	M	SD		M	SD	Two-Sided p
Current (in-person) Friends	4.08	1.9	3.91	2.05	112	0.17	1.97	0.364
Current (online) Friends	2.85	2.09	2.96	2.12	89	-0.1	1.53	0.535
Prior Friends	3.23	2.01	3.13	2.03	110	0.1	1.59	0.513
Mother	3.66	1.96	3.35	1.97	110	0.318	1.69	0.052
Father	3.17	1.94	2.9	1.91	106	0.27	1.38	0.043*
Siblings	3.35	1.92	3.3	2.06	98	0.05	1.73	0.77
Extended Family/Relatives	1.94	1.33	1.83	1.37	109	0.11	1.36	0.401
Strangers/New Acquaintances	1.34	0.74	1.12	0.491	103	0.22	0.83	0.007**
Physical Health Care Providers	2.94	1.95	2.82	2.12	105	0.12	1.84	0.493
Mental Health Care Providers	5.66	1.88	5.53	1.99	91	0.13	1.39	0.369
Romantic Partners	4.58	1.83	1.37	0.76	96	0.36	1.51	0.02*
Community Members	1.46	0.73	1.37	0.76	104	0.09	0.68	0.198

*indicates significance at the $p < .05$ level, ** indicates significance at $p < .01$ level

Implications

Given that disclosure rates and self-perceived “outness” for SITB may not differ between NSSI and SI, this study highlights a need to educate the public on how best to respond to a disclosure event regardless of the thought or behavior type being disclosed. Future research should strive to identify disclosure recipient responses that suicidal or self-injuring individuals deem helpful to not only inform public health campaigns but also to increase the likelihood of SITB disclosure events and thus, increase opportunities for intervention.

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Non-Suicidal Self-Injury Persistence Patterns, Risk Factors, And Clinical Outcomes During the College Period

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Keywords: college, emerging adulthood, non-suicidal self-injury, persistence, suicidality

Introduction and Study Aims

Although non-suicidal self-injury (NSSI) is known to begin in adolescence, longitudinal information is lacking about patterns, predictors, and clinical outcomes of NSSI persistence among emerging adults. Therefore, the present study was designed to (1) estimate NSSI persistence during the college period, (2) identify risk factors and high-risk students for NSSI persistence, and (3) evaluate the association with future mental disorders and suicidal thoughts and behaviors (STB).

Methods and Measures

Using prospective cohorts from the Leuven College Surveys (n=5,915), part of the World Mental Health International College Student Initiative, web-based surveys assessed mental health and psychosocial problems at college entrance and three annual follow-up assessments. These included traumatic experiences, stress and social support, mental disorders and impairment, STB, and NSSI characteristics.

Results and Discussion

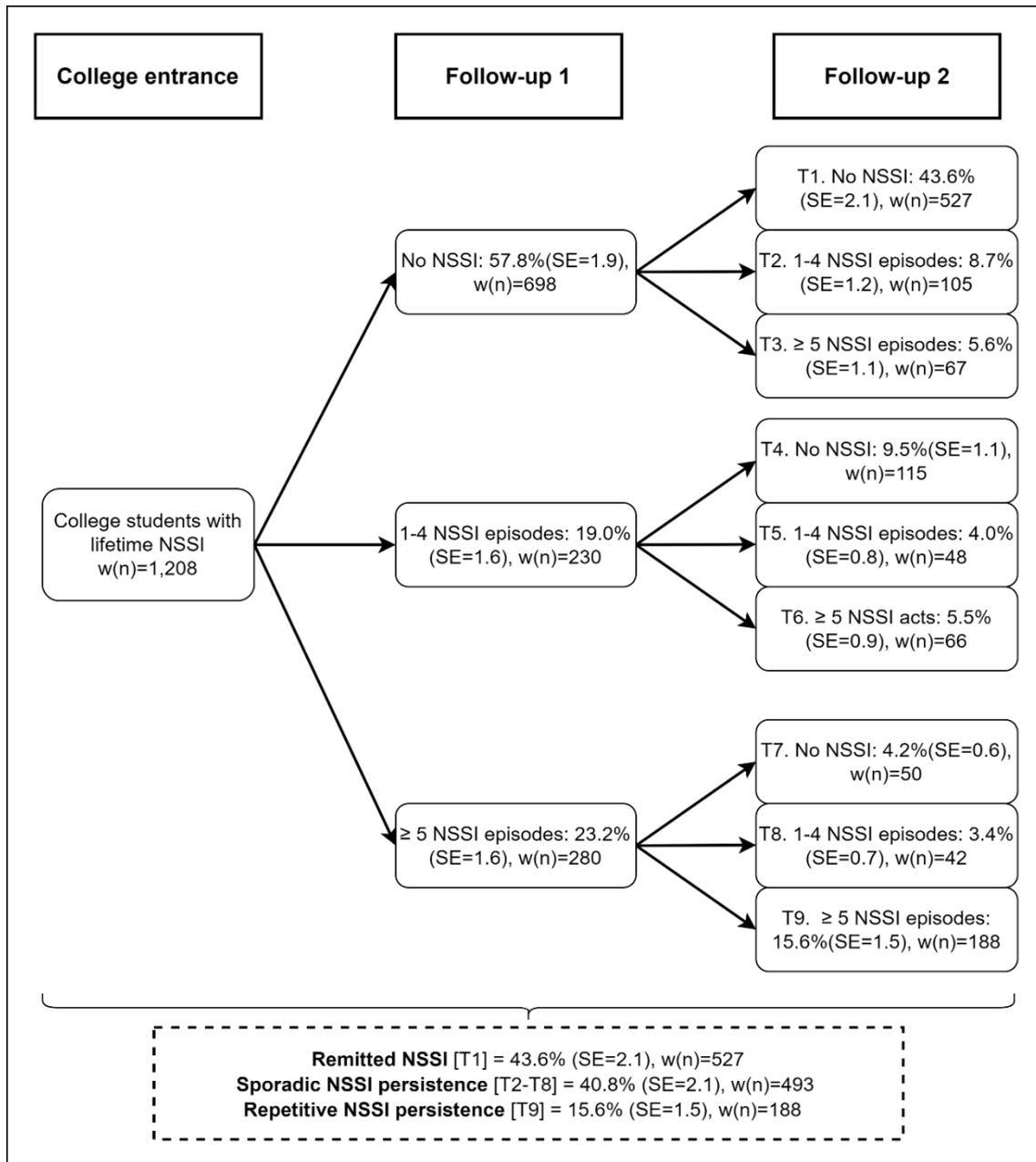
Approximately one in five (20.4%) students reported lifetime NSSI at college entrance. NSSI persistence (i.e., ≥one episode during the first two college years) was estimated at 56.4%, with 15.6% reporting repetitive NSSI persistence (>five episodes each year; Figure 1). Many hypothesized risk factors were associated with NSSI persistence patterns, with the most potent effects observed for pre-college NSSI characteristics. Multivariate models suggest that an intervention focusing on the 10-20% at the highest predicted risk could effectively reach 34.7-56.7% of students with persistent repetitive NSSI (PPV=81.7-93.2; AUC=0.88-0.91). Persistent NSSI during the first two college years predicted 12-month mental disorders, severe impairment, and STB during year three, including suicide attempts. While most emerging adults with a childhood-adolescent onset of NSSI continue to self-injure during their college years, it is possible to detect students at risk for a highly persistent NSSI pattern and future mental disorders and suicidality.

Implications

Web-based screening may be a promising approach for detecting students at risk for a highly persistent NSSI pattern characterized by subsequent adverse outcomes.

Figure 1.

The course of non-suicidal self-injury among students with a lifetime history



Acknowledgment: The authors wish to thank the student services of KU Leuven for their assistance in data collection.

Trauma-Informed Supervision of NSSI

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Keywords: supervision, trauma, self-injury

Introduction

According to the National Child Traumatic Stress Network (NCTSN; n.d.), trauma-informed care requires providers to “recognize and respond to the impact of traumatic stress” on those who have contact with the system of care. Trauma-informed care is undertaken from a collaborative systems approach and requires the systematic infusion of trauma knowledge and skill across the various organizational levels—from therapeutic practices to organizational policies and culture (NCTSN, n.d.). Trauma-Informed Supervision (TIS) requires an application of trauma informed principles to the supervision process, in an effort to support supervisee development and enhance client care. Considering the established link between NSSI and trauma (see Briere & Eadie, 2016; Franzke et al., 2015; Holden et al., 2022; Horowitz & Stermac, 2018), mental health professionals (MHPs) who operate in a supervisory capacity should consider the impact of MHP retraumatization and vicarious traumatization on supervisees.

Discussion

According to Berger and Quiros (2014), trauma-informed systems must “demonstrate an understanding of the complexity of trauma and recognition of it as both interpersonal and sociopolitical” (p. 296) and is based on the five basic assumptions of “safety, trustworthiness, choice, collaboration, and empowerment” (Quiros & Berger, 2013, p. 155). NCTSN (n.d.) provides a list of specific facets of trauma-informed care: (a) trauma screening; (b) use of evidence-based and culturally sensitive assessment and treatment for trauma; (c) providing psychoeducational resources on trauma and its effects; (d) enhancing resiliency and protective factors; (e) addressing effects of trauma on family systems; (f) collaboration with other providers to achieve holistic care; and (g) proactive care for service providers to minimize the effects of secondary traumatic stress.

The nature of trauma-informed care presents additional risks to MHPs, particularly related to retraumatization and vicarious traumatization. Retraumatization can occur when earlier traumas are triggered or reactivated, whereas vicarious traumatization may occur when hearing detailed and/or intense trauma narratives (Carello & Butler, 2014). Etherington (2009) states that vicarious trauma can lead to disruptions in the MHP’s “sense of safety, self-esteem and identity” (p. 182), which can have deleterious effects on their provision of care. Indeed, the ability to work effectively with trauma survivors while managing one’s own intrapersonal response to trauma work is an essential skill for MHPs. For this reason, TIS is an approach to the supervision process that monitors for adverse effects on supervisees while promoting trauma-informed client care.

Implications for Therapeutic Application and Research

TIS is a multifaceted approach that must also be flexible in nature to allow for adaptation to meet supervisees’ unique developmental needs. Generally, Quiros and Berger (2013) recommend the application of the aforementioned five basic assumptions of “safety, trustworthiness, choice, collaboration, and empowerment” to the supervisory process (p. 155). Safety may include factors such as having a safe and calming physical environment in which to conduct supervision, maintaining a consistent supervision schedule, maintaining clear professional boundaries but developing a strong working alliance (Berger & Quiros, 2014; see also Borders et al., 2022). Trustworthiness can develop through giving and receiving feedback, appropriate use of vulnerability, maintaining a supportive tone, and encouraging the supervisee’s reflective practice (Berger & Quiros, 2014; see also Borders et al., 2022). Choice and collaboration may manifest through the supervisee’s active participation in the treatment

planning process while honoring the supervisee's knowledge and skill as equal to that of the supervisor (Berger & Quiros, 2014; see also Borders et al., 2022). Finally, empowerment may be nurtured through allowing opportunities for supervisees to practice skills under supervision while receiving consistent and supportive feedback (Berger & Quiros, 2014; see also Borders et al., 2022).

Although supervisors may not be knowledgeable of supervisees' trauma or NSSI history, supervisors should carefully monitor for signs of retraumatization and vicarious traumatization in their supervisees. Further, as with trauma-informed care, supervisors should consider using a titrated approach when addressing potentially triggering matters or content with supervisees. Approaches that rely on overstimulation or abrupt exposure may contribute to retraumatization (Berger & Quiros, 2014). Etherington (2009) states that TIS is most effective when it focuses on the "inter-relationship between the trauma itself, the person of the counsellor [sic], the helping relationship, and the context in which the work is offered" (p. 179). As such, much of the supervision process may address matters of process, dynamics, and relationships, as opposed to specific interventions. However, supervisors are cautioned to avoid the inclination to "rescue" or assume a therapeutic role with supervisees who are experiencing adverse reactions and/or difficulty in their provision of care (Berger & Quiros, 2014, p. 299).

Additionally, supervisors may utilize psychoeducation on trauma-informed care, retraumatization, vicarious traumatization, and the connection between trauma and NSSI to support supervisees in taking a proactive approach in their work, thereby minimizing the negative impact of trauma (Berger & Quiros, 2014; Borders et al., 2022). Supervisors may also work closely with supervisees to develop and utilize a self-care plan (Berger & Quiros, 2014) that supports holistic wellness as one method of prevention. Helping supervisees to achieve a balanced workload that is not overly representative of trauma clients or clients who self-injure may also help to minimize the risk of supervisees developing adverse reactions (Etherington, 2009). Multiple efforts can be made to prevent the development of adverse reactions, but supervisors must also be prepared to support supervisees who experience retraumatization and/or vicarious traumatization. As appropriate, supervisors may recommend individual therapy for supervisees who are adversely affected by their work with trauma clients and/or clients who self-injure.

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Nonsuicidal Self-Injury Amongst Sexual And Gender Minorities: The Role Of Psychological Distress

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Keywords: gender and sexual minorities, nonsuicidal self-injury, psychological distress

Introduction and Study Aims

Nonsuicidal self-injury (NSSI) refers to the direct, deliberate, self-inflicted, and culturally/socially unacceptable destruction of body tissue, which occurs in the absence of suicidal intent (International Society for the Study of Self-Injury, 2018). Given the myriad of adverse outcomes associated with NSSI, identifying and characterising populations who are at elevated risk is extremely important. Rates of nonsuicidal self-injury (NSSI) amongst sexual and gender minorities are high. As such, research is needed which seeks to explain the mechanisms which underpin this behaviour.

This study aims to assess (i) whether individuals with sexual or gender minority identities have higher rates of lifetime NSSI than individuals with cisgender heterosexual identities, and (ii) if this can be explained by their higher levels of psychological distress. We hypothesise that gender minorities will have the highest rates of lifetime NSSI, followed by sexual minorities and then cisgender heterosexual individuals, and that this will be explained by the levels of psychological distress in these groups, as assessed by mediation analysis.

Methods and Measures

This study is a secondary analysis of pre-collected, cross-sectional data^[SEP]. Participants completed an online survey which assessed their gender and sexual orientation, engagement in NSSI (DASI), and psychological distress (K10). They were then categorised accordingly as either cisgender heterosexual (n=1100), cisgender sexual minorities (SM) (n=272), or gender non-conforming (GNC) (n=103).

All analyses were conducted using STATA 17. Descriptive statistics were conducted to determine the demographic characteristics of the sample. Binary logistic regressions were carried out to assess whether it was appropriate to combine cisgender men and women in the cisgender heterosexual and SM identity groups (as women typically report higher rates of NSSI than men). Various analyses were conducted to assess age as a potential confounding variable. A binary logistic regression assessed the relationship between identity and NSSI prevalence, and identity and psychological distress. Finally, mediation analyses considered whether K10 score statistically mediated the relationship between identity and binary lifetime NSSI.

Results and Discussion

This study found that rates of lifetime NSSI and levels of psychological distress were significantly higher for GNC participants than SM participants (NSSI: OR=2.68, 95%CI[1.57,4.59], p<0.001 | Distress: Coef.=5.22, 95%CI[3.24,7.19], p<0.001), and also significantly higher for SM participants than cisgender heterosexual participants (NSSI: OR=3.39, 95%CI[2.57,4.47], p<0.001, | Distress: Coef.=3.08, 95%CI[1.91,4.25], p<0.001). Psychological distress partially mediated the relationship between identity and lifetime NSSI in a stepwise fashion, explaining higher lifetime NSSI in the GNC group compared to the SM group, and higher lifetime NSSI in the SM group compared to the cisgender heterosexual group. As such, our results indicate that higher rates of NSSI in GNC and SM groups can be partly explained by their greater levels of psychological distress, with a stepwise progression with increasingly marginalised identity.

Implications

Interventions should seek to enact wide-scale societal change which minimise the experiences/contexts that contribute to elevated levels of psychological distress. However, as our results do not tell us why SM and GNC groups are disproportionately experiencing this distress, future work should establish what the causes of this distress are. Additionally, our study only found a partial mediating effect, and thus other variables must also be contributing to NSSI risk within sexual and gender minority populations, which future work should also explore.

Social Media Use as A Trigger Factor For NSSI: A Study Protocol For An Ecological Momentary Assessment

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Keywords: Ecological Momentary Assessment, Non-Suicidal Self-Injury, Social Media, Trigger Factor

Introduction and Study Aims

NSSI is a global concern for mental health. NSSI describes the intentional infliction of harm to the body surface without suicidal intent and often co-occurs with affective and stress-related disorders (Plener et al., 2018; Cummings et al., 2021). Particularly in adolescents, social context is an important predictor for both the initiation and the maintenance of NSSI. One of the main purposes of NSSI is its use for emotion regulation (Brown & Plener, 2017). Interpersonal aspects such as interactions with peers in online contexts have been shown to influence affective states and possibly effect NSSI (You et al., 2013). Another factor than can promote NSSI is digital social media use, e.g. through participation in online communities and related mechanisms of social reinforcement, heightened exposure to NSSI-related material and normalization of self-injurious behavior (Jacob et al., 2017; Brown et al., 2018). Social interactions on digital social media can cause negative emotions which provoke or enforce NSSI (Latina et al., 2022). The aim of this study is to investigate the influence of social contextual factors, affective states, and social media use on affective states and aspects of NSSI in the everyday life of adolescents.

Methods and Measures

Ecological Momentary Assessment (EMA) will be used to collect data on intra- and interpersonal variables in a fashion that is valid for everyday life. 50 adolescents (25 of them with at least one single act of NSSI in the past 12 months and 25 healthy control subjects without a history of NSSI or mental illness) will be invited to participate in a 7-day EMA study. Inclusion criteria for both groups will be 14 – 18 years of age, and an IQ of over 70. Additionally, participants for the NSSI group need to report at least one NSSI act during the past 12 months; participants for the control group are required no lifetime history of NSSI as well as no current mental or somatic illness. Exclusion criteria for both groups are the display of criteria of Autism-Spectrum-Disorder, acute suicidality or severe aggression, and current psychological or somatic condition that requires immediate treatment. The assessment will be conducted using the Movisens XS software on either the participants' mobile phones or a rental device. During the survey, questions addressing social context, social media use, current affective state, NSSI-related thoughts and behaviors as well as motives for NSSI will be asked up to six times a day between 7:00 and 22:00. Additionally, participants will be asked to answer event-based questions regarding social context, affective states and NSSI-related thoughts after stressful situations, social conflicts or after NSSI related thoughts and / or behaviors. At the baseline time point, additional variables on non-suicidal self-injurious thoughts and behaviors (Self-Injurious Thoughts and Behaviors Interview - German; SITBI-G), Post-Traumatic Stress Disorder (Clinician-Administered PTSD Scale for DSM-5 – Child/Adolescent; CAPS-C/A), Depression (Beck Depression Inventory II; BDI-II), personality traits (Junior Temperament and Character Inventory; JTCI), subjective stress (Perceived Stress Questionnaire; PSS), and general symptomatology (Strengths and Difficulties Questionnaire; SDQ) will be assessed.

Results

The data from this EMA study will be analyzed using multilevel models and repeated measures ANOVA. A detailed analysis plan will be presented in the protocol.

Implications

The planned study aims to provide insight into the motives, risks, and benefits of social media use on affective states and NSSI among adolescents, with a particular focus on the bidirectional

relationship between NSSI characteristics (such as frequency and intensity) and NSSI-related content on social media. The results of this study will provide insight into stressors and trigger factors for NSSI that are relevant to everyday life and will serve as a basis for further research regarding the influence of social exclusion, physiological and subjective stress as well as attentional control while watching NSSI-related content on social media.

Acknowledgement: This project was funded by the Austrian Science Fund (FWF): KPKL1963FW.

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“I Can’t Escape My Scars, Even If I Do Get Better”: A Discourse Analysis Of Adolescent Talk About Their Self-Injury Scars During Therapy

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Keywords: Adolescence; cognitive-behavioural therapy; discourses; self-injury; stigma

Introduction and Research Aims

Adolescent self-injury is a rising cause for clinical and public health concern.¹ Emerging evidence has highlighted that perceptions of self-injury scars may thwart recovery;² yet limited research has examined adolescent accounts of their self-injury scars. In particular, research has neglected to consider how sociocultural discourses influence adolescent accounts of their self-injury scars, despite the prominence of negative or stigmatizing societal discourses around adolescent self-injury.³ The current study examined the various ways adolescents engaging in self-injury constructed their self-injury scars during therapy, and explored the sociocultural discourses in which these constructions are situated.

Methods

The current study employed audio-taped data from cognitive-behavioural therapy (CBT) sessions from a larger study investigating the effectiveness of CBT and short-term psychoanalytic psychotherapy in maintaining reductions of depressive symptoms at a one-year follow-up.⁴ Participants were six female adolescents ($M_{age}=16.33$ years, $SD=1.21$) engaging in self-injury throughout the duration of their participation in manualized CBT sessions for depression. Participants’ data was transcribed verbatim and analyzed using Discourse Analysis. Discourse Analysis operates under the epistemological framework that knowledge, meaning, and understanding are socially constructed by humans through language within their social world.⁵

Results

Adolescents constructed their self-injury scars as shameful and stigmatizing, and as validation of the legitimacy of their mental health difficulties both to themselves and to communicate such legitimacy to others. Excerpts of transcript and analytic content are presented in Table 1.

Table 1. Example Participant Quotes and Analytic Content.

“My body is scarred and disgusting from all the cuts and things so it’s like I can’t escape it even if I do get better—that’s what I was thinking [...]”

The use of the conjunction “and” equates the participant’s scars with disgust. This talk draws upon discourses around societal beauty standards; specifically, westernized societies places value on perfection and disfigurement from scars violate these ideals and elicit stigma.⁶ Drawing upon such beauty discourse gives weight to the construction of scars as stigmatizing themselves, beyond the stigma associated with self-injury engagement. The participant then describes that if she were to “get better” she would still not be able to “escape” the stigma evoked by her scars, further emphasizing the construction of scars as stigmatizing.

“I’m saying for me like [self-injury scars are] a sort of way to reassure myself I’m not— I wouldn’t say like this applied to everyone who had depression I’m just saying for me it’s—it’s like I need that kind of physical proof thing [...]”

This participant employs the phrases: “way to reassure myself,” “physical proof,” and “better to see” construct her scars as validation to herself of the legitimacy of her mental health difficulties. In essence, she depicts her scars as a way to make the invisibility of depression become visible. She may draw upon discourses that question the legitimacy of mental health difficulties as a justification for the need for “reassurance” and to support the construction of scars as validation of suffering.

“Well mainly just doing my wrists in again. I usually think that now and again to see if anyone will actually listen to me this time (.) see how many times I can do it before they actually listen and realize that I really do need help [...]”

The participant describes wanting to “see if” those around her will “actually” listen to her “this time.” The use of these terms in conjunction implies that the legitimacy of her mental health difficulties are typically dismissed, and wrongfully so. The employment of the term “realize” indicates that *others* must come to the *factual* conclusion that her mental health difficulties are legitimate. Here, the participant’s self-injury scars are constructed as way to signal to others or to validate that she requires support for her mental health difficulties.

Discussion

Adolescents’ construction of their self-injury scars as shameful and stigmatizing, and as validation of their mental health difficulties highlights the necessity of keeping self-injury scars private and hidden, which is dissonant with scars simultaneously serving as a communicative act. Adolescent descriptions, which informed the shameful and stigmatizing constructions, drew upon normative discourses around mental health, self-injury, and beauty. These results suggest that these discourses do not merely exist independently from one another, but rather intersect as compounding stigmatizations. For example, drawing upon beauty discourses in which disfigurement from self-injury scars violates beauty standards elicits shame and stigma beyond the self-injury engagement itself and associated stigmatizing discourses. These results contribute to Matthew and colleagues (2017) concept of “doubling up” in which physical markings of addictions (a stigma in itself) advertises to individual moral failing (addiction, second stigma), leading to an exacerbation of shame and self-stigmatization.⁷ Adolescent constructed self-injury scars as a proof in seeking validation from self and others as to the reality and legitimacy of their mental health difficulties. This perceived proof utility may be derived in part from stigmatizing discourses around mental health that cast aspersions onto adolescent reality, positioning them as merely “attention-seeking” rather than experiencing legitimate mental health difficulties. The construction of scars as validation to self and others indicate scars may serve the functional purpose of combating these discourses. In this way, the desire for validation of mental health difficulties to self and others through scars may serve as a maintenance factor for self-injury.

Implications

The construction of scars as shameful and stigmatizing highlights the clinical significance for the continued therapeutic focus on scars and their meanings to adolescents even after cessation of self-injury. This study underscores the central focus scars take in adolescent talk which is significant given that shame, stigmatization, and self-stigmatization are barriers to recovery. Constructions of self-injury scars as validation may indicate a maintenance factor for self-injury. These findings support that clinicians could validate the emotional experience of the adolescent apart from the self-injury, and give importance to, and remain curious of, the hidden components of the adolescent experience, such as feelings of depression, so as not to contribute to the stigmatizing discourses. This study indicates that awareness of the use of language and intersecting sociocultural discourses can inform person-centered therapeutic approaches.

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Suicidality As an Indicator Of DBT-A Treatment Response

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Keywords: DBT-A, suicide attempt, treatment response, emotion regulation, BPD, life problems

Introduction

According to the most recent report from the CDC in 2019, suicide is the second leading cause of death amongst adolescents aged 15-19 years, and therefore should be considered a major public health issue. Dialectical behavior therapy for adolescents (DBT-A) is a type of cognitive behavioral therapy originally developed as a treatment for youth engaging in chronic non-suicidal self-injurious and/or suicidal behaviors. Although the efficacy of DBT-A has previously been examined across randomized clinical trials, with findings suggesting that DBT-A is effective for reducing suicide attempts amongst highly suicidal adolescents, no extant work has specifically examined history of suicide attempts as a predictor of treatment response. Thus, the current study seeks to examine the effect of prior suicide attempts on response to DBT-A.

Methods

Participants were 254 patients aged 12-18 who completed a fully-adherent DBT-A program at an outpatient clinic within an academic medical center. Participants completed self-report scales, including the Borderline Symptom Checklist (BSL), the Difficulties in Emotion Regulation Scale (DERS), and the Life Problems Inventory (LPI) prior to starting treatment, as well as at the completion of treatment. Analyses compared youth who entered the program with a history of suicide attempts (defined as one or more prior attempts) with youth who entered the program without a history of suicide attempts, to examine differences in improvement in emotion regulation, impulsivity, interpersonal effectiveness, confusion about self, and distress tolerance.

Results

Independent samples t-tests found that youth with a history of suicide attempts (YSA; N=124) displayed higher scores on all measures at baseline in comparison to youth without a history of suicide attempts (YNSA; N=130). Specifically, youth with a history of suicide attempts ($M=46.68$, $SD=22.30$) displayed more severe borderline psychopathology than youth without a history of suicide attempts ($M=39.82$, $SD=24.34$), $t(250)=-2.33$, $p=.021$. Youth with a history of suicide attempts ($M=119.66$, $SD=26.45$) also reported significantly worse abilities to regulate their emotions than youth without a history of suicide attempts ($M=111.25$, $SD=30.71$), $t(252)=-2.33$, $p=.020$. Finally, youth with a history of suicide attempts ($M=178.98$, $SD=42.10$) reported significantly more life problems than youth without a history of suicide attempts ($M=157.72$, $SD=47.41$), $t(250)=-3.76$, $p<.001$. Notably, when comparing scores on self-report measures at the completion of treatment, no significant differences were found between youth with and without a history of suicide attempts on the BSL ($M_{YSA}=20.74$, $SD_{YSA}=20.11$; $M_{YNSA}=16.70$, $SD_{YNSA}=18.57$), the DERS ($M_{YSA}=82.46$, $SD_{YSA}=25.51$; $M_{YNSA}=79.00$, $SD_{YNSA}=24.24$), or the LPI ($M_{YSA}=116.49$, $SD_{YSA}=43.29$; $M_{YNSA}=117.13$, $SD_{YNSA}=76.95$) [all p 's > .05].

Discussion

Results suggest that although youth with a history suicide attempts display worse emotion regulation, impulsivity, interpersonal effectiveness, confusion about self, and distress tolerance than youth without a history of suicide attempts prior to beginning DBT-A treatment, by the completion of treatment, they report similar successes in these treatment areas to youth without a history of suicide attempts. These results thus evince the efficacy of DBT-A treatment specifically for higher severity adolescents with a history of one or more suicide attempts.

Figure 1: Differences between youth with and without a history of suicide attempts on the BSL before and after treatment

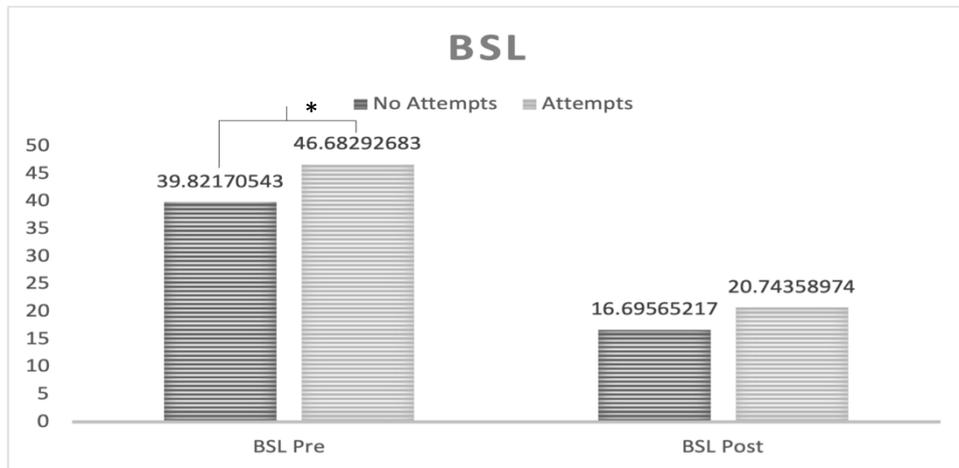


Figure 2: Differences between youth with and without a history of suicide attempts on the DERS before and after treatment

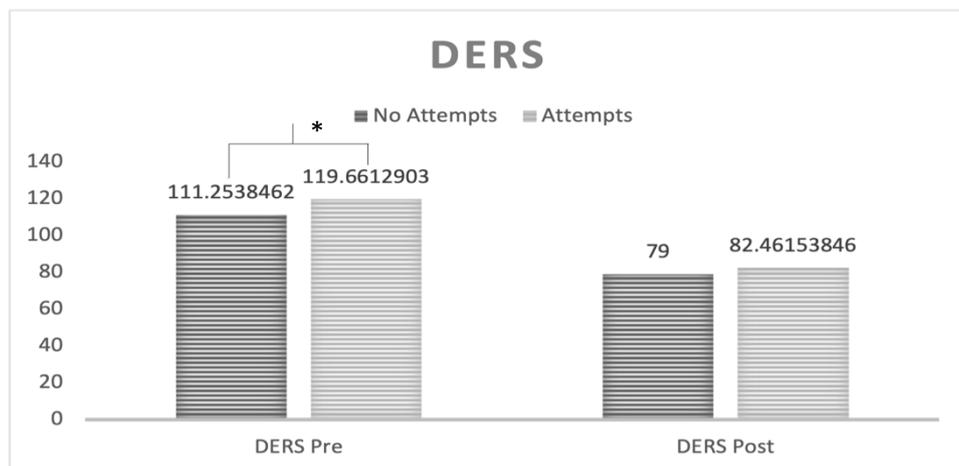
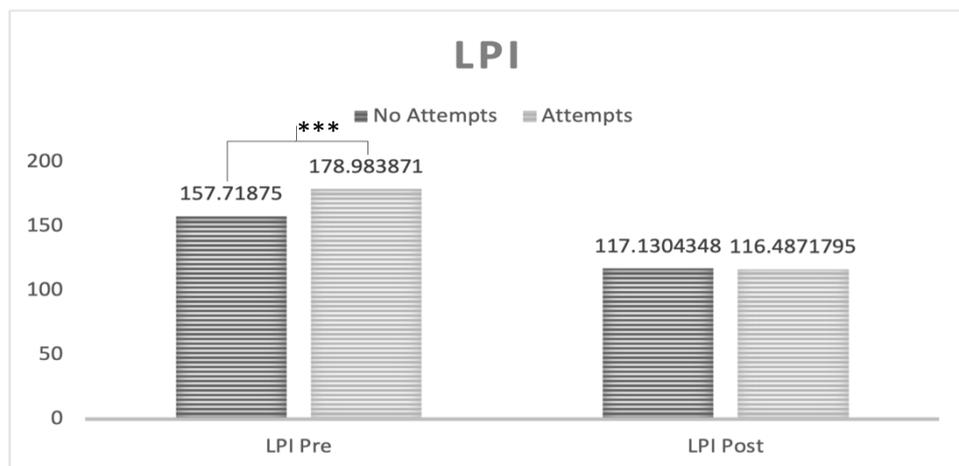


Figure 3: Differences between youth with and without a history of suicide attempts on the LPI before and after treatment



Symposia

Empirical Investigations Aimed at Defining and Conceptualizing NSSI as it Relates to NSSI Disorder Diagnostic Criteria

How Should we Define NSSI? Experiences From the Perspective of Those with Lived Experience

Greg Lengel | Drake University

Jason Washburn | Northwestern University Feinberg School of Medicine

Peggy Andover | Fordham University

Brooke A. Ammerman | University of Notre Dame

Days Versus Acts: Implications for NSSI Assessment

Jason Washburn | Northwestern University Feinberg School of Medicine

Greg Lengel | Drake University

Peggy Andover | Fordham University

Brooke A. Ammerman | University of Notre Dame

Operationalizing the Medical Severity of NSSI Behavior

Peggy Andover | Fordham University

Greg Lengel | Drake University

Jason Washburn | Northwestern University Feinberg School of Medicine

Brooke A. Ammerman | University of Notre Dame

Exploring Co-Occurrence of Substance Use & NSSI

Brooke A. Ammerman | University of Notre Dame

Online Ethnography and Computational Methods: An Interdisciplinary Approach to NSSI Practices on Social Media

Communities of Practice as a Performative & Communicative Engagement in NSSI

Gerald P. McKinley | Department of Pathology & Laboratory Medicine, Department of Anthropology, Schulich Interfaculty Program in Public Health, Western University

Understanding Online NSSI Communities of Practice through Technology-Assisted Ethnography

Steve H. Lee | Department of Epidemiology & Biostatistics, Western University

“Spicy Beans” & “Barcodes”: Understanding the Language Practices of NSSI on Social Media

Federica Guccini | Department of Anthropology, Western University

Network Analysis Methodology for Describing Communities & Connections on Social Media

Dan Lizotte | Department of Computer Science, Department of Epidemiology & Biostatistics, Western University

Oral Presentations

Attitudes & Beliefs About NSSI

Hungarian School Psychologists' Knowledge & Attitudes on NSSI: An Explorative Study

Richard Flach | University of Pécs, Faculty of Humanities & Social Sciences of, Institute of Psychology
 Dora Vajda | Psychosomatic Outpatient Center, Budapest
 Robert Fodor | University of Pécs, Faculty of Humanities & Social Sciences of, Institute of Psychology
 László Nagy | University of Pécs, Faculty of Humanities & Social Sciences of, Institute of Psychology

"What do you think about self-injurious behavior?" A Study to Assess Attitudes Towards NSSI

Tina In-Albon | University of Koblenz-Landau, Germany
 Laura Kraus | University of Koblenz-Landau, Germany
 Simone Pfeiffer | Clinical Child & Adolescent Psychology & Psychotherapy | University of Koblenz-Landau, Germany

The Self-Injury Stigma Questionnaire

Lexy Staniland | enAble Institute, Curtin University
 Penelope Hasking | enAble Institute, Curtin University
 Mark Boyes | enAble Institute, Curtin University
 Stephen Lewis | University of Guelph

NSSI & Emotion

NSSI: A Systematic Review & Bayesian Meta-Analysis

Sophie Haywood | School of Population Health, Curtin University
 Penelope Hasking | enAble Institute, Curtin University
 Mark Boyes | enAble Institute, Curtin University

Emotion Regulation in Young Adults with Recent, Distal, or No History of NSSI

Carolyn Helps | University of Victoria
 Brianna Turner | University of Victoria

Amplified Emotional Responding in NSSI? A Systematic Review of Two Decades of Investigation

Kealagh Robinson | Curtin University, Australia
 Marc S. Wilson | Te Herenga Waka—Victoria University of Wellington, New Zealand
 Gina M. Grimshaw | Te Herenga Waka—Victoria University of Wellington, New Zealand

PTSD & Trauma

Childhood Abuse & NSSI in Adolescents: The Role of Emotional Dysregulation & Trauma Symptoms

Hedvig Andersson | Center for Social & Affective Neuroscience, Department of Biomedical & Clinical Sciences, Linköping University, Sweden
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Posttraumatic Stress Symptoms and NSSI Engagement Among First Year University Students

Maria Ilieff | Ontario Institute for Studies in Education, University of Toronto

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Experiential Avoidance, PTSD, & NSSI: A Moderation Analysis in a National Veteran Sample

Tapan A. Patel | Florida State University

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Nathan A. Kimbrel | Durham VA Health Care System

Social Connection & Social Media

Peer Relationship Closeness and Concordant & Discordant NSSI Dyads

Cory A. Chaves | University of Massachusetts, Dartmouth

Akshay V. Trisal | University of Massachusetts, Dartmouth

Elizabeth E. Lloyd-Richardson | University of Massachusetts, Dartmouth

Social Support and the Impact of COVID-19 on University Students with a History of NSSI

Lisa Van Hove | Faculty of Psychology and Educational Sciences, Free University of Brussels

Imke Baetens | Faculty of Psychology and Educational Sciences, Free University of Brussels

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NSSI and Social Media

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Dr. Shannon Sibbald | Department of Family Medicine, Schulich School of Medicine & Dentistry | Western University

Dr. Gerald McKinley | Department of Pathology & Laboratory Medicine | Western University

Examining A Linguistic Marker of Emotion Regulation in Online Help-Seeking Communities

Andrew C. Switzer | University of Victoria

Christina L. Robillard | University of Victoria

Brianna J. Turner | University of Victoria

Psychobiology

Pain Analgesia or Desensitization? A Longitudinal Lab Study on the Link Between Pain and NSSI

Holly Boyne | University of Toronto

Chloe A. Hamza | University of Toronto

The Impact of Childhood Trauma on Plasma Endocannabinoid Levels in Female Adolescents

Marc D. Ferger
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Neurocognition in Adolescents who Engage in NSSI

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Individual Differences

OFF OR ON TRACK? Positive & Negative Life Experiences Related to Continued Versus Discontinued NSSI

Benjamin Claréus | Department of Psychology, Lund University, Sweden
 Daiva Daukantaité | Department of Psychology, Lund University, Sweden

Latent Profiles & Profile Correlates of NSSI Functions Among Undergraduates with a History of NSSI

M. S. Wilson | School of Psychology, Victoria University of Wellington, New Zealand
 C. Taylor | School of Psychology, Victoria University of Wellington, New Zealand
 K. R. Robinson | School of Population Health, Curtin University, Australia
 J. A. Garisch | School of Psychology, Victoria University of Wellington, New Zealand

BPD Symptom Severity/Features Among Adolescents Engaged In Youth Protection & First-Line MH Services

Stephanie McLellan-Lamarche | Biomedical Sciences, University of Quebec in Three Rivers; University of Montreal
 Lyne Desrosiers | Department of Occupational Therapy, University of Quebec in Three Rivers
 Lise Laporte | Department of Psychiatry, McGill University

NSSI & Other Behaviors

NSSI in Undergraduate Students: Eating Habits, Impulsivity, Negative Life Events, & Savoring

Boglárka Drubina | Institute of Psychology, ELTE Eötvös Loránd University, Hungary; National Child Protection Services, Child Protection Service of Budapest, Expert Committee, Hungary

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Self-Criticism & NSSI, Disordered Eating, & Substance Misuse: Role of Psychological Needs Frustration

Christina L. Robillard | University of Victoria

Andrew Switzer | University of Victoria

Nicole K. Legg | University of Victoria

Brianna J. Turner | University of Victoria

Self-Harm in Treatment Seeking Adults with Gambling Disorder: Prevalence and Clinical Correlates

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Research & Clinical Practices

A Comparative Randomized Control Trial: Disseminating Clinical Guidelines for NSSI in Germany

Elisa Koenig
Ulrike Hoffmann
Jörg M. Fegert
Paul L. Plener
The Star-Consortium

Applying a Human Rights-Based Framework in Community-Based Adolescent Self-Harm Research

Rachel Parker | Royal Society for Public Health, DECIPHER, Cardiff University

Why Do People with Lived Experience Participate in NSSI Research? A Content Analysis

Sylvanna Mirichlis | School of Population Health-Discipline of Psychology, Curtin University, Perth Australia
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Treatment & Help-Seeking

Efficacy of Psychotherapeutic Interventions for Adolescent NSSI: Systematic Review & Meta-Analysis

Valeska Pérez Arqueros

Help Negation & Suicidal Ideation Among Young Adults Engaging in NSSI: Associations Over Time

Michael M. McClay | Texas Tech University
Sarah E. Victor | Texas Tech University

NSSI, Psychosocial Functioning, & Underutilization of Mental Health Services: A Veteran Cohort

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Disclosure & Recovery

Disclosure of NSSI: Distinctions in Patterns Among Black and Non-Black Individuals

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Brooke A. Ammerman | University of Notre Dame

An Examination of Disclosures in a University Sample with Recent NSSI

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Chloe A. Hamza | Ontario Institute for Studies in Education, University of Toronto

What is Important to the Decision to Disclose NSSI?Sylvanna Mirichlis | Discipline of Psychology, School of Population Health, Curtin University,
AustraliaMark Boyes & Penelope Hasking | enAble Institute, School of Population Health, Curtin University,
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Stephen P Lewis | Department of Psychology, University of Guelph, Canada

Understanding the Impact of Involuntary Discoveries of NSSI: A Thematic Analysis

Mathew Pugh | University of Guelph

Stephen P. Lewis | University of Guelph

Views of Self in the Context of Self-Injury Recovery: A Thematic Analysis

Brooke C.T. Farrell | University of Guelph, Canada

Therese E. Kenny | University of Guelph, Canada

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LGBTQIA+

Exploring the Lived Experience of Young Trans People who Self-Injure

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Mark Boyes | Curtin enAble Institute, Curtin University

Penelope Strauss | Telethon Kids Institute | School of Population and Global Health, University of
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Penelope Hasking | Curtin enAble Institute, Curtin University

***NSSI Onset Age is Associated with Perceived Burdensomeness & NSSI Among Sexual Minority
Young Adults***

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Cindy J. Chang | Graduate School of Applied & Professional Psychology, Rutgers University

Brian A. Feinstein | Rosalin Franklin University of Medicine & Science

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