SELF-INJURIOUS BEHAVIOR IN EDUCATION AND IMPLEMENTATIONS FOR EDUCATORS

Nicholas Charles Garro*

*Eastern New Mexico University, **USA***

ABSTRACT

The following paper reviews and discusses Self-Injurious Behavior (SIB) and Non-Suicidal Self-Injury (NSSI) in the educational setting. The main focus of this text is SIB among youth who have significant cognitive and intellectual disables. However, NSSI could not be dismissed due to a large majority of adolescents who engage in non-suicidal self-injury. Furthermore, the text will cover signs, symptoms, diagnosis, treatment, and how to hand self-injurious behavior in a school environment. A significant portion of this text will cover implementations for educators when working with a student who has severe development delays in the school setting.

Keywords: *Self-injurious Behavior (SIB), Non-Suicidal Self-Injury (NSSI)*

INTRODUCTION

Self-injurious behavior or SIBs is a phenomenon that can occur in a wide range of personalities, age groups, and IQ level. Self-injurious behavior is most common among people who are severely intellectually disabled, impulsive, psychotic, borderline personality disorders, and depression. The characteristic that will be further discussed later in my research are vast in origin; some people engage in self-injurious behavior to relieve social anxieties by cutting one's own body tissue, to a student who is severe and profound intellectually disabled that are engaging in self-injurious behavior for self-stimulatory reasons. There are wide varieties of reasons or onsets to self-injurious behavior from a disrupted childhood, to feelings of pleasure.

HISTORY

Self-injurious behavior has been around for thousands of years from biblical exploits that involve self-harm or self-injurious behavior is described in a story from the bible of a man who was crying aloud and screaming; while, scraping his hand with a rock to the point of tissue damage on his hand (Mark, 5:2-5). However, the true question is how did they perceive this man's behavior? Was it because he was insane, or was it because he needed to be saved by Jesus? Perception is in the eye of the beholder.

* *Nicholas Garro is currently part of the Intensive Support Program, Rio Grande High, Albuquerque Public Schools. His address is 1987 Panza Dr SW Los Lunas, NM 87031*

Self-injurious behavior can also be found in Indian culture for religious or societal purposes. For instance, piercing one's cheek is considered respectful in worshiping Maha Mariamman. Other cultural items that can take place in Indian culture are walking over hot coals to prove masculinity.

Self-injurious behavior has been described in early academic literature via anthropological accounts. Nevertheless, the anthropological accounts were from foreign lands which indicate that self-injurious behavior can happen across most, if not all cultures. The notion that self-injurious behavior happens across all cultures lends itself to self-injurious behavior being interpreted by social norms. Thus, what is self-injurious behavior? Throughout the years, self-injurious behavior has been defined in many ways because a self-injurious behavior has taken on many different meaning, hats, and instances of being defined. In recent years self-injurious behaviors have included cutting, carving of skin, attempted suicide, parasuicide, tissue damage, pulling out of nails, eye gouging, pica, self-poisoning, and dismembering limbs in some extreme cases (Cooper et al. 2009). Nevertheless, the language used to describe self-injurious behavior has changed as well from self-harm, self-mutilation, non-suicidal disorder, and parasuicide (Kauffman & Landrum, 2013). With the various descriptors of self-injurious behavior evolving to societal placement of exhibited behaviors and is now most commonly defined as an individual inflicting tissue damage to their own self without the help of others.

DEFINING SELF-INJURIOUS BEHAVIOR

Defining self-injurious behavior can be difficult and is necessary for labeling and classification of the exhibited behavior. Without a proper definition of self-injurious behavior; collecting data on incidence and prevalence of self-injurious behavior can be difficult to manage and to maintain relevance. Moreover, without a proper definition, self-injurious behavior could be left to the individual mind to determine what characterizes self-injurious behavior.

In recent years, the most common definition of self-injurious behavior can be described as self-inflicted tissue damage completed alone without any help from others (Cooper, 2009). The current definition accepts all forms of tissue damage as self-injurious behavior from cutting of self, to biting of limbs, or dismembering of limbs/digits (fingers).

To further define self-injurious behavior, we need to look at the rate that the behavior occurs, and in what instance/setting. The rate of the exhibited behavior can determine the severity of the self-injurious behavior. Furthermore, the instance in which self-injury occurs can determine the trigger or antecedent to the cause of self-injurious behavior; whether, the exhibited behavior is from social anxiety or avoidance, and self-stimulatory behavior. Onset can further define self-injurious behavior by the age in which the individual's behavior of self-injurious behavior occurs.

Onset of age can help dramatically when defining self-injurious behavior. The reason being is that when self-injurious behavior occurs at a young age it can be a sign of autism spectrum disorder, early onset of schizophrenia, or severe bipolar disorder (Devine, 2014). When the age of onset is during adolescents, the cause or reasoning behind the decision to inflict a wonder to one's self is very different than that of a five year old because social expectations, societal limitations, and disturbance in emotion; not to mention that massive chemical change that adolescence naturally go through. Late onset of self-injurious behavior can also help define the individual case. Later onset of self-injurious behavior can have different ramifications as well impart due to depression or borderline personality disorder. Thus, it can be very difficult to have an exact definition of self-stimulation because the range of age, onset, prevalence, characteristics, and warning signs are all different and vary case to case to the individual's needs and exceptionalities. And again, self-injurious behavior is impart what society makes of the behavior; not the actual behavior.

CULTURAL ASPECTS OF SELF-INJURIOUS BEHAVIOR

Self-injurious behavior can take on multiple different meanings when looking at self-injury through various cultures, for instance; in America, it is common practice to get a tattoo, or a piercing that suits the individual personality. However, in other cultures, tattoos and piercings are considered self-injurious, like in the case of the Catholic Church who does not condone tattooing of altering the human body in any form. As mentioned earlier, in Indian culture, adolescents frequently and willingly walkover hot coals to prove their manhood. In American culture walking over hot coals does not happen because it is viewed as painful and outlandish. In other cultures in Africa some tribes engage in the use of lip discs. The lip disc stretches the skin outward to make the bottom lip seem larger, and in other tribes they pierce their cheeks or elongate their necks to show importance and socioeconomic classes. In the United States, the aforementioned cultural activities are viewed as painful and different that our societal norms. Under the current definition tissue damage is the main clause to determine self-injurious behavior and stretching of body parts inflict damage on the tissue; thus, is the definition true to all cultures? No, the current, most common definition of self-injurious behavior does not suit all cultural aspects because each culture is unique and has their own set of social norms that are followed for the most part (Iannaccone, Cella, Manzi, Visconti, Manzi, & Cotrufo, 2013). When looking into the individual case, culture should be taken into account before the report is made. This is not to say that smashing ones face into their desk repeatedly is a cultural issue. Moreover, other cultural aspects may be considered to be self-injurious such as drinking alcohol, smoking tobacco, or over eating (Iannaccone et al. 2013).

ETIOLOGY

Self-injurious behavior can take on many forms, but still begs the question of why? There are various factors that contribute to the etiology of self-injurious behaviors that range from biological, neurological, social, behavioral, and physiological reasoning's. A biological factor that may persist with an individual who engages in self-injurious behavior is usually due to a chemical imbalance within the endocrine system. For instance, serotonin in an individual who is self-injurious is not at the same levels as a person who does not engage in self-injurious behavior (Coccaro, Kavoussi, & Hauger, 1997). In fact, serotonin is shown to be at decreased levels when committing the act of self-injury (Coccaro, Kavoussi & Hauger, 1997). When serotonin is at normal levels, acts of aggression or impulsivity are non-self-injurious, and better forms of communication are presented such as throwing items and making vocalizations to communicate rather than engaging in self-injurious behavior (Devine, 2014).

Furthermore, the endorphin level in individuals who engage in self-injurious behavior has been proven to increase (Thompson, Hackerberg, Cerulti, Baker, & Axtell, 1994). With the increased levels of endorphins that are queued to release upon injury; now act as a stimulant such a heroin or morphine to the individual engaging in self-injurious behavior (Thompson et al. 1994). Given the increase in endorphins that are acting upon as analgesic towards the opiate receptors of the individual; it would be a realistic thought to compare self-injurious behavior to drug addiction in which endorphins are attacking opiate receptors to ultimately create euphoric state of mind or numbness.

Moreover, if the case of self-injury in intellectually disabled individuals is sudden; the individual may have an inner ear infection which is causing the individual to repetitively bang their head on a table or desk. Self-injurious behavior may also take place after a seizure in a person who is cognitively disabled and has a seizure disorder (Oliver, Petty, Ruddick, & Bacarese-Hamilton, 2012).

Aside from biological and neurochemical etiology; social and environmental etiology also gives fair analysis of self-injurious behavior. In a social context, an individual may engage in self-injurious behavior to avoid or gain social stimulation (Medeiros, Petty, Ruddick, & Bacarese-Hamilton, 2014). Again, point toward self-injurious behavior as being communication related. Self-injurious behavior may also occur when an individual finds the situation too difficult or frustrating to complete and the only way for the individual to communicate his/her frustration is to engage in self-injurious behavior because it puts the task or assignment off (Medeiros et al. 2014).

NON-SUICIDAL SELF-INJURY (NSSI)

Non-suicidal Self-Injury has become more prevalent within the past ten years. Non-suicidal Self-Injury occurs in about 13-25 percent of adolescents in the United States (Wood & Craigen, 2011). Non-suicidal Self-Injury, being a somewhat new topic can be defined by the International Society for the Study of Self-Injury as "the deliberate, direct, and self-inflicted destruction of body tissue resulting in immediate tissue damage, for purposes not socially sanctioned and without suicidal intent".

By definition the words "socially sanction" is in the definition to protect socially acceptable practices of self-injurious behavior. One such socially acceptable self-injurious behavior is tattooing. When the individual receives excessive amounts of tattoos that action can be deemed socially unacceptable and bring the individual into a category of non-suicidal self-injury. There must be differentiation between excessive and socially acceptable rates of occurrences for non-suicidal self-injury definitive purposes; however, it leaves the question of who or why does society set limits on behavior that an individual chooses to partake in both formal, and informal settings?

The age of onset for individuals that partake in non-suicidal self-injury is typically around the age or onset of puberty. The behavior or warning signs that is most likely to occur before self-injury can be; low self-esteem, difficulty managing feeling, or uneasiness at home school or work. The individual may begin to wear long pants to cover the legs, large diameter bracelets to cover wrist wounds; blouse may become less revealing, and may wear hoodies during spring and summer months (Richardson & Surmitis, 2014). Individuals may also suffer from being depressed or experiencing a life altering event such as a loss of family member to a breakup of relationship (Richardson, 2014). In some cases the individual may feel lonely, and misunderstood by others leaving seemingly little to no one to communicate their issues with; thus resulting in self-injury to relieve their feeling or frustrations from past experiences to daily life events (Richardson, 2014).

The danger of non-suicidal self-injury is that some cases of self-injury may go too far and exceed what was originally intended as a cry for help to a disastrous incident of actual suicide. The issue of non-suicidal self-injury is real, and should be taken seriously as adolescence are experiencing body changes and influx of chemicals that can be difficult for some individuals to handle.

To help the individual is a must and can be done by reporting the individuals behavior to a professional. A professional such as a counselor or psychiatrists can better help a person who is dealing with non-suicidal self-injury (Whisenhunt et al. 2014). Evaluation of non-suicidal self-injury should be completed by a trained professional in mental health. Treatment for individuals who partake in non-suicidal self-injury can range from talks with a counselor, to being admitted to a hospital as an inpatient for better and more localized treatment of the individual case (Whisenhunt et al. 2014).

SELF-INJURIOUS BEHAVIOR AMONG INTELLECTUALLY DISABLED

Self-injurious behavior among intellectually disabled people is prevenient. The range of people who engage in self-injurious behavior is 8 to 23 percent among mentally disabled (Kauffman & Landrum, 2013, p.320). Higher rates have been found in more severe and profound cases of intellectual disabilities around 36 percent of mentally disabled individuals (Kauffman & Landrum, 2013, p.320). It is important to understand that not every individual with intellectual disabilities participates in self-injurious behavior, but it can be a warning sign to parents for early intervention.

Self-injurious behavior among intellectually disabled can be different from non-suicidal self-injury because in many cases the individual does not know or is participating in self-injurious behavior due to stereotypy, and self-stimulation (Richards, Oliver, Nelson, & Moss, 2012). Some common forms of self-injurious behavior that occur with mentally disabled individuals can be, but are not limited to face punching/slapping, scratching, pinching, gouging, rumination, vomiting, mouthing, and pica can be exhibited (Cooper et al. 2009). Pica is a severe condition that involves the consumption of nonedible objects or substances (Kauffman & Landrum, 2013, p. 321). The behavior exhibited can be brought about by environmental conditions, behavior limitations, psychiatric conditions, or medical conditions. The aforementioned reasons for self-injurious behavior among intellectually disabled can be comorbid; meaning that two or more conditions can contribute to self-injurious behavior (Cooper et al. 2009).

Environmental factors can trigger self-injurious behavior (Oliver, Petty, Ruddick, & Bacarese-Hamilton, 2012). The environment that an individual feels uncomfortable in or fearful of may trigger self-injury as a means to escape reality or as a coping method (Oliver et al. 2012). The individual partakes in self-injurious behavior may have a trigger that involves hunger; thus, if an individual is hungry and enters an establishment where a person is eating food, said person may engage in self-injury. Self-injury can also be brought on by lack of sleep, and demands made in the environment itself (Jensen et al. 2012).

Behavior limitations can also give way to self-injurious behavior. In the case of behavior and self-injury an individual may engage in self-injurious behavior for attention from others (Jensen et al. 2012). In other cases, individuals may become self-injurious to avoid certain tasks or activities. Moreover, communication and self-stimulation may be the cause of self-injurious behavior (Jensen et al. 2012).

Communication for students who are non-verbal and in some cases non-ambulatory is lacking communication skills to express their thoughts, feelings, pain, and joys (Peebles & Price 2012). Lack of communication skills can be extremely frustrating to normal functioning individuals, but to individuals who are severely disabled the lack of communication can be unbearable. Lack of communication can result in self-injurious behavior as a form of communication (Peebles & Price, 2012). For example, a student who is hungry, but cannot communicate this issue, the individual may begin to bite his or her hand to signify hunger, or communicate frustration.

Individuals with severe intellectual or comorbid disabilities self-stimulation or stereotypy may become self-injurious if the behavior is persistent, at a high rate, and is causing tissue damage. Self-stimulation may be exhibited by repeated rocking of the trunk, hand flapping, eye poking, and mouthing; nevertheless, the behaviors mentioned are not set parameters and can include a variety of other self-stimulating or stereotypy that is pectinate to the individual needs. Stereotypy or self-stimulation can be induced in intellectually disabled individuals for a sense of sensation or self-fulfillment (Medeiros, Petty, Ruddick & Bacarese-Hamilton, 2014). One reason why individuals engage in stereotypy is out of boredom, or lack of engagement between the individual and their environment or socially (Oliver, Petty, Ruddick & Bacarese-Hamilton, 2012). Thus, all students need to be engaged in a manner that is suitable for them, and their level of learning. Individuals who are blind and have a comorbid disability have a higher rate of stereotypy than other individuals who are not blind and have comorbid exceptionalities (Oliver et al. 2012). Stereotypy should not be changed or altered unless the individual is becoming harmful to their self as stereotypy can bring a sense of relief and stimulation to an individual. The stimulation that an individual receives room stereotypy is mainly sensory. Sensory for individuals with significant cognitive disabilities is great and can keep individuals from engaging in self-injurious behavior by keeping them engaged; although, engaged in themselves.

DIAGNOSIS

Diagnosing self-injurious behavior should be done by a trained professional. Psychiatric professionals may be able to best help parents and individuals with self-injurious behavior. Self-injurious behavior can be a significant sign of multiple personality disorders such as; borderline personality disorder, bipolar disorder, depression, anxiety disorders, and psychoses (Devine, 2014). Thus, enlisting help of a licensed psychiatric professional is best for the individual who suffers from self-injurious behavior. Nevertheless, educators can help collected data to provide to a trained professional who is diagnosing or figuring out medication dosages. Educators are not psychiatric professional; so, we cannot diagnose a student with self-injurious behavior, but we can observe rate, intensity, and environmental factors that may be inducing self-injury. Educators can also collected data when an individual receives new medication or their medication levels are being adjusted in order to help the individuals diagnosing doctor.

TREATMENT

Treatment for self-injurious behavior can vary from case to case depending on the severity and intensity of the behavior exhibited. The variation of self-injury makes treatment a multimodal task (Kauffman & Landrum, 2013). Using multiple modalities is considered to be the best form of treatment for self-injurious behavior. Nevertheless, treatment should be determined by a trained profession and not an educator. As an educator we can try to regulate and control the behavior but we cannot undergo our own form of treatment for the individual with self-injurious behavior.

Moreover, pharmacological treatments do help combat self-injurious behaviors (Kauffman & Landrum, 2013, p.321). One study by Coccaro et al. (1997) found that Selective Serotonin Re-uptake Inhibitors or SSRI's in high dosages decreased the likelihood of an individual engaging in self-injurious behavior. Another form of pharmacological treatment is the use of Naltrexone which is an opiate antagonist that has been proven to help decrease the rate of self-injurious behavior (Buzan, Thomas, Dubovsky, & Treadway, 1995).

More specifically, Naltrexone is most useful in decreasing stereotypy behaviors in children with severe intellectual disabilities and individuals who are covered by Autism Spectrum Disorder (Buzan et al. 1995). To further help individuals with self-injurious behavior individuals may benefit from Anti-psychotic remedies to withdraw the individual's engagement in self-injury (Devine, 2014). Some anti-psychotic medication that has been studied are as follows: Clozapine, Risperidone, Olanzapine, and Fluphenazine (Buzan, Thomas, Dubovsky, & Treadway, 1995). Other forms of pharmacological treatments may involve the following medications; Lithium, Carbamazepine, Beta Blockers, Baclofen, Stimulants, Clonidine, and Amantadine. Again, a multiple modality approach is best for self-injurious behavior. More than one medication may be employed to help decrease self-injury.

There are other treatments that do not use pharmaceuticals that are the basis for eliminating self-injurious behavior. One such approach is ECT or Electroconvulsive Therapy. Electroconvulsive therapy has been shown to decrease the rate of self-injurious behavior substantially decreased at a quicker rate than medication (Jones, 2001). Electroconvulsive therapy is usually reserved for severe self-injurious behavior that includes castrations and eye enucleation (Jones, 2001).

Another approach that is non-pharmacological is Cognitive Behavioral Therapy which can help the individual mange feelings of frustrations, anger, impulsivity, and aggression by self-control and thought (Sungwoo et al. 2015). Cognitive Behavioral Therapy may include a behavioral chart for the individual to visualize what is occurring, how often, and when.

Another form of Cognitive Behavioral Therapy can be journaling one's own self-thoughts or reflections in order to exit their feelings of aggression, anger, impulsivity, and frustrations (Sungwoo et al. 2015). In education modifying an individual's self-injurious behavior can be achieved by replacing the self-injurious behavior with a behavior that is less abrasive and injury prone.

Social or interpersonal training is another approach to build positive behavior supports when interacting with peers. Social training for individuals who are self-injurious can be crucial as some individuals engage in self-injury for escape or fears of a social situation (Wood & Craigen, 2001). Moreover, building social skills can help form relationships among peers in school and in their communities.

IMPLEMENTATIONS FOR EDUCATOR WHERE SIBS AND ID ARE COMORBID

Self-injurious behavior in the educational setting can be abrasive to most educators but there are individuals who are more equipped both mentally and physically than others to engage and educate students who are self-injurious (Jensen et al. 2012). Students who are self-injurious and intellectually disabled do have the intellect to know whether they enjoy a teacher or not. If, a student does not enjoy a teacher they may engage in self-injury simply to escape the classroom, or the teacher. Self-injurious behavior can affect the teacher as well as the student. For example, if a student is consistently poking the side of their neck, long enough to penetrate the dermis and become bloody; how is a teacher to react if they are not trained nor have the mental ability to not be affected by such extreme self-injurious behavior? Thus, the teacher is the first line of defense to combat self-injurious behavior in school settings (Jensen et al. 2012).

Students who engage in self-injurious behavior can be difficult to teach or engage in some cases. This does however mean that the teacher must engage the student in a consistent and positive manor. Students who are self-injurious need a rigorous diet of academics that suits their learning needs. If the academics that are being taught become frustrating, boring, or unrealistic the student may engage in self-injurious behavior (Cooper et al. 2009).

When students engage in self-injurious behavior, teachers can look for signs of anger, frustration, disliked peers or staff, and pain. Nevertheless, the teacher must begin to collect data on the behavior exhibited. The data collected can benefit both the student and teacher for the simple reason that the antecedent or trigger can be found to help determine when and why the student engages in self-injurious behavior. Data collection and self-injurious behavior should go hand and hand, but can be difficult to maintain because of various other tasks that can make a teacher feel inundated with testing and work. Nevertheless, consistent and concise data collection must take place for the benefit the students' needs and wants.

Data can also be collected on rate and intensity. The data collected on rate and intensity can help teachers gain knowledge of the student to see whether the student is impulsive or consistent with their behaviors (Kauffman & Landrum, 2013, p. 303). If, the data is conclusive to impulsivity then the teacher's tactics and implementations may change depending on the individual. The teacher who is working with a student who is impulsive and self-injurious may want to engage the student frequently and in their preferred environment (Kauffman & Landrum, 2013, p.180).

Changing self-injurious behavior can be difficult, if not impossible to get the individual to completely subside the exhibited behavior because the behavior may elicit a drug like effects on opiate receptors, or the behavior give way for stimulation that they may have engaged in since the individual was a toddler (Thompson, Hackerberg, Cerulti, Baker & Axtell, 1994). In some cases, stopping or correcting self-injurious behavior is not in the best interest for the student, but for the educator that finds the behavior disgusting or repulsive (Cooper et al.,2009).

Thus, if the behavior is only bothering the society members and is impeding on the individuals daily regimen or health then the behavior should be left alone; even if, school officials find the behavior morally unacceptable or repulsive because to that student who engages in self-injurious behavior it may be their only form of communication that they are able to grasp or formulate. The notion of changing a self-injurious behavior solely on the basis that the staff members are disgusted by it only brings us back to societal and cultural morals and beliefs on what is a social norm versus what is frowned upon by the surrounding culture in lieu of the individual's self-injurious behavior.

FUNCTIONAL BEHAVIOR ASSESSMENT

Furthermore, data collection will become most useful when conducting a Functional Behavior Assessment or FBA and later used to implement a Behavior Intervention Plan or BIP. A Functional Behavior Assessment should be conducted once the behavior is noticed by the educator or parent, or is apparent and is causing distress to the individuals tissue (Sungwoo et al. 2015). Data collection for a Functional Behavior Assessment should be clear and concise to help the Individual Education Plan team decide on why, when, and where the behavior is being exhibited. An FBA should be a comprehensive assessment of the individual's behavior (Sungwoo et al. 2015). Functional Behavior Assessment should contain information that is relevant to the student and their behavior. The data collected should be pectinate and without individual opinion to ensure that there are no biased conclusions to the behavior.

BEHAVIOR INTERVENTION PLAN

After a Functional Behavior Assessment has been completed by the IEP team the teacher, parents, and others who encounter the individual must implement the Behavior Intervention Plan which follows the data collected for the FBA. Following a Behavior Intervention Plan can be difficult for some parents to follow once a week, and there are other parents who are fully ready to engage in a routine regimen in order to help decrease the behavior. In some cases a Behavior Intervention Plan may not be needed if the Functional Behavior Assessment is completed and comprehensive. Nevertheless, for educators, the BIP must be followed stringently in order to see the best results and to accurately know if the hypothesized reason for the behavior is actually correct, or if modifications need to be corrected on the FBA/BIP.

Moreover, data should still be collected regardless if there is a FBA/BIP implemented or if there is not a FBA/BIP. The reason being is that the student's behavior may begin to change during the course of the Behavior Intervention Plan for the better or for the worst. If, behaviors are changing as a result of the Behavior Intervention Plan then the teacher and IEP team need to document what techniques, queues, environmental settings, and personnel the student works better with or in to keep the BIP updated and consistent with the students exhibited behaviors.

IMPLEMENTATIONS FOR EDUCATORS: NSSI

As self-injurious behavior varies in degree, style, reasoning, age, and gender it is imperative that teachers of students who are in both regular education classes and special education classes know the warning signs of suicide or non-suicidal self-injury because both populations have some of the same social, learning, and home life misfortunes that can seriously depress a student (Richardson & Surmitis, 2014). Teachers need to be aware of possible warning signs of non-suicide self-injury that were previously mentioned. Students who engage in non-suicidal self-injury are still at risk for suicide by mistake or otherwise (Wood & Craigen 2011). Thus, the teacher must be aware that self-injury can happen across many different realms of individual from multiple backgrounds and childhood experiences and is not simply a disorder that is prevalent is Autism Spectrum Disorder. Some signs of potential suicide can be as follows; drawing of graves, giving objects away, planning has taken place, recent rejection by peers, family, boyfriend, or girlfriend, saying "you won't be seeing me around", or talking philosophy of life, and studying famous individuals who have committed suicide (Richardson & Surmitis, 2014).

Non-suicidal self-injury among youth that normal functioning and those who are functioning above a 70 IQ are more prone to feel social stressors that can lead to non-suicidal self-injury as a result of the individual not being able to communicate their emotions effectively and efficiently to help relieve some of life's stressors (Whisenhunt et al. 2014).

Educators must be in tune with their students and know if the student is having an off day or is wearing a nice wide width bracelet when that student never has worn a bracelet to the teacher's classroom. Along with effective teaching, a teacher must be observant of their students in almost every aspect such as; the way they dress, new apparel, facial expressions, tone of voice, eye movements, friends, family situations, boyfriend/girlfriend, and if various things happen, when did they happen?

Students who engage in non-suicidal self-injury are usually normal functioning students and even adults in and out of college (Richards & Surmitis, 2012). Educators of students who engage in non-suicidal self-injury must be aware of various difficulties in life that a student might have difficulties with. For instance, when a student is dating, and there becomes a breakup later down the road; the student or students may not know how to handle their emotions because they have never experienced them before or have had good parental role models to show them how to deal with a stressful situation. Nevertheless, not all students will handle the situation the same, but for some there can be extreme difficulties when handling a breakup. This issue can be compounded if the student has lost a loved one before to divorce or breakup of parents.

Students who exhibit signs of non-suicidal self-injury should be placed on a Behavior Intervention Plan after a comprehensive Functional Behavior Assessment has been completed by the IEP, assuming that the student is in special education. However, if the student is not in special education, then he or she should be referred to the counselor or school phycologist for further evaluation by a trained and licensed professional.

There is significant danger for individuals who engage in non-suicidal self-injury. The intention to engage in non-suicidal elf-injury may not begin as a deadly thought, but if the student engages at a high rate, or penetrate too deep into their tissue they may commit suicide without the true intention of suicide. Thus, teacher need to be proactive when looking for warning signs, or gathering information for parents on what to look out for and what are some signs of non-suicidal self-injury in adolescents, teens, and adults.

CONCLUDING REMARKS

Self-injurious behavior should not be taken lightly; whether, the student has intellectual exceptionalities, or if the student is a normal functioning student in the regular education setting. Teachers need to be observant of students who may be at risk to engage in self-injury. A teacher may be the last person they talk to before they commit non-suicidal self-injury to try to gain some evidence that a person cares for said individual. The teacher must take time to build and foster strong relationships with their students in hope to stop or slow self-injurious behavior.

Staff and teachers who work with students who are on the other side of the self-injury spectrum and working with students who are intellectually disabled, or autistic need to stand up for their child's behavior. Therefore, students who have severe mental and cognitive exceptionalities need to have a teacher who is willing to look past the bad comments and enlighten other teachers about the activities that the individual is engaging in, and why he or she is engaging in self-injurious behavior because some teacher are not sure about appropriate placement.

Furthermore, work needs to be done for students who are self-injurious and in the classroom. Some students need more help than a single teacher and staffed classroom can give them in a classroom with five other students. Students who are self-injurious need to have peer relations and time in their community and if they do not get social or community interaction then we are simply leaving the student to engage in their own form of stimulation by way of stereotypy movements, or self-injurious behavior (Oliver, Petty, Ruddick & Bacarese-Hamilton, 2012).

REFERENCES

1) Buzan, R. D., Thomas, M., Dubovsky, S. L., & Treadway, J. (1995). The use of opiate antagonists for recurrent self-injurious behavior. *Journal of Neuropsychiatry and Clinical Neurosciences, 7(4),* 437-444
2) Coccaro, E. F., Kavoussi, R. J., & Hauger, R. L. (1997b). Serotonin function and antiaggressive response to fluoxetine: a pilot study. *Biological Psychiatry, 42(7),* 546-552
3) Cooper, S., Smiley, E., Allan, L. M., Jackson, A., Finlayson, J., Mantry, D., & Morrison, J. (2009). Adults with intellectual disabilities: prevalence, incidence and remission of self-injurious behaviour, and related factors. *Journal Of Intellectual Disability Research*, *53*(3), 200-216. doi:10.1111/j.1365-2788.2008.01060.x
4) Devine, D. (2014). Self-injurious behaviour in autistic children: a neuro-developmental theory of social and environmental isolation. *Psychopharmacology*, *231*(6), 979-997. Doi: 10.1007/s00213-013-3279-2.
5) Iannaccone, M., Cella, S., Manzi, S. A., Visconti, L., Manzi, F., & Cotrufo, P. (January 01, 2013). My body and me: self-injurious behaviors and body modifications in eating disorders--preliminary results. *Eating Disorders, 21,* 2, 130-9.
6) Jensen, C. C., Lydersen, T., Johnson, P. R., Weiss, S. R., Marconi, M. R., Cleave, M. L., & Weber, P. (2012). Choosing Staff Members Reduces Time in Mechanical Restraint Due to Self-Injurious Behaviour and Requesting Restraint. *Journal Of Applied Research In Intellectual Disabilities*, *25*(3), 282-287. doi:10.1111/j.1468-3148.2011.00664.x
7) Jones, A.B. (2001). Self-injurious behavior in children and adolescents, Part II: Now what? The treatment of SIB, KidsPeace Healing Magazine
8) Kauffman, J., & Landrum, T. (2013). *Characteristics of emotional and behavioral disorders of children and youth* (10th ed.). Boston: Pearson Education.
9) Mark: 5:2-5. (1898). In *The Holy Bible, containing the Old and New Testiments;*. New York: Oxford University Press, American branch.

10) Medeiros, K., Petty, J., Ruddick, L., & Bacarese-Hamilton, D. J. (2014). Functional properties of behaviour problems depending on level of intellectual disability. *Journal of Intellectual Disability Research*, *58*(2), 151-161. doi:10.1111/jir.12025
11) Oliver, C., Petty, J., Ruddick, L., & Bacarese-Hamilton, M. (2012). The Association between Repetitive, Self-Injurious and Aggressive Behavior in Children with Severe Intellectual Disability. *Journal of Autism & Developmental Disorders*, *42*(6), 910-919. doi:10.1007/s10803-011-1320-z
12) Peebles, K. A., & Price, T. J. (2012). Self-injurious behaviour in intellectual disability syndromes: evidence for aberrant pain signaling as a contributing factor. *Journal of Intellectual Disability Research*, *56*(5), 441-452. doi:10.1111/j.1365-2788.2011.01484.x
13) Richards, C., Oliver, C., Nelson, L., & Moss, J. (2012). Self-injurious behaviour in individuals with autism spectrum disorder and intellectual disability. *Journal of Intellectual Disability Research*, *56*(5), 476-489. doi:10.1111/j.1365-2788.2012.01537.x
14) Richardson, B. G., & Surmitis, K. A. (2014). Responding to the rise in self-injury among youth. *Counseling Today*, *57*(5), 40-45.
15) Sungwoo, K., Hausman, N. L., Fisher, A. B., Donaldson, J. M., Cox, J. R., Lugo, M., & Wiskow, K. M. (2015). The saftey of functional analysis of self-injurious behavior. *Journal of Applied Behavior Analysis, 48*(1), 107-114.doi: 10.1002/jaba.168
16) Thompson, T., Hackerberg, T., Cerulti, D., Baker, D., Axtell, S. (1994), Opioid Antagonist Effects on Self-Injury in Adults with Mental Retardation. American Journal on Mental Retardation, 49: 85-102.
17) Whisenhunt, J. L., Chang, C. Y., Brack, G. L., Orr, J., Adams, L. G., Paige, M. R., &... O'Hara, C. (2014). Professional Counselors' Conceptualizations of the Relationship between Suicide and Self-Injury. *Journal of Mental Health Counseling*, *36*(3), 263-282.
18) Wood, S. M., & Craigen, L. M. (2011). Self-Injurious Behavior in Gifted and Talented Youth: What Every Educator Should Know. *Journal for The Education Of The Gifted*, *34*(6), 839-859. doi:10.1177/016235321 1424989