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Self-injury Outreach & Support

A GUIDE FOR MEDICAL 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 a quarter of those have done it many times.

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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.

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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.

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Diagnosis & Evaluation

Unfortunately, there are many misconceptions about NSSI; people often assume that it only involves cutting, that only females engage in NSSI, or that it is only associated with specific social cliques, such as 'emo' culture. Because of these myths, NSSI is often overlooked in individuals who do not fit these criteria. NSSI is also frequently misidentified as a suicide attempt, which can lead to conflict and undermine the therapeutic alliance. Accordingly, physician knowledge about NSSI, including its prevalence, can go a long way in its management.

Individuals frequently attempt to hide their NSSI, and may not want to discuss their injuries with their physicians. However, sometimes in routine physical examinations these injuries may become apparent.

A thorough risk assessment helps to distinguish between non-suicidal and suicidal behaviors. Although NSSI is not a suicidal behavior, individuals who engage in NSSI may be at higher risk for suicidality. A risk assessment helps to evaluate current and future risk of suicidality. With the understanding that NSSI and suicide are two distinct concepts, physicians will be better able to determine whether a patient is experiencing suicidal ideation and suicidal intent; this includes planning suicide and whether the client has access to suicide methods (e.g., weapons).

It can be helpful to review standardized measures used to assess NSSI as a guide when working with a client who self-injures. A questionnaire like the Self-Injurious Thoughts and Behaviors Interview (SITBI) can be used as a guide for assessment (reference provided below).

It is important for physicians to assess the severity of the injuries. Although individuals who engage in NSSI are not necessarily doing so for suicidal reasons, they may injure themselves seriously enough to require medical intervention.

Finally, physicians should evaluate whether there are any comorbid mental health issues. Although NSSI is not necessarily an indicator of any one mental illness, as noted above, individuals who engage in NSSI may be suffering from other issues, such as depression, substance abuse, anxiety, eating disorders, or post-traumatic stress disorder (PTSD).

Evaluation

After determining patient safety, including a suicide risk assessment and determining if medical attention is necessary for presenting injuries, it is important to make a referral to appropriate therapy.

NSSI assessment will help to guide referral and intervention. Assessment offers insight into NSSI management and includes examining the patient's history of NSSI (i.e., age of onset, frequency, methods used, severity and location of injuries) and reasons for engaging in NSSI.

This information will be important for tracking the progression of NSSI over time. Individuals that increase their NSSI behaviors may be at elevated risk of suicidality.

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Treatment & Management

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). CBT has demonstrated effectiveness for NSSI (references below).

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. including the communication of emotional experiences to others.

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.

Pharmaceutical Therapy:

Use of pharmacological treatment, such as SSRI/SnRI use, has not demonstrated efficacy as a standalone treatment for NSSI. In some cases, medication may be prescribed to treat a comorbid psychiatric illness (e.g., major depression, GAD). In some cases, this can yield reductions in NSSI as other symptoms remit. For an excellent overview of pharmacological treatment and recommendations for NSSI please consult Plener, Libal and Nixon (2008), listed below.

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References & Additional Resources

References to Assessment Measures

Inventory of Statements about Self-injury

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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.

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The above volume has an excellent guide to pharmaceutical treatment for NSSI by Plener, Libal and Nixon (2008)

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