SiOS
Self-injury Outreach & Support

A GUIDE FOR MENTAL HEALTH PROFESSIONALS

Contents:

Definition of non-suicidal self-injury

Non-suicidal self-injury (NSSI) is the deliberate and direct destruction of one's body tissue, without suicidal intent and for reasons that are not socially sanctioned. This definition excludes tattooing, piercing, and indirect harm such as substance abuse or eating disorders.

NSSI should also be distinguished from self-injurious behavior (SIB) that is commonly seen among individuals with intellectual and developmental disabilities (e.g. repetitive stereotyped head-banging).

Self-Injury Methods

The most common methods of NSSI include cutting, burning, scratching, and bruising. These injuries can range from superficial to moderate. Extreme body mutilation such as amputation is generally excluded from the definition.

Prevalence

Although any one at any age may begin to engage in NSSI, the most common age of onset for NSSI is early adolescence. Between 14 to 24% of adolescents and about 4% of adults in the community report engaging in NSSI at least once in their life. This range is between 60 and 80% in clinical samples. Recent research indicates that there is little to no sex difference in prevalence of NSSI in community samples. However, in clinical samples NSSI is more prevalent in females.

Individuals who engage in NSSI may injure themselves repetitively, with increasing severity, and may use different methods over time. The behavior can also occur on a more episodic basis with repetitions occurring during high stress periods.

Approximately 14-24% of youth or young adults have engaged in self-injury at least once. About one quarter of those have done it many times.

University of Guelph | McGill

SiOS
Self-injury Outreach & Support

Functions of non-suicidal self-injury

Different people self-injure for different reasons, and it is important to consider each individual's unique NSSI experiences when working with someone who self-injures. Overall, research has shown that reasons for NSSI tend to fall within two different categories: intrapersonal (reasons related to the individual) and interpersonal (reasons related to other people or external situations).

Emotion Regulation

Although NSSI serves a variety of reasons, the most frequently reported function is emotion regulation. In this case, NSSI is used by an individual to cope with difficult feelings (e.g., distress, anxiety, stress, sadness). In a review of the literature, all studies examining NSSI functions found strong empirical support for NSSI's use as a means to regulate aversive emotions. These studies included clinical and community samples of participants with a mean age ranging from 15 to 37 years.

Reports from individuals who use NSSI as a means to cope with overwhelming feelings, and to regulate otherwise unmanageable emotions, suggests a specific pattern to NSSI. Specifically, before the individual self-injures, he or she experiences acute negative affect. Following the injury, the individual reports feeling relief.

Other Functions

Other NSSI reasons have been empirically supported by research. These include, but are not limited to: self-punishment, communicating feelings, to avoid acting on thoughts or urges related to suicide, or to end a feeling of dissociation or numbness.

Some individuals may self-injure for more than one reason. Indeed, multiple reasons for self-injury often co-exist; additionally, some individuals may begin to self-injure for one reason, but repeat the behavior for an entirely different one.

Although NSSI serves a variety of functions, the most frequently reported function is emotion regulation.

SiOS
Self-injury Outreach & Support

Co-occurring Mental Health Issues

Although NSSI may indicate an individual has a mental illness (e.g., major depression, anorexia, PTSD), not all people who self-injure have a mental illness; most, however, have mental health difficulties.

Studies of community samples have shown that the issue most commonly co-occurring with NSSI is suicidality. Of individuals who engage in NSSI, 21 to 41% report having attempted suicide at some point in their lives. These rates are much higher in outpatient samples (57 to 59%) and inpatient samples (70 to 74%). This does not necessarily mean that individuals who self-injure are also making concurrent suicide attempts; it does, however, highlight that individuals who self-injure are likely to have had suicidal thoughts and/or actions at some point, past or present.

NSSI has often been associated with borderline personality disorder (BPD). However, a growing body of research indicates that while many individuals who have a diagnosis of BPD do self-injure, a large number of individuals who self-injure do not have a diagnosis of BPD.

Major depression also frequently co-occurs with NSSI. Knowing specifically that there is a diagnosis of comorbid depression, allows the clinician to tailor his/her intervention for the client.

In addition, substance abuse is also reported to co-occur with NSSI. For those that do, a client may use substances to manage negative emotions in one context, and NSSI to deal with similar emotions in another. Co-occurring substance abuse may also lower inhibitions and this might lead to a greater likelihood to injure when urges arise. This may also lead to more severe injuries due to dampened pain.

Finally, individuals with post-traumatic stress disorder (PTSD) may be likely to engage in NSSI as a means to manage the traumatic stress inherent in this disorder.

In summary, NSSI may occur with a variety of mental illnesses including, but not limited to, those mentioned above. This highlights the importance of a comprehensive assessment.

Although NSSI may indicate an individual has a mental illness not all people who self-injure have a mental illness; most, however, have mental health difficulties.

SiOS
Self-injury Outreach & Support

Building Rapport

A strong rapport and collaborative alliance with a client who self-injures is essential for both accurate assessment and effective management of the behavior.

Reacting to NSSI

When individuals who self-injure confide in others about their behavior, they may be faced with a wide range of reactions. Friends and family may react negatively; common reactions include the expression of negative feelings toward NSSI, discomfort, or even horror. Therefore, it is essential to begin to build rapport starting with your initial reaction to NSSI.

If a mental health professional expresses negative feelings regarding NSSI, the client may feel less comfortable talking about it. He or she may not share important information, or may avoid dealing with the subject altogether. In addition, if a mental health professional seems overly interested in a client's NSSI, two consequences may occur. First, the professional may inadvertently reinforce, or support, the behavior. Alternatively, the client may feel an increased urge to self-injure.

Although effusive expressions of support may seem warranted and stem from genuine concern, in some cases, this may reinforce the behavior. As such, a more balanced supportive approach is recommended – one that conveys genuine concern but in a calm manner.

The recommended interpersonal approach to work with clients who self-injure is to adopt a "low-key, dispassionate demeanor."

The purpose of this method, recommended by NSSI treatment expert Dr. Barent Walsh, is to convey genuine interest in understanding your client's NSSI experiences in a way that is respectful and curious, yet neutral and calm. It may be useful to adopt the client's own language with respect to his/her NSSI and address the subject in a way that defers to the client's expertise of their personal experience with NSSI. In addition, guidelines for NSSI assessment also suggest clinicians adopt a respectful curiosity which conveys a genuine interest in wanting to understand the client's perspective about his/her experiences.

The recommended interpersonal approach to work with clients who self-injure is to adopt a "low-key, dispassionate demeanor."

University of Guelph
McGill

SiOS
Self-injury Outreach & Support

Stages of Assessment

Once rapport has been established and the client has been informed about the limits of confidentiality, a comprehensive NSSI assessment can be conducted. The following section, adapted from Nixon and Heath, highlights the basic stages of assessment and can be used as an outline for assessing a client's NSSI behavior.

Stage 1: Triage

The first stage of assessment should consist of a **suicide risk assessment** (see below). Additionally, the professional should assess the **severity or type of injury** in order to determine the client's level of risk to self. Finally, this stage should include an **assessment of co-occurring mental health issues**. A client who self-injures and who has other mental health difficulties may be at greater risk than one who only self-injures. If a client is high-risk, the professional may decide to refer the client to medical or inpatient services. If not, the professional can move to the next stage of assessment.

Stage 2: Basic Assessment for Intervention

The goal of this stage is to determine the **scope, severity, and functions** of the client's NSSI. Important information to collect includes: the **history of NSSI** (methods, age of onset, frequency, most recent occurrence, severity of wounds), the **context** in which the client self-injures (external environment, cognitions, emotional state, biological factors), and the **reasons** the client gives for self-injuring. It is recommended that a weekly functional assessment be used which records the: (a) events/interactions, thoughts, and feelings that preceded NSSI episodes, (b) the events/interactions, thoughts and feelings during NSSI episodes (or what happened if NSSI did not occur), and the (c) events/interactions, thoughts, and feelings following the NSSI episode.

Stage 3: Comprehensive Assessment

The purpose of a comprehensive assessment is to determine all **predisposing, precipitating, perpetuating,** and **protective** factors. This can be conducted by a professional with experience in this area or by a case management team. Standardized assessment measures, such as the Inventory of Statements about Self-injury (ISAS) and Self-injury Thoughts and Behavior Inventory (SITBI), can help to guide a more comprehensive and thorough assessment of NSSI features, history, and functions. References for these measures are provided below.

Suicidality

It may be comforting to the client if you convey your understanding that NSSI is distinct from suicide. Although NSSI and suicide are distinct, NSSI may still elevate suicide risk and many who self-injure think about suicide. A client who self-injures and indicates suicide risk should be considered high-risk, which merits appropriate safety planning measures in line with professional, legal, and workplace policies.

SiOS
Self-injury Outreach & Support

Empirically-informed Treatment

NSSI is often used as a coping mechanism to deal with negative thoughts and feelings. Treatment for NSSI can be effective when these underlying reasons are addressed, and when the client is motivated to change their behavior.

Cognitive Behavior Therapy (CBT):

The use of CBT with clients who self-injure focuses on: a) fostering more adaptive coping strategies when stress occurs and b) modifying negative thinking styles that may perpetuate NSSI (e.g., negative self-views). This also involves consideration of thoughts individuals have about NSSI itself (e.g., viewing it as effective or as something that has to be done to cope with distress). The use of CBT has demonstrated effectiveness for NSSI (see references below).

Motivational Interviewing:

Research has also indicated promise for Motivational Interviewing (MI) as a means to manage NSSI. MI may be particularly useful as many clients who self-injure may be ambivalent about stopping NSSI. MI has been used to manage a number of other behaviors including alcohol and drug abuse.

Specifically, MI involves exploring both the advantages and potential disadvantages of the behavior (i.e., NSSI) in order to provide a safe, empathic atmosphere conducive to facilitating a readiness to change on the part of the client. This includes fostering a desire and ability to change.

Dialectical Behavior Therapy (DBT):

DBT is an advanced form of CBT. In addition to targeting maladaptive thinking, it includes enhancing emotion regulation and fosters adaptive coping strategies through several key components, including:

1. Mindfulness: Fosters the ability to remain grounded in the present as well as decrease rumination and self-judgment by fostering moment-to-moment awareness. This allows the client to let go of self-directed negative feelings.

2. Distress tolerance: Includes developing the ability to tolerate negative emotions or distress with a focus on skills to manage stressful situations.

3. Emotion regulation: Involves focusing on the emotions being experienced and processing and/or modifying one's own emotional reactions. In addition, this may include teaching clients how to cope with distress in the moment through distraction techniques.

4. Interpersonal effectiveness: Aims to help the client improve their communication and interaction with others, including the communication of emotional experiences to others.

SiOS
Self-injury Outreach & Support

References & Additional Resources

Scientific Articles/Chapters

Glenn, C. R., & Klonsky, D. E (2009). Social context during non-suicidal self-injury indicates suicide risk. *Personality and Individual Differences, 46,* 25-29.

Klonsky, E.D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27,* 226-239.

Klonsky, D.E., Muehlenkamp, J.J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology, 63*(11),1045-1056. doi: 10.1002/jclp.20412

Klonsky, E.D. (2009). The functions of self-injury in young adults who cut themselves: Clarifying the evidence for affect-regulation. *Psychiatry Research, 166,* 260.

Lewis, S. P., Heath, N. L., St. Denis, J. M., & Noble, R. (2011a). The scope of non-suicidal self- injury on YouTube. *Pediatrics. 127,* e552-e557. doi:10.1542/peds.2010-2317.

Muehlenkamp, J. J., & Gutierrez, P. M. (2007). Risk for suicide attempts among adolescents who engage in non-suicidal self-injury. *Archives of Suicide Research, 11,* 69–82.

Nock, M. K., & Prinstein, M. J. (2004). A functional approach to the assessment of self-mutilative behavior. *Journal of Consulting and Clinical Psychology, 72,* 885–890.

Nock, M. K., & Prinstein, M. J. (2005). Contextual features and behavioral functions of self-mutilation among adolescents. *Journal of Abnormal Psychology, 114*, 140–146.

Nock, M. K., Joiner, T. E., Gordon, K. H., Lloyd-Richardson, E., & Prinstein, M. J. (2006). Nonsuicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry Research, 144,* 65–72.

Nock, M.K. (2009) U*nderstanding non-suicidal self-injury: Origins, assessment, and treatment.* Washington, DC: American Psychological Association.

Nock, M.K. (2009). Why do people hurt themselves? New insights into the nature and functions of non-suicidal self-injury. *Current Directions in Psychological Science, 18,* 78-83.

Ross, S., & Heath, N. L. (2002).A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence, 31,* 67–77.

Whitlock, J.L, Eckenrode, J. & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics, 117,* 1939-1941

University of Guelph

McGill

SiOS
Self-injury Outreach & Support

References & Additional Resources

References to Assessment Measures

Inventory of Statements about Self-injury

Klonsky, E. D., & Glenn, C. R. (2009). Assessing the functions of non-suicidal self-injury: Psychometric properties of the Inventory of Statements about Self-Injury (ISAS). *Journal of Psychopathology and Behavioral Assessment, 31,* 215-219.

Self-injurious Thoughts and Behaviors Interview

Nock, M. K., Holmberg, E. B., Photos, V. I., & Michel, B. D. (2007). The Self-Injurious Thoughts and Behaviors Interview: Development, reliability, and validity in an adolescent sample measure. *Psychological Assessment, 19,* 309-317.

Books

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

Klonsky, E.D. ,Muehlenkamp, J.J., Lewis, S. P. & Walsh, B. (2011). *Non-suicidal self-injury*. Hogrefe & Huber, Cambridge, MA.

Nixon, M. K., & Heath, N. L. (2009). *Self-injury in youth: The essential guide to assessment and intervention.* New York, NY: Routledge Press.

Nock, M.K. *Nonsuicidal self-injury: Definition and classification. Understanding non-suicidal self-injury: Origins, assessment and treatment .* Washington, DC: American Psychological Association.

Walsh, B. W. (2006). *Treating self-injury: A practical guide.* New York: Guilford Press.