Treatment for Cutting and Other Nonsuicidal Self-Injury Behaviors

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TREATMENT FOR CUTTING AND OTHER NONSUICIDAL SELF-INJURY BEHAVIORS

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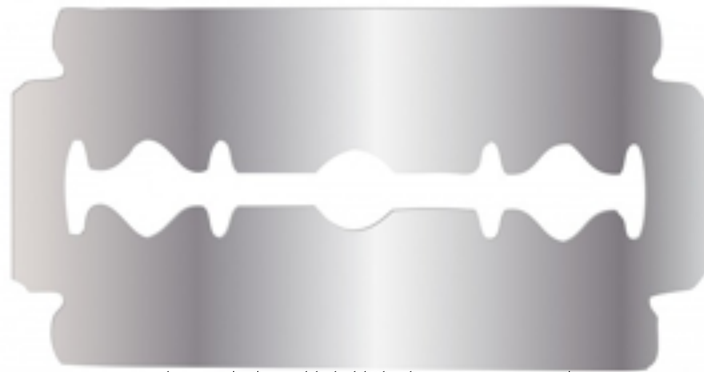
Introduction

This resource is for anyone in the health care field. This includes those in mental health, social work, nurses, physicians, physician assistants, and anyone else that may be part of a health care establishment or working with those that self-injure.

This article examines: the behaviors that are considered nonsuicidal self-injury; the populations that self-injury is most commonly seen in and the reasons for such behaviors; the link between self-injury and suicide; and how to measure and treat nonsuicidal self-injury behaviors.



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What Is Nonsuicidal Self-Injury?

Nonsuicidal self-injury (NSSI) is "the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned."[1] "'Not socially sanctioned' is important because it implies that behaviors

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such as tattooing and piercings are not technically considered nonsuicidal self injury - although excessive tattooing and piercing may sometimes be harmful and may be undertaken with the same intentions."[2] "Self-injury is differentiated from the stereotypical self-injurious behaviors seen in individuals with mental retardation, and from severe forms of self-mutilation such as limb amputation seen in psychotic individuals."[3]

Although this behavior has now been officially labeled as *nonsuicidal self-injury*, in the past is has been referred to by many different descriptions, such as:

- Deliberate self-harm[4]
- Cutting[1]
- Self-mutilation[1]
- Self-inflicted violence[1]
- Self-injurious behavior[1]
- Self-injury[1]
- Self-wounding[3]
- Parasuicide[3]
- Self-abuse[5]
- Self-harm[6]

Nonsuicidal self-injury has become the subscribed to term, not only by the health care community, but also by those that participate in these behaviors.

> *Individuals who engage in NSSI have advocated for the use of self-injury in place of self-mutilation, as the latter is deemed pejorative and possibly stigmatizing - a sentiment echoed by several clinicians and researchers. Unlike self-mutilation, the term deliberate self-harm does not connote a severe or possibly permanent behavior. However, while the definition of deliberate self-harm includes NSSI (e.g., cutting, burning), it is much broader, and encompasses behaviors that do not necessarily involve tissue damage or that are ambiguous in terms of the degree of resulting injury (e.g., overdosing). Deliberate self-harm also includes acts that carry lethal intent (i.e., suicide attempts). Individuals who engage in NSSI, when compared with those who attempt suicide, tend to use more methods (e.g., cutting and burning) and engage in more frequent episodes of the behavior. In this way, using deliberate self-harm synonymously with NSSI is problematic not only conceptually but also empirically, as it impedes meaningful comparisons across studies. Parasuicide (like deliberate self-harm) refers to behaviors that would be considered NSSI (e.g., cutting) but also acts that would not, such as overdosing and suicide attempts. Other terms, including self-abuse and self-inflicted violence also fail to capture the essence of the act being nonsuicidal in nature.[5]*

"NSSI is further divided into subtypes: major NSSI, stereotypic NSSI, and superficial-to-moderate NSSI. Major NSSI includes extreme but rare acts typically observed in severe psychoses (e.g., self-amputation, eye enucleation, and self-castration). Stereotypic NSSI tends to occur quite frequently, tends to not involve the use of an implement, and results in superficial and minor tissue damage. Stereotypic NSSI also tends to occur in the context of a developmental disability or neuropsychiatric disorder. Examples of stereotypic NSSI include repeated head banging and biting of one's tongue or extremities. Finally, superficial-to-moderate NSSI refers to the types of behaviors addressed in the definition provided [and] can be compulsive, episodic, or repetitive. Compulsive NSSI refers to acts that are non-severe and more ritualistic in nature, including hair-pulling. Episodic and repetitive NSSI are similar in the method used (e.g., cutting, burning, or hitting) but differ in terms

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of the act's frequency, with [episodic] occurring a few times in a year and [repetitive] more regularly."[5]

The most common forms of self-injury consist of:[7]

- Cutting
- Scratching
- Carving
- Self-hitting
- Self-burning
- Excoriation of wounds
- Picking
- Abrading
- Banging or punching objects[1]
- Biting oneself[1]
- Scraping[8]
- Self-tattooing[8]
- Bone braking[5]
- Inserting objects under the skin (e.g., safety pins)[6]
- Pulling out one's hair[6]
- Pulling out eyelashes or eyebrows with the overt intention of hurting oneself[2]
- Tearing at cuticles[9]
- Scalding the body[10]

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"Nail biters don't stop until their fingers bleed. Pickers pick and scratch until they damage their skin or inflame old wounds. Cutters always have a razor blade handy to score, mark, or slash their body. Others punch themselves black and blue or burn themselves with cigarettes. Some break bones. Anorexia, or purposeful starvation, is a form of self-injury that can accompany other forms or act as a gateway to further self-abuse. Men and women who severely restrict their diet are perfectionists who can never be perfect. They also try to hide from their feelings, which creates an environment in which cutting and hitting can thrive."[11]

"Many individuals who self-injure use more than one method. Estimates for the average number of lifetime instance of self-injury are variable, ranging from 3.4 to 50."[3] "The most commonly cited methods involve skin cutting, scraping, or carving, which is thought to be engaged in by between 70% and 90% of persons who self-injure. This is followed by banging, bruising, and self-hitting which comprise 21-44% of NSSI episodes, and then burning, which occurs at a rate of 15-35%."[5]

"It is common for those who repeatedly self-injure to have a preferred method and body location."[9] "Most self-injurers harm the extremities or abdomen. Body areas that are rarely harmed and are particularly alarming are face, eyes, breasts in women, and genitals in either sex. Generally, people who injure these body areas are experiencing either psychotic decompensation or some type of trauma-related behavior. Some self-injurers inflict words, symbols, or other patterns on their bodies. Common examples are words like 'hate,' 'pain,' a partner's name, or an inverted crucifix."[7]

"For many self-injurers, the length of a single episode tends to be quite brief, such as a few minutes. Length of episode points to the amount of time it takes to achieve relief. Longer episodes suggest greater levels of distress, and are thereby more concerning."[7]

Risks of Self-Injury:[1]

- *Infection from injuries or sharing implements*
- *Accidental severe injury such as life threatening blood loss or infection*
- *Scars and disfigurement from healed injuries*
- *Worsening shame and guilt, or other painful emotions*
- *An increased risk for suicide*

A New Type Of Self-Injury

Now on the horizon with everything going on-line, there is a new type of self-injury. "'Digital [self-injury],' described as 'teens out there who are self-harassing by 'anonymously' writing mean questions to themselves and then publicly answering them.'"[12]

This phenomenon is also known "as 'Digital Munchausen' because of its resemblance to the psychiatric disorders known as Munchausen's Syndrome and Munchausen Syndrome by Proxy. The Syndrome's central identifying symptom is the patient's infliction of [self-injury] in a quest for sympathy, attention, and admiration for their ability to cope with their (so-called) 'victimization.'"[12]

Who Self-Injures?

"The focus in mental health services as well as in mainstream society has been on girls who cut themselves. However, the world of [self-injury] includes boys, men, and people of all ages, races, and backgrounds. [Self-injury] is not confined to a particular class or culture. People from all economic levels, who perform many different kinds of work, self-injure. The stressors that move people to self-injure are universal, pervasive, and powerful. Anyone who is overwhelmed and unable to find other forms of relief may turn to [self-injury] in the hope of changing their experience. The illusion that the only people who self-injure are very disturbed and incapable of being functional, contributing members of society is just that: an illusion."[10] In fact, "studies have

reported a history of self-injury in 4% of the United States population, 4% of military recruits, and 14% or more of college students."[3]

It is most typical that NSSI first begins between 12 years[13] of age and 16 years[2] of age, however, for those with early onset, NSSI may appear as young as 7 years[9] old, and sometimes even younger. It also may emerge in later adolescence and adulthood, as "studies suggest that well over a quarter of those with self-injury experience report initiating it at 17 years of age or older"[9] and "about a quarter of those reporting self-injury started in the college years."[2]

Population Differences

The prevalence of NSSI varies greatly between the general population, the clinical population, and the incarcerated. "Recent studies have suggested prevalence rates ranging from 12-39% in the general population and as high as 61% in clinically-referred adolescents. This is compared to a rate of 1-4% in the general adult population and up to 21% in a clinical sample of adults."[14] "Studies using community or school-based samples of adolescents and adults report that most people who engage in self-injury do so only a few times (e.g., <10 lifetime episodes), whereas studies using inpatient psychiatric samples report that the majority of self-injurers have engaged in the behavior much more frequently (e.g., average of >50 episodes in the past year)."[6]

Differences Between The Sexes

The difference between male and female NSSI, isn't the prevalence, but is instead the method of self-injury chosen. In one study among college students, "females were more likely to endorse scratching and cutting and report injuries to their wrists, arms, and thighs. Males were more likely to endorse punching objects with the intention of hurting themselves and report hand injuries. The authors suggest that the strategies preferred by males can more easily be explained away as outward-focused aggression which may mask self-injurious intent and support the common misperceptions that self-injury primarily affects females."[1] In addition, males report "more burning, more pain experience, less wound care, less concealing of wounds, social-function (attention-getting), self-hitting, [and] less concern about body disfigurement."[13] Females report "more cutting, more sexual abuse experiences, scored higher on agoraphobic and interpersonal problems measures, more scratching, [and] earlier onset."[13]

Demographic Variables

"The only demographic variable to be significantly linked to NSSI is sexual orientation. Sexual minorities appear to be at higher risk than their heterosexual peers. In fact, youth identifying as bisexual or questioning have been shown to be at significantly elevated risk for self-injury compared to both their heterosexual and homosexual peers. This is particularly true for females."[2]

Co-occurring Disorders

"Though not all individuals who engage in NSSI meet criteria for a mental disorder, NSSI is predictive of a psychiatric diagnosis. NSSI is a diagnostic criterion for borderline personality disorder (BPD) and is also suggestive of bipolar I disorder."[8] Furthermore, NSSI is also seen in "posttraumatic stress disorder [and] schizophrenia."[3] "Clients with anxiety, depression, an eating disorder, or substance abuse are at increased risk of NSSI. Clients who present with NSSI are more likely to have particular personality characteristics including 'harm avoidance,' 'negative emotionality, deficits in emotion skills, and self derogation,' and 'neuroticism and openness to experience.' These deep-seated traits may contribute to initial or chronic NSSI and may in some cases result from attachment disorders or childhood abuse."[8]

Self-Injury In The Prison Population

Although in the general population, there doesn't seem to be a difference between female and male NSSI rates, among the prison population there is a definite difference in rates between the sexes. "According to the Corston Report of 2007, women alone accounted for 46% of [self-injury] incidents while being less than 6% of the total prison population."[4] Another study found that "the absolute risk for [self-injury] during an incarceration [is] 0.5%, [and the risk ratios] for [self-injury] increased sharply with the length of stay in jail, [with the risk ratios being] highest for inmates with [serious mental illnesses] and those aged 18 years or younger. Inmates ever assigned to solitary confinement were 3.2 times as likely to commit an act of [self-injury] per 1000 days [of incarceration] at some time during their incarceration as those never assigned to solitary. These inmates assigned to solitary were 2.1 times as likely to commit acts of [self-injury] during the days that they were actually in solitary confinement and 6.6 times as likely to commit acts of [self-injury] during the days that they were not in solitary confinement, relative to inmates never assigned to solitary confinement. Length of stay in jail, [serious mental illness], solitary confinement, and young age appear to be important and independent predictors of [self-injury] in jail."[15]

Self-injuring "people suffer from serious interpersonal problems that can be aggravated in an incarcerated environment."[4] Those in prison use "it as an attempt to cope with the strains of incarceration [such as] incapacitating living conditions, disturbed relations with fellow prisoners and jail staff, solitary confinement, inconsistent prison rules, delayed justice, fear of losing custody of children, trauma, impulse control problems, dissociation, a need to express anger and frustration, negative life events, guilt, rejection by families, and self-criticism."[4] In one prison study of female inmates, the "majority of the women expressed that they indulged in [self-injury] to release their

anger and inner tension and turmoil; one-third of the group reported that they harmed themselves out of feelings of hopelessness and helplessness. Nearly half of [the female inmates] had begun to harm themselves in jail, lending further support to the view that [self-injury] is a means to rebel against the lack of control over their lives and circumstances during incarceration."[4]

Where Do Those That Self-Injure Get Their Information?

"Young people don't feel comfortable seeking information or support from the places they think they *should* be getting information. Low awareness of helpful information sources can drive young people to potentially 'wrong' sources of information. Conversations with friends are the most common source of information on [self-injury] for young people. Information online, from websites, social media sites, blogs, etc, is second most common."[16] Young people are least comfortable seeking knowledge on self-injury from their parents, which they feel should be one of the top sources of guidance on the topic, and although their friends are the most common source, young people actually are most comfortable finding information on self-injury from 'Google.'[16]

> *Studies on visitors to [self-injury] discussion boards have found that teenagers constitute the majority, which tends to be female. Given the secrecy and shame associated with some types of [self-injury], some communities serve as 'safe spaces' for these individuals to collectively cope, share, and support each other. This may help participants recover, but it may also serve to normalize and thus perpetuate [self-injury] practices. Some argue that reducing the visibility of [self-injury] content is of utmost importance, out of a reasonable but empirically-contested concern that problematic [self-injury] content might encourage new people to engage in [self-injury]. This stems from what is known as the 'Werther Effect,' a term coined by David Phillips that refers to imitation suicides such as those that occurred following the publication of Goethe's first novel, The Sorrows of Young Werther. Copycat suicides are often inspired by the media, which has often been accused of sensationalizing and romanticizing the act of suicide. While little is known about whether or not the media heightens self-injury, concern about the potential effects of this content persists.*[17]

How Is Self-Injury Linked To Suicide?

"Self-injury is not generally meant as a suicide attempt. It is an unhealthy attempt to cope."[1] "Suicide and suicide attempts represent a small share of all acts of [self-injury]"[15] and self-injurers "typically want to live; they just don't know how to live with turbulent emotions."[11] In addition, "very few people (1.4%) [who die by suicide] die by means of cutting, the most common form of self-injury. Moreover, for those that do die, the cutting generally involves cutting the neck and severing the carotid artery or jugular vein. Most self-injurers cut the extremities or abdomen, not the neck. The other forms of self-injury listed above do not appear on the CDC's list of lethal methods. This argues for self-injury being considered a different form of self-harm than suicidal behavior."[7]

Most studies find that self-injury is often used as a means of avoiding suicide. Those who report self-injury without suicidal intent are also more likely than others to report having considered or attempted suicide. Nevertheless, since the majority of individuals (approximately 60%) with self-injury history report never considering suicide, non-suicidal self-injury may be best understood as a symptom of distress that, if unsuccessfully resolved, may lead to suicidal behavior.[9]

With that being said, "one of the most important groups with a high risk of suicide consists of people who present to services following an episode of non-fatal [self-injury]. Indeed, it has been estimated that approximately 50% of all people who kill themselves have a history of [self-injury], an episode having occurred within a year before death in 20% - 25%. It has been suggested that enhanced treatment of those who [self-injure] could help reduce the overall rate of suicide."[18]

In spite of the fact that "individuals who self-injure are generally aiming to feel better, not end life,"[2] "NSSI is the strongest predictor of eventual death by suicide in adolescence [as] risk of suicide increases up to 10-fold for adolescents displaying NSSI."[13] "Individuals with a history of self-injury are at higher risk for suicide thoughts, gestures, and attempts and, because of this, need to be assessed for suicide risk. Even individuals who have ceased practicing self-injury may be at heightened risk for suicidality at a later point in life."[2] "Communication with parents is one of the most important protective factors (and risk factors when absent) in later risk of suicide among individuals with self-injury history."[1]

What Are The Reasons For Self-Injury?

"More and more children and young people are using [self-injury] as a mechanism to cope with the pressures of life. [Self-injury] is often dismissed as merely attention seeking behavior but it's a sign that people are feeling terrible internal pain and are not coping."[16] "There is considerable evidence that most people self-injure to regulate emotional distress and interpersonal relationships. Self-injury is effective in markedly reducing intense feelings of anxiety, anger, sadness, depression, guilt, shame, or even deadness. Internal emotional regulation is the most commonly cited reason for self-injuring. A smaller proportion of self-injurers cite interpersonal motivations such as communicating distress to peers

"In short, self-injury brings peace."[11]

thephoenixcentrewexford.com/self-harm

or regulating distance in relationships. Interpersonal motivations for self-injuring may include a desire to communicate, coerce others, compete with other self-injurers, resolve conflicts, or generate intimacy."[7] "Shame appears to be a critically important emotion in self injury. Individuals who chronically self-injure often view themselves as evil [or] bad and deserving of punishment."[13]

> *[Self-injury,] regardless of the form it takes, is driven by the underlying need for self-regulation, not self-destruction. It helps the person manage intense, seemingly overwhelming feelings, memories, and experiences. It is best understood as an act of self-defense, a behavior used to defend oneself from being consumed by the overwhelming distress of despair, numbness, the re-experiencing of trauma, or other triggers people identify that lead them to [self-injurious behavior. Self-injury] is a way of controlling the internal pressure, deflating the intensity of the feeling, and re-establishing a bearable equilibrium. People living with [self-injury] often feel isolated and lonely, separated from others who would judge them harshly. Both the aftereffects of trauma, as well as the need to cope with self-injury, disconnect one from other people. Subjects with the most severe separation and neglect histories [are] the most self-destructive. Child abuse contributes heavily to the initiation of self-destructive behavior, but the lack of secure attachments maintains it.*[10]

"Self-injury shares many of the risk factors of other negative coping mechanisms: poor family communication, low family warmth, and/or perceived isolation."[2] Moreover, "a clear association between child maltreatment, especially child sexual abuse, and self-injuring has been established."[19] In addition to "a history of childhood abuse, the presence of a mental disorder, poor verbal skills, and an identification with Goth subculture are associated with the presence of self-injury."[6]

> *Unresolved trauma is the single greatest common denominator for people who live with [self-injury, as self-injury] and trauma are inseparable. As varied and different as people living with [self-injury] are, there is always one constant factor in their lives: having a history of some form of trauma in their pasts, often in their childhoods. The traumatic experiences disconnect and disempower the victim. A person who has survived multiple ongoing traumatic experiences in childhood will likely struggle greatly to establish a 'sense of self' in later life. He or she is likely to struggle with personal boundaries, tolerating brutally painful emotions, invasive memories and re-experiencing past trauma, disconnection from self and others, and confusion about meaning and spirituality. [Self-injury] is often used to address many of these intense struggles. It is often described as an 'all-purpose tool' for the management of the lasting wounds of trauma, even though the persons living with it might not be aware of their traumatic histories. Traumatic experiences are based in helplessness. Trauma impacts one's sense of having power and control, of being able to acknowledge and guide internal and external experiences. Control is a crucial issue for many trauma survivors, and it is the thread that runs through the experience of [self-injury]. People who self-injure do so to achieve intentional and deliberate control over their internal experiences. While some state that people self-injure to feel pain, it is much more likely that the person feels no pain at the time of self-injury. People self-injure not to create physical pain, but to soothe profound emotional pain.*[10]

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"Self-injury is also used to:"[9]

- Feel in control over one's body and mind
- Exhibit control over something in their lives[14]
- Express feelings
- Distract oneself from other problems
- Communicate needs
- Create visible and noticeable wounds
- Avoid putting feelings into words[14]
- Reenact a trauma in an attempt to resolve it
- Protect others from one's emotional pain
- Communicate between personalities in those with Dissociative Identity Disorder (formerly known as Multiple Personality Disorder)[10]
- Feel real, get a sense of their physical boundaries[10]
- Diminish intense emotions such as despair, terror, self-hate, rage, shame, or helplessness[10]
- Facilitate dissociation, to disconnect from oneself[10]
- Feel part of a group of peers who self-injure, have a sense of belonging[10]
- Ground oneself when dissociated (feeling as if one's spirit and body are disconnected)[10]
- Stop flashbacks of abuse[10]
- Facilitate remembering[10]
- Punish oneself, especially for talking about abuse or as a consequence of believing that one deserves to be hurt or that it is unacceptable to have needs[10]
- Upset parents[14]
- Symbolize spiritual beliefs[10]
- Purify oneself
- Punish themselves[14]
- Express self-hatred[19]

"Most often, NSSI is performed to alleviate intense and overwhelming negative emotions, and accomplishes this aim more efficiently than alternative behaviors - at least in the short-term."[5]

"There is evidence that NSSI 'spreads' in part through social forces. NSSI is particularly prevalent on high school and university campuses, and is featured in media outlets, such as movies and music, that play important roles in the social lives of adolescents and young adults. There is also a significant presence of NSSI on the Internet, including social networking websites and other popular sites such as YouTube."[5]

> *An integration of results indicates that: (a) acute negative affect precedes self-injury; (b) decreased negative affect and relief are present after self-injury; (c) most self-injurers identify the desire to alleviate negative affect as a reason for self- injuring; and (d) the performance of proxies for self-injury in the laboratory leads to reductions in negative affect and arousal. Several studies also provided strong evidence for a self-punishment function. The anti-dissociation, interpersonal-influence, sensation-seeking, anti-suicide, and interpersonal boundaries functions received modest support. Of note, the general pattern of findings regarding the functions tended to remain consistent, regardless of the type of sample (e.g., non-clinical vs. clinical vs. forensic, adult vs. adolescent, outpatient vs. inpatient, women vs. men).*[3]

Among a study of college students, most "with a history of self-injury, reported using it as a means of regulating their emotions. The study found females were more likely than males to report using self-injury as self-punishment or experiencing an uncontrollable urge to self-injure. Males were more likely than females to use self-injury for sensation-seeking and to self-injure while angry or under the influence of drugs or alcohol. Males were also more likely to engage in self-injury in a social context rather than self-injuring alone."[1]

> *From a functional perspective, self-injury is proposed to be maintained via four possible reinforcement processes. These processes differ according to whether the reinforcement is positive or negative, and whether the consequent events are intrapersonal or interpersonal. As such, self-injury may be maintained by intrapersonal negative reinforcement, in which the behavior is followed by an immediate decrease or cessation of aversive thoughts or feelings (e.g., tension relief, decrease in feelings of anger). Self-injury also may be maintained by intrapersonal positive reinforcement, in which the behavior is followed by the occurrence or increase in desired thoughts or feelings (e.g., self-stimulation, feeling satisfied from having 'punished' oneself). In contrast, self-injury can be maintained by interpersonal positive reinforcement, in which the behavior is followed by the occurrence or increase in a desired social event (e.g., attention, support). Finally, self-injury may be maintained by interpersonal negative reinforcement, in which the behavior is followed by a decrease or cessation of some social event (e.g., peers stop bullying, parents stop fighting). Empirical studies have more systematically examined the reported functions of self-injury using structured interviews and rating scales, and such studies have shown consistently that the motives reported for engaging in self-injury fit closely with the four-function model outlined. Laboratory-based studies have demonstrated that self-injurers show decreased physiological arousal following imaginal exposure to self-injury (i.e., listing to prerecorded scripts of self-injury episodes), supporting the intrapersonal negative reinforcement function. The proposed theoretical model suggests that some people possess intrapersonal and/or interpersonal vulnerability factors that limit their ability to respond to challenging and stressful events in an adaptive way and thus increase the odds of using self-injury, or some other maladaptive behavior, to regulate their affective/cognitive or social experience. Relative to demographically matched controls, people with a recent history of self-injury show intrapersonal vulnerabilities characterized by higher physiological arousal in response to a frustrating task, higher self-*

reported arousal in response to stressful events, greater efforts to suppress aversive thoughts and feelings, and a poorer ability to tolerate experienced distress. They also show the hypothesized interpersonal vulnerabilities, such as poor verbal, communication, and social problem-solving skills. Similar vulnerabilities have been reported among those with other behavior disorders that can be similarly conceptualized as serving affective/ cognitive and social regulation functions, such as eating, drinking, and drug use disorders. This model proposes that these different behaviors are related to self-injury, and to each other, because they represent different forms of behavior that serve the same functions, and as such, likely share vulnerability factors. Although people who engage in self-injury are more likely than non-injurers to have drug and alcohol use disorders, those who engage in self-injury report using drugs or alcohol during less than five percent of self-injurious thoughts, suggesting that self-injurious thoughts and behavior typically occur during periods of sobriety. Interestingly, when self-injurious thoughts occur, adolescents report simultaneously having thoughts of using drugs or alcohol and of engaging in bingeing and purging approximately 15-35% of the time, suggesting that these behaviors may represent different forms of behavior that serve the same function.[6]

People may choose to engage in self-injury as a means of affect/cognitive regulation and social influence because it simultaneously provides a vehicle for punishing oneself for some perceived wrongdoing or responding to general self-hatred or self-deprecation. This can be seen in instances in which self-injurers carve words into their skin such as 'failure,' 'loser,' and 'disgrace.' Empirically, recent studies testing the potential influence of self-punishment have revealed that (a) self-punishment is among the primary reasons self-injurers give to engaging in the behavior, (b) 'self-hatred' and 'anger at self' are reported as the thoughts/feelings precipitating nearly half of self-injury episodes in [ecological momentary assessment] studies, and (c) those who engage in self-injury report significantly higher levels of self-criticism than do noninjurers. The presence of a self-punitive or self-critical style may emerge as a result of major depression and/or could be the result of earlier abuse or criticism from others that results in a person learning to respond to perceived failures with self-criticism and ultimately 'self-abuse' in the form of self-injury. Self-criticism has been shown to moderate the association between parental criticism and self-injury, such that the association between parental criticism and self-injury is especially strong among those with a self-critical cognitive style.[6]

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A proposed explanation is that people use self-injury as a means of communicating or signaling distress because it is more effective at eliciting help from others than milder forms of communication, such as speaking, yelling, or crying. Clinical descriptions of self-injurers have depicted the use of self-injury as a means of communication and help-seeking when words fail to adequately do so. It has been proposed that self-injury can develop through a process of escalation in which the failure of weaker signals (e.g., talking) to achieve some desired social outcome leads individuals to escalate the strength of their social signal (e.g., yelling) or change from verbal to physical forms of communication (e.g., crying ⟶ gesturing ⟶ self-injuring), which if reinforced will be strengthened and maintained over time. Self-injurers show deficits in their ability for word generation and emotional expression, supporting a poorer ability to produce a clean and effective verbal signal.

> *Moreover, families of self-injurers show higher levels of hostility and criticism than those of matched controls, suggesting potential problems with the reception of weak verbal signals. In addition, adolescents who engage in self-injury report higher levels of peer victimization and identification with Goth subculture.*[6]

> *People may choose to engage in self-injury over other self-regulating strategies because it is a rapid, effective, and easily implemented method of regulating one's affective/cognitive and social experiences. These aspects of the behavior are especially important to consider in the case of adolescent self-injury, as adolescents are less likely than adults to have the coping skills required to deal effectively with stressful situations, are less likely to be skilled at effectively communicating confers to members of their social network, and are less likely to have access to other maladaptive methods of affective/cognitive regulation (e.g., alcohol and drugs). In contrast, adolescents have ready access to the use of self-injury, which can be performed quickly, quietly, and in private in virtually any setting.*[6]

"Most self-injurers report feeling little or no pain during episodes of this behavior. This decreased pain sensitivity has been confirmed in multiple behavioral studies in which relative to noninjuring controls, those with a history of self-injury show less pain sensitivity and higher thresholds to various types of pain. Potential explanations for this decreased pain sensitivity are that it results from habituation to physical pain, the release of endorphins during self-injury, or the belief that one deserves to be injured, however, the actual mechanism is not known. Endogenous opiates (endorphins) are released in the bloodstream following bodily injury; they reduce the experience of pain and also can lead to a feeling of euphoria. There is some evidence that opiate antagonists such as naltrexone decrease engagement in self-injury; however, this finding has not been replicated consistently across studies."[6] Due to this euphoria, "self-injury shows some addictive qualities and may serve as a form of self-medication for some individuals. The 'addiction hypothesis suggests that self-injury may engage the endogenous opioid system (EOS). The EOS regulates both pain perception and levels of endogenous endorphins. The activation of this system can lead to an increased sense of comfort or integration - at least for a short period of time. Repeated activation of the EOS can cause a tolerance effect: over time, those who self-injure may feel less pain while injuring. The theory also suggests that overstimulation of the EOS can then lead to withdrawal symptoms that spur the desire to self-injure even when there is no obvious trigger."[9] "Research suggests that some adolescents become addicted to the emotional relief-seeking due to the high they experienced with the associated endorphin release."[13]

As for the 'digital [self-injury],' there are "three possibilities: [self-injurers] might be uttering a 'cry for help,' they might want to appear 'cool,' or they may be trying to 'trigger compliments.' Both male and female subjects were most likely to say that they actually did this in an attempt to gain the attention of a peer, and were least likely to have done it 'as a joke' on someone else. Girls were more likely than boys to say that their motivation was 'proving I could take it,', encouraging others 'to worry about me,' or to 'get adult attention.' Boys were more likely to say that they did this because they were mad, as a way to start a fight (presumably, they would falsely blame the person they were angry at). For both boys and girls, about 35% said that the self-cyberbullying strategy was successful for them, in that it helped them achieve what they wanted to achieve, and they felt better because of it."[12]

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"In clinical populations, self-injury is linked to:"[9]

- Childhood abuses, such as: sexual assault, including incest; physical assault; emotional abuse; bullying; witnessing domestic violence; and neglect (emotional and/or physical)[10]
- Living in a home environment with family members who experience alcoholism or mental illness[13]
- Parental divorce[13]
- Eating disorders
- Substance abuse
- Post-traumatic stress disorder
- Borderline personality disorder
- Depression
- Anxiety disorder
- Early loss and separation, especially of a parent / caregiver or sibling owning to: illness, death, divorce / separation, drug and/or alcohol abuse, incarceration, neglect[10]
- Poverty and deprivation, homelessness[10]
- Severe illness, hospitalization, surgery[10]
- War[10]
- Natural disaster[10]
- Racism[10]

"Individual variables associated with self-injury:"[14]

- General perfectionism
- Low self-esteem
- Coping skills
- Emotional regulation
- Age
- Psychopathology
- Trauma history
- Affect intensity / reactivity[13]
- Alexithymia: Inability to express feelings verbally[13]

Models Of Self-Injury

"The *affect-regulation* model of self-injury suggests that self-injury is a strategy to alleviate acute negative affect or affective arousal. Early invalidating environments may teach poor strategies for coping with emotional distress. Individuals from these environments and/or with biological dispositions for emotional instability are less able to manage their affect and are therefore prone to use self-injury as a maladaptive affect-regulation strategy."[3]

"The *anti-dissociation* model characterizes self-injury as a response to periods of dissociation or depersonalization. Individuals who self-injure experience prolonged dissociative episodes when loved ones are absent. Episodes of dissociation or depersonalization may also occur as a result of the intense emotions that self-injurers feel. Causing physical injury to oneself may shock the system - perhaps through the sight of blood or the physical sensation - and thereby interrupt a dissociative episode, and lead to regain a sense of self. *Feeling generation* is another term used to characterize this function. Individuals who dissociate may describe feeling unreal or nothing at all, and self-injury may be a way to generate emotional and physical sensations that allow individuals to feel real or alive again."[3]

"The *anti-suicide* model views self-injury as a coping mechanism for resisting urges to attempt suicide. From this perspective, self-injury may be thought of as a means of expressing suicidal thoughts without risking death, and serves as a replacement for or compromise with the desire to commit suicide."[3]

"The *interpersonal-influence* model stipulates that self-injury is used to influence or manipulate people in the self-injurer's environment. Self-injury is conceptualized as a cry for help, a means of avoiding abandonment, or an attempt to be taken more seriously or otherwise effect people's behavior."[3]

"The *interpersonal boundaries* model holds that self-injury is a way to affirm the boundaries of the self. Proponents of this model tend to draw upon object-relations theory. Self-injurers are thought to lack a normal sense of self due to insecure maternal attachments and a subsequent inability to individuate from the mother. Marking the skin, which separates individuals from the environment and other people, is thought to affirm a distinction between oneself and others, and assert one's identity or autonomy."[3]

"The *self-punishment* model suggests that self-injury is an expression of anger or derogation towards oneself. Self-injurers have learned from their environments to punish or invalidate themselves.

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Many have reported that self-directed anger and self-derogation are prominent characteristics of those who self-injure. Self-injury may therefore be experienced as familiar and ego-syntonic, and become a way of self-soothing when faced with emotional distress."[3]

"The *sensation-seeking* model regards self-injury as a means for generating excitement or exhilaration in a manner similar to sky-diving or bungee jumping."[3]

Measuring Self-Injury

The newest edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, was released in 2013. In this edition, NSSI, described as 'Nonsuicidal Self-Injury is self-harm, without the intention of suicide' is included in Section III. "Inclusion of conditions in Section III [are] contingent on the amount of empirical evidence available on a diagnosis, diagnostic reliability or validity, a clear clinical need, and potential benefit in advancing research. [NSSI was] judged to need further research before [being] considered as [a] formal disorder."[20]

"Only a few instruments have been developed to measure self-injury [and] vary as to the evidence in support of their validity and reliability, and all bear the distinct disadvantage (from a clinical perspective) of having been developed primarily for research purposes."[7] These include:

- Functional Assessment of Self-Mutilation (FASM)[7]
- Deliberate Self-Harm Inventory (DSHI)[7]
- Suicide Attempt Self-Injury Interview (SASII)[7]
- Self-Injurious Thoughts and Behavior Interview (SITBI)[7]

> *Of the four instruments listed, the SASII and the SITBI have the most empirical support for their validity and reliability. They are also the most complete (and thereby lengthy) and, though developed primarily for research purposes, are said to have clinical usefulness. A limitation of using such instruments in clinical settings is that some clients, particularly adolescents, object to more formal assessment procedures within psychotherapy; not infrequently, such clients complain that they find highly structured interviews or written questionnaires to be off-putting and disempowering. The SASII offers methods for measuring the level of medical treatment and physical condition after the [self-injury]. For someone wanting more objective measures regarding level of physical damage, the SASII provides a useful framework.*[7]

"It is important to note that although many self-injurious youth do become emotionally withdrawn, not all do. There are a significant number of highly functional and socially engaged individuals who self-injure."[2] Nonetheless, there are some very common and typical signs that self-injury is taking place.

Signs of Self-Injury:[1]

- Unexplained or clustered wounds or scares
- Fresh cuts, bruises, burns, or other signs of bodily damage
- Bandages worn frequently
- Inappropriate clothing for the season
  (e.g., always wearing long pants or sleeves in the summer)
- Constant use of wristbands or other jewelry that covers the wrist(s) or lower arms
- Unexplained cutting implements (e.g., razor blades or other equipment)
- Heightened signs of depression, anxiety, or social withdrawal
- Unwillingness to participate in events that require less body coverage (such as swimming)[2]
- Physical or emotional absence, preoccupation, distance[2]
- Social withdrawal, sensitivity to rejection, difficulty handling anger, compulsiveness[2]
- Expressions of self-loathing, shame, and/or worthlessness[2]

Assessment And Treatment For Self-Injury

Assessment

"A common concern is that asking about the presence of self-injury will have an iatrogenic effect by giving individuals the idea to engage in this behavior when they would not have otherwise thought to do so. However, recent research has shown that asking questions about self-injurious behaviors does not increase the likelihood of self-injurious thoughts or behaviors or even lead to increased levels of distress, so such concerns appear unwarranted. Nevertheless, it is recommended that the assessment of self-injurious thoughts and behaviors follow the assessment of less-sensitive constructs such as the presence of depressive and anxious symptoms in order to gradually work up to questions that may be more difficult to discuss."[6]

Although the assessment should start off slow, first and foremost should be to "assess immediate danger such as the severity of the injury (does it need immediate medical attention?). If you are a medical or mental health provider, assess suicide risk and, if you are based in a school or youth group, risk of contagion. Studies conducted in clinical institutional settings show that self-injury can be very contagious. A number of scholars have suggested that the same trends occur in school settings."[2] Recommendations for preventing self-injury contagion:[2]

- *Be sure staff are educated about NSSI characteristics and point people are identified with whom self-injurious students can speak*
- *Help self-injurious students - especially those who are considered 'cool' or serve as role models - to understand that it hurts others when they talk about or show their self-injury to peers*
- *Ask students not to appear in school with uncovered wounds or scars (this may require extra sets of clothing to be kept at school)*

"While participants' opinions about their motivations for self-injury can offer valuable insight into its functions, this approach has important limitations. Verbal reports of mental processes are often invalid. Self-injurers may not know why they self-injure or have difficulty verbalizing reasons and offer explanations that are not accurate. Others may fabricate explanations if they are embarrassed by their true reasons."[3]

It is recommended to look "at the wounds of clients - with their permission, and within the bounds of modesty, as this can provide a great deal of objective information about frequency and level of physical damage [since] clients may not always be accurate reporters about their self-injury."[7]

It is suggested that mental health professionals "respond calmly with what has been termed 'respectful curiosity' (e.g., listening and asking questions in a way that demonstrates care and respect). Avoid displaying extreme reactions like shock, pity, or criticism because such reactions will likely limit the opportunity to talk, build trust, and assist in opening the door to recovery."[1] "Also ill-advised are effusive expressions of support; such responses may inadvertently reinforce the behavior. Thus, as a rule, the most helpful strategy is to proceed in a dispassionate way, which is neither reinforcing nor punitive. Respectful curiosity conveys the message that 'I am interested in your self-injury and want to better understand it and you before we proceed.' Once the practitioner has set a low-key, nonjudgmental, respectfully curious tone, he or she can launch into a more detailed assessment."[7]

"Examples of 'respectfully curious' questions include:"[2]

- 'Where on your body do you tend to injure yourself?'
- 'Do you find yourself in certain moods when you injure yourself?'
- 'Are there certain things that make you want to injure yourself?'
- 'What does self-injury do for you?'[7]

When the patient inflicts certain words or symbols, "it is useful to explore why the self-injurer has chosen to impose this specific content on his or her body [with] a nonjudgemental, respectfully curious question such as 'Of all the words (or symbols) you have carved (or burned) into your body, how did you decide on X?'"[7]

"Assessment identifies (a) which emotions are managed by self-injury, (b) how the antecedents to these emotions might be reduced as to frequency and intensity, and (c) how these emotions might be managed more effectively using replacement skills."[7]

> *Functional assessment should play a prominent role in the assessment and treatment of NSSI. Broadly speaking, functional assessment refers to identifying factors that motivate and reinforce NSSI. This is accomplished in part by determining the factors that precipitate and follow instances of NSSI, and that may therefore provide motivation and reinforcement for the behavior. Functional assessment is useful at the beginning of treatment to inform case conceptualization and treatment planning, as well as during treatment to assess new instances of NSSI and the functions served by the behavior in each instance for a given client. [Limitations include asking] clients about previous NSSI thoughts and behaviors, thereby implicitly asking*

clients to aggregate across numerous instances of NSSI; clients must report on their NSSI retrospectively, [relying] on their recollections of NSSI, which may suffer from limitations in memory; [and] to the extent that functions of NSSI evolve or change over time, it may be more useful clinically to assess recent and new instances of NSSI, in addition to an individual's experience of NSSI in general. Each of these limitations can be addressed by the use of diary cards to assess NSSI during treatment. Diary cards can be used to help clients track a variety of clinically relevant thoughts, feelings, behaviors, and events. These cards have the advantage of (a) focusing the client's attention on a particular instance of NSSI thoughts or behaviors rather than on a lifetime of NSSI, (b) requiring minimal retrospective recall since they are completed within hours or minutes of a clinically relevant event, and (c) focusing the client's attention on current NSSI thoughts and behaviors, which can then provide extremely useful material for the next therapy sessions.[5]

There are several components to a thorough assessment:

The psychological assessment of self-injury looks at the cognitive, affective, and behavioral antecedents: automatic thoughts, intermediate, and core beliefs that may precede self-injury. A common cognition that supports self-injury is that 'it works better than anything else.' For many individuals, the detailed assessment of thoughts can elucidate how habituated the process leading to self-injury has become. Stepping back from these automatic thoughts and reexamining their accuracy is a key part of assessment and treatment. For example, a therapist might say, 'Yes, self-injury is one way to reduce emotional distress, but what else works well for you?'[7]

The biological aftermath involves how the individual feels physically after the [self-injury]. Did he or she experience physical pain at the time of the act? What about immediately afterwards? Does it hurt now? Moreover, an odd but important question may be does the pain feel good or bad? Another biological dimension is whether the self-injurer provides physical aftercare. Does he or she clean the wounds and take care to prevent infection? Is the wound picked at or excoriated? A critical question that transitions to treatment: Is the client willing to use medicated tape or bandages to cover the wounds and enhance healing?[7]

Behavioral elements at the conclusion of the self-injury sequence need to be assessed for their role in fostering recurrence. For example, does the self-injurer clean and return his or her tool to a hidden spot, to be ready for another day? Does he or she take care to clean up blood so as to be undiscovered? Or is evidence left in open view, all but guaranteeing discovery by others. These aftermath behaviors can also be targeted for change.[7]

Another important topic to assess in self-injury is body image. Some self-injuring individuals may report intense negative thoughts and feelings about their bodies. This bodily hatred can serve to support and facilitate the assaults on the body that are self-injury. Profound body alienation can be associated with childhood experiences of physical and/or sexual abuse, or sustained childhood physical illness. A thorough assessment of self-injury needs to evaluate whether such aversive experiences have been part of a client's history. Body image can be assessed using standardized instruments such as Orbach's Body Investment Scale (BIS) and the Body Attitude Scale (BAS). The challenge of working with body-alienated self-injurers, who are survivors of childhood abuse and/or illness, is often far greater than those without such traumatic histories.[7]

Social context is an additional detail of import. Does the self-injury occur alone or with others? Most people self-injure alone, but some teens and young adults cut or burn together. Other individuals may be triggered to

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self-injure after (or even while) participating in a self-injury chat room or message board. Therefore, identifying these social reinforcers is a critical part of assessment.[7]

The physical location where the self-injury occurs might also be addressed. Such information is useful in identifying situational antecedents. For example, if a client usually self-injures in a locked bedroom, he or she may want to try not locking the door. Altering established habits or rituals is conducive to behavior change.[7]

Also useful is to record the time between episodes. Such information can be used to concretely chart progress and to document a pattern of heightened distress and escalation. Some clients take great satisfaction in setting a 'personal best' for time without self-injury.[7]

Many self-injurers harm themselves at bedtime to reduce intense emotions and to get to sleep. Identifying high-risk times of day can be used to practice replacement skills and to alter habituated routines.[7]

Other very important details regarding self-injury are the number of wounds per episode and the level of physical damage. In general, the greater the number of wounds per episode indicates a higher level of distress. The therapist will want to explore what circumstances result in lower versus higher numbers of cuts. Most incidents of self-injury involve only modest tissue damage that do not require medical intervention. It is rare for individuals to hurt themselves in ways that require suturing or other medical response. When such damage occurs, an emergency mental health evaluation is indicated and protective interventions such as hospitalization may be necessary.[7]

Treatment

"Treatment goals:"[14]

- Tolerance of the present moment
- Identification and acceptance of feelings
- Distraction by journaling, drawing, or thought-stopping techniques
- Self-soothing in positive ways, relaxation, and stress management
- The development of positive social skills

"Clinicians working with self-injurers need to monitor in an ongoing way whether their self-injuring clients are also experiencing suicidal ideation, planning, and behavior. In such cases, the priority is always to respond to the suicidal crisis first. Therefore, clinicians need to carefully explore the complex motivations for self-injury in their clients; persons who say they self-injure to die may be at greater risk of subsequent suicide than those who cite the more standard emotion regulation or interpersonal factors."[7]

"People who have healed from the need for [self-injury] say that the factors that helped them include: having an understanding, compassionate, and noncoercive relationship, whether with a therapist, friend, or peer; contextualizing the [self-injury] as a coping strategy that has helped them survive; creating alternative strategies and behaviors for coping with the stressors that lead to [self-

injury]; and being free of threats of institutionalization, shaming, or other attempts to control them. The ground of healing is control and choice."[10]

> **"NSSI represents a coping skill, albeit a problematic one, and providers who lack this understanding of NSSI may not develop sufficient empathy or understanding to assist their clients."[8]**

"The power of the therapeutic relationship cannot be underestimated when working with this client population; some clinicians have suggested that it may be the most important factor when working with a [self-injuring] client. Relationships are often an area of difficulty for clients who [self-injure], thus, the therapeutic relationship is often seen by the clients as the most important aspect of treatment, whereas the clinicians may have different views. One study found that while clinicians ranked open discussions, skills building, and psychotherapy as the most helpful strategies in treatment of self-injury, clients ranked a long-term working relationship with a provider, open discussions, and access to caring individuals as the most helpful strategies."[14] "Acknowledging the connection between past trauma and the present ways people cope is crucial to healing from that trauma as well as from any addiction or other coping behavior, such as [self-injury]. As people feel the urge to self-injure they can learn to pause and identify what is bringing on the urge."[10]

"Listening to the person becomes the only way to discover what the self-injuring actions mean for that person. Understanding the meaning behind the self-injury is the avenue into finding safer alternatives to the self-injuring behaviors."[19] "Help the client to find words to express [their pain by asking]: 'If your wounds could speak, what would they say about you?' At each meeting, briefly ask the client whether or not there are any new injuries. With each new cut, ask [them] to verbalize [their] feelings before, during, and after the act. DO NOT treat as a suicide attempt."[13] "Attempted suicide can involve aggressive and unpleasant treatment options, such as involuntary hospitalization. Thus, it is crucial that mental health professionals understand how to distinguish NSSI from attempted suicide to avoid inaccurate diagnosis and treatment selections."[5]

"The key to addressing [self-injury] is not to address the coping strategy, but to address the underlying issues that require coping. Efforts to take away the coping strategy further alienates and isolates those who are already alienated and isolated."[17] "'Telling an individual to not injure him- or herself is both aversive and condescending . . . [self-injury] is used as a way of coping and is often used as a final attempt to relieve emotional distress when other methods have failed. Most people would choose not to hurt themselves if they could. Although [self-injury] produces feelings of shame, secrecy, guilt, and isolation, it continues to be used for coping. That people will engage in self-injurious behaviors despite the many negative effects is a clear indication of the necessity of this action to their survival.'"[10] "Unfortunately, a common response to self-injury is often an attempt to quickly 'contract for safety.' Clients may view efforts to contract for safety as an implicit form of

condemnation. A more effective strategy is to emphasize that the client learn new skills to regulate emotions as opposed to 'forbidding' the behavior of self-injury."[7] "For example, a therapist helped a client to develop a 'safety kit' that had gauze, Band-Aids, antibacterial ointment, alcohol swabs, and other self-care items, so that if she did self-injure, she was less likely to get an infection."[19] Emergency or crisis interventions that force someone to do something they are not ready to do can result in even more shame and increased reliance on behaviors that have developed around shame and pain: self-injury."[19] "Interventions that seek to eliminate [self-injury] at all costs may actually increase the risk of successful suicide by removing an effective coping strategy that acts as an alternative to ending one's life."[10]

To go about treating self-injurious behavior, "ask about how and what self-injury helps *before* talking about stopping. Talking about self-injury is a first step toward managing the behavior."[19]

Be curious:[19]

- Ask, How does self-injury help?
- Ask, Why now?
- Ask, what might this behavior be trying to express?

Discuss patterns and self-awareness:[19]

- Ask about times when the person was able to resist [self-injury].
- Ask if the behavior is getting better (less) or worse (more).
- Ask the person to track the behavior on a calendar to see if it follows a pattern.

Discuss learning new behaviors:[19]

- Make a list of other options that have been successful.
- Make a list of new behaviors to try.
- Ask for agreement to try an alternative before reverting to [self-injury].

Suggestions for clients that self-injure depend on the reason for the self-injuring.

When the client needs to feel the pain from self-injury, they can try something less severe but that will still give pain, such as:

- Squeeze ice hard (this really hurts) or hold it where you want to burn. It hurts and leaves a slight red mark.[19]
- Put a finger into a frozen food (like ice cream) or in a pitcher of ice water and salt for a few seconds.[19]
- Bite into a hot pepper or chew a piece of gingerroot.[19]
- Rub liniment under your nose.[19]
- Slap a tabletop hard.[19]
- Snap your wrist with a rubber band.[19]
- Take a cold bath or shower.[19]

When there is a desire to see blood:

- Draw on yourself with a red felt-tip pen or lipstick.[19]
- Take a small bottle of liquid red food coloring and warm it slightly by dropping it into a cup of hot water for a few minutes. Uncap the bottle and press the tip against the place you want to cut. Draw with the bottle in a cutting motion while squeezing it slightly to let the food color trickle out.[19]
- Draw on the areas you want to cut using ice that you've made by dropping six or seven drops of red food color into each of the ice-cube tray wells.[19]
- Paint yourself with red tempera paint.[19]

When there is a desire to see scars or pick scabs:

- Get a henna tattoo kit. You put the henna on as a paste and leave it overnight; the next day you can pick it off as you would a scab and it leaves an orange-red mark behind.[19]

Methods for delaying self-injury:

- The fifteen-minute game: tell yourself that if you still want to [self-injure] in fifteen minutes, you can. When the time is up, see if you can go another fifteen minutes.[19]
- Tell yourself you'll do it later.[19]
- Make your tools hard to get at; commit to using only one particular set of tools and put them in a small box. Wrap the box completely in duct tape and a list of reasons not to hurt yourself to the outside. Put that box in another box and repeat; and then put the package on a high, out-of-the-way shelf.[19]
- Fill a gallon jug halfway with water, freeze it, put your tools in, then fill the jug with water and freeze again. When an urge comes you have the amount of time it take for the ice to thaw to try other distractions.[19]

Treatment Methods

"If the primary function of the self-injury is emotion regulation, then treatment will need to target: (a) reducing emotional triggers, and (b) teaching alternative emotion regulation skills. If the primary functions are interpersonal in nature, social skills training or interpersonal work may be in order. Of course, for many individuals, both aspects apply."[7] "In general, psychotherapies that emphasize emotion regulation, functional assessment, and problem solving appear to be most effective in treating self-injury. An approach that incorporates both problem-solving and standard cognitive-behavioral methods - manual-assisted cognitive-behavioral therapy - has resulted in significant reductions in NSSI, a pattern which holds even at follow-up 12 months after treatment."[5]

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A study about adult females with severe NSSI found that "patients conceptualize recovery in six steps: (a) limit setting for safety, initially by inpatient unit staff but gradually moving to limit setting by the patient [themselves]; (b) developing self-esteem; (c) discovering why the NSSI took place and what role it served for the patient; (d) realizing that [they] can choose whether or not to self-injure; (e) replacing NSSI with other coping skills; and (f) a maintenance phase. Feeling removed from one's emotions and experiences was a primary reason for NSSI and psychotropic medication was felt to have exacerbated this problem. An excess of attention from staff following NSSI events created a temptation to repeat the behavior to gain attention. High unit expectations resulted in increased anxiety as the patient worried about [their] inability to live up to these expectations. The clients felt that each of these interventions increased the frequency of NSSI rather than reducing it. The intervention the females perceived as most helpful was having a long-term relationship with a single clinician. Being encouraged to express their emotions was also felt to be helpful. Relaxation training was felt to have been counterproductive. Though their NSSI often followed a buildup of tension and stress, the females felt that attempting relaxation during these moments decreased their ability to resist the urge to [injure] themselves."[8]

Acceptance And Commitment Therapy

It is "postulated that acceptance instead of avoidance of negative feelings would lead to a decrease in [self-injury]. Acceptance-based emotion regulation group intervention has already been shown to have positive effects on [self-injury], and there is a growing body of evidence that Acceptance and Commitment Therapy is an effective approach, covering areas such as psychosis, addiction, GAD, even clients seen in general outpatient practice."[18]

Life Charting

"The life chart is an activity used in treating bipolar disorder. With this activity, the client and therapist identify times of depression and mania and events that occurred around these incidents. Clients draw a horizontal line in the middle of a page to symbolize their baseline, or typical mood. Then, they draw peaks and valleys above and below the lines to symbolize times of depression/ dysthymia and mania/hypomania. Once these experiences are drawn, the therapist assists the client in adding triggers, associated symptoms, and life events. Life charts are useful in helping to identify signs, triggers, and patters of symptomatology. Similarly, life charting is an activity that can help self-injuring clients."[14]

Self-Esteem Mandala

"The self-esteem mandala is a twist on the commonly used mandala activity, which has been shown to reduce anxiety and promote physical and mental well-being. The word mandala is Sanskrit for 'circle' or 'completion' and represents wholeness. Mandalas are circles with patterns inside, and are used in therapy to reflect the inner self."[14]

Distraction Box Therapy

Distraction Box Therapy "teaches the skill of distraction as a way to help manage overwhelming emotions. Distraction is, quite literally, doing other things to keep oneself from [self-injuring]. Distraction techniques can help take clients' focus off of the pain and give clients time to find an appropriate coping skill. Clients are taught to calm the urge to [injure] themselves by learning to match healthier behaviors to how they are feeling in the moment. Then, the therapist helps the client identify a list of distracting actions, called a 'distraction plan.' This plan also encompasses pleasurable activities that can be done in place of [self-injury]."[14]

The 'My Body Needs' Activity

"For [a client] who self-injures, learning to treat [their] body better is an important part of treatment. The 'My Body Needs' activity allows for the therapist to learn more about the clients' body image while also promoting elements of self-care that the client has already incorporated into daily life. First, the client is instructed to draw a picture of [themselves]. Then the clinician asks questions related to body-image, such as:"[14]

- What parts of your body do you like?
- What parts of your body do you wish were different?
- When you look at yourself in the mirror, what do you see?
- What do you think others see when they look at you?

"Following this discussion, the therapist helps the client identify ways in which [they care] for different parts of [their] body. These are written or drawn on the picture and are meant as direct opposites to the [self-injury]."[14]

Self-Esteem Sticky Notes

"Another self-esteem activity that can be useful with this population is the self-esteem sticky notes. This activity involves the client as well as important individuals in [their] life. The client takes two pads of sticky notes home. On the first pad, the client identifies things [they like about themselves]. Each sticky note has one characteristic or trait on it. The client and therapist can make a game out of this and work towards a reward (i.e., one point per sticky note). The second pad is for people in the client's life. [They give] sticky notes to others and ask them to identify things they like about [them]. The client then posts these notes in places that [they] will regularly see them: [bedroom], locker, car, refrigerator, and/or bathroom."[14]

Care Tags

"The goal of 'Care Tags' with [those that self-injure] is to help them identify clues to their feelings and what it is that they need when these feelings occur. The idea behind the activity is that unlike clothes that come with a tag to inform the owner of the care instructions, individuals do not have

such care instructions. With the help of the therapist, the client creates care tags that include the following statement:

> 'When I ______________________________________ (behavior, action, or situation),
> I am feeling ______________________, and I need _________________________.'

This activity can be particularly useful with clients who do not have a clear understanding of either their feelings or what they need when they feel certain emotions."[14]

Expressive Arts

"There is much research to suggest the usefulness of incorporating expressive arts techniques into child and adolescent treatment. Therefore, using expressive arts activities would appear to benefit [self-injuring] adolescents more so than adult treatments alone."[14]

Peer Support

"The least-often discussed, yet most effective, tool that facilitates healing is peer support. There can be no questioning of the power and hope that people who have been through similar experiences can offer to those who are struggling. Systems of care often isolate those who live with [NSSI] from one another in the mistaken belief that meeting in a group will escalate self-injury. Yet when people are able to communicate with each other, whether in person or through newsletters or websites, the opportunity for understanding and support is very meaningful. People who have journeyed down the road to healing can mentor those who are in the midst of pain and confusion. Knowing that you are not alone and have the opportunity to be heard and supported without judgement is highly instrumental in healing."[10]

Motivational Interviewing

"Motivational interviewing (MI) represents a particularly promising treatment for NSSI. MI is a 'directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence.' A central premise of MI is that the more a therapist argues that a client should stop performing a behavior, the more the client will 'resist' and provide reasons the behavior is useful and not really harmful. In MI, therapists explore the benefits of such behaviors as much as the drawbacks, and provide a safe and empathic environment designed to enhance readiness, desire, and ability to change. The five basic principles of motivational interviewing are expressing empathy, avoiding argumentation, rolling with resistance, supporting self-efficacy, and developing discrepancy. MI views behavioral change not as a single event, but as a sequence of events through which people progress. The main aim is to provide a therapeutic context that facilitates movement through the stages of change. At Stage 1, precontemplation, clients are not ready to consider change, and lack the desire and/or confidence required to change. Clients in the precontemplation stage are not directly asked to acknowledge they have a problem, nor are they confronted with evidence contradicting their current perspective. Instead, the therapeutic focus is on building rapport, validating the client's perspective and experience, and utilizing certain MI techniques to

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raise awareness of other perspectives. At Stage 2, contemplation, clients are thinking about change, but remain ambivalent. A primary emphasis in MI is helping clients process their ambivalence in a safe and nonjudgmental manner designed to help them progress through the stages of change. At Stage 3, preparation, clients are ready and determined for change. Therapists do not take on an 'expert' role in offering ways to stop self-injuring, but treat the client as the expert on his/her life, and work collaboratively with the client to craft and implement strategies that fit the client's particular experiences, abilities, and environment. Finally, at Stage 4, action and maintenance, the client has started to take steps toward change. It is important to note that progress through stages of change is not linear. Halts or reverses in progress are expected parts of the process, not failures on the part of the client or therapist."[5]

Dialectical Behavior Therapy

"Research on Dialectical Behavior Therapy (DBT) for patients who self-injure has been encouraging. DBT is an intensive treatment involving individual and group modalities developed by Marsha Linehan. When compared to treatment as usual in the community, DBT appears to produce better improvements in frequency of self-injury, hospitalizations, and many other outcome variables. Many patients treated with DBT continue to self-injure even if less frequently."[3] "Despite its efficacy, this treatment has been criticized as not being easily implemented in a traditional clinical setting in its full empirically supported package and also for its long term commitment (1 year), which may be difficult for some clients."[18]

Assessment

Even the assessment itself is beneficial, as "interventions found to be helpful include psychosocial assessment in the emergency department [and] therapeutic assessments by mental health providers. Simply performing a psychosocial assessment correlates with reduced future incidence of [self-injury as] evidence suggests that psychosocial assessment of clients with NSSI presenting to the emergency department correlates with a decreased future incidence of NSSI for the assessed patient. The outpatient use of specialized assessments including 30 [minutes] of psychotherapy correlates with increased rate of return for follow-up care in adolescents with NSSI."[8]

Harm Reduction Model

"The harm reduction model [has been advocated for] by an adult client. When [she] was 18 years old, a nurse responded to her NSSI by providing patient education. Basic anatomy and physiology of skin and underlying structures as well as methods for reducing infection risk were explained to her. [She] avoided severe injury despite worsening NSSI and she attributed this relative safety to patient education. She advocate[s] teaching first-aid, infection-reduction strategies, anatomy and physiology, and scar reduction and concealment strategies to patients who engage in NSSI. She also provide[s] specific suggestions such as encouraging clients to visualize the bottom of a wound for white cords (tendons) before cutting deeper into the wound."[8]

Medication

"The most encouraging findings to date have been among studies demonstrating the effects of selective serotonin reuptake inhibitors, partial agonists for dopamine and serotonin receptors, and opioid antagonists. These pharmacological agents are believed to decrease the high aversive arousal hypothesized to lead to self-injury and to eliminate potential pleasurable effects of the behavior resulting from the release of endorphins."[6]

Other Helpful Methods

"Grounding techniques to help the person detach from emotional pain and become more centered in the physical reality of the here-and-now often brings relief and provides an alternative to self-injury."[19]

"Higher education [is] an important factor in the healing process. Education [aids] clients in developing their written expressive abilities and facilitated improved self-understanding."[8]

After Treatment

"The preliminary findings from this work suggest that a history of self-injury predicts later suicide-related behavior and suicide action. Those who have high lifetime frequency of self-injury and/or use more severe methods to self-injure are at greater risk for suicide. This key finding has implication not only for the intervention and treatment of self-injury, but also for the prevention of suicide since self-injury may serve as a 'red flag' for later suicide risk."[1]

Conclusion

Nonsuicidal self-injury often stems from some sort of trauma and is used to emotionally cope. In order to help those who self-injure, focus should emphasize the reason behind this coping technique being employed as much as helping them find different, healthier ways to look after themselves. Due to the connection between self-injury and suicide, a continual assessment of suicidal thoughts and/or acts needs to be at the forefront of any treatment method used. Finally, patient education about properly caring for their injuries is important to prevent long-lasting physical damage, as they may still turn to self-injurious behaviors while learning new coping strategies and healing from past traumatic events in their life.

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Additional Resources

- For a list of therapists by location that specialize in self-injury treatment:

  http://www.selfinjury.com/referrals/therapists/

  http://locator.apa.org

- The 'Hurt Yourself Less' Workbook: http://studymore.org.uk/hylw.pdf
- The Cornell Research Program on Self-injurious Behaviors: http://www.crpsib.com
- Other self-injury sources:

  http://www.girlshealth.gov/feelings/sad/cutting.html

  http://www.thesite.org/mental-health/self-harm

  http://suicidology-online.com

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