NONSUICIDAL SELF-INJURY

OVERVIEW

The terms self-injury, parasuicide, deliberate self-harm, self-abuse, self-mutilation, self-inflicted violence, or cutting is the deliberate harming of one's body, resulting in tissue damage, without the intent of suicide. It does not include culturally-sanctioned activities, including tattoos or actions within a religious or cultural ritual. The information contained in this section addresses nonsuicidal self-injury (NSSI). For additional information on self-inflicted injury with suicidal intent, see the "Youth Suicide" section of the *Collection*.

KEY POINTS

- **Characterized by deliberate harming of one's body, resulting in tissue damage, without the intent of suicide.**
- **Sometimes used to regulate emotion through the release of endorphins, which can temporarily reduce negative emotions such as tension, anxiety, and self-reproach.**
- **No evidence-based treatments have been identified at this time.**
- **Treatments such as cognitive behavioral therapy aim to replace NSSI with healthier coping skills.**

NSSI occurs without regard for age, gender, ethnicity, or socioeconomic status; however, much research is centered on adolescents, as this behavior tends to begin during teen years. Family members can look for signs of self-injury, including:

- Scratching (excoriation)
- Cutting
- Burning
- Hitting or biting oneself
- Ingesting or embedding toxic substances or foreign objects
- Hair pulling
- Interfering with wound healing

This list is not exclusive, and families may also see other types of personal harm. Children who self-harm may exhibit more than one form of self-injurious behavior.

It is not always clear whether an act of self-harm should be categorized as NSSI or as a suicide attempt because the intended outcome is not certain. Suicide attempts are not always lethal and NSSI may be lethal. Furthermore, this distinction may not be important since NSSI is one of the strongest predictors of suicide ideation and future suicide attempts.

Repeated shallow but painful injuries that the youth inflicts on his or her body are the critical feature of NSSI. Youth most frequently injure the top of the forearm or thigh with knives, needles, razors, or other sharp objects,

and they often create several cuts or scratches in a single session. Commonly, these cuts bleed and leave scars. Injury may also be caused by stabbing, burning, or causing burns by rubbing the skin with another object. Other forms of self-injury discussed in this *Collection* are trichotillomania and excoriation (skin-picking) disorder, discussed in the "Obsessive-Compulsive and Related Disorders" section. Stereotypic self-injury, such as head banging, self-biting, or self-hitting, may be connected to developmental delay.

Suicide attempts and NSSI are thought to serve different functions, with suicide being used as a way to escape from pain and NSSI used to regulate emotion. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) notes the most common purpose of NSSI is to reduce negative emotions such as tension, anxiety, and self-reproach. In certain cases, the injury is conceived as a deserved self-punishment to make up for acts that harmed or distressed others. The youth may then report an immediate sensation of relief that occurs during the process.

Some reasons that youth may engage in NSSI include:

- Distracting from emotional pain (this is most common)
- Punishing oneself
- Relieving tension
- Sense of being real by feeling pain or seeing evidence of injury
- Numbing feelings; to not feel anything
- Experiencing a sense of euphoria
- Communicating pain, anger, or other emotions to oneself or others
- Nurturing oneself through the caring for wounds

Studies show that females self-injure more frequently than males. While self-injury typically begins in adolescence, it may begin earlier or later and can continue into adulthood.

CAUSES AND RISK FACTORS

Researchers have identified many risk factors associated with NSSI, which are outlined in Figure 1.

Studies have shown that adolescents with any comorbid condition are at increased risk of NSSI and those with greater than two comorbid conditions have nearly three times the risk of developing the disorder. Specific comorbid conditions revealed in research include obesity, alcoholism, borderline personality disorder (BPD)**,** and suicidal behavior disorder (discussed in the Youth Suicide section of the *Collection*).

Research has indicated that there is a clear familial component to NSSI, but point out that it is still uncertain whether this is due to genetics, environment, or both. Relatives of individuals who have engaged in NSSI are three times more likely to engage in such behavior themselves. Patients diagnosed with BPD often grow up in environments where emotional expression goes unrecognized or is punished, the outcome being that emotional regulation skills are underdeveloped. There is also consistent evidence to support a genetic component for impulsivity, affective instability, and aggression—all risk factors for NSSI.

Figure 1
Risk Factors Associated With NSSI

- Risk taking and reckless behavior
- Childhood sexual abuse
- Childhood physical abuse
- Neglect
- Family violence during childhood
- Family alcohol abuse
- Childhood separation and loss
- Single parent family
- Parental illness or disability
- Poor emotional regulation skills, which can be due to family environments in which emotional expression is unrecognized or punished
- Poor security with childhood attachment figures
- Emotional reactivity
- Emotional intensity
- Hopelessness
- Loneliness
- Anger
- Alcohol use or alcoholism
- Obesity
- Comorbid mental health condition, especially borderline personality disorder and suicidal behavior disorder

TREATMENT

No evidence-based treatments for NSSI have been identified at this time. Table 1 lists available treatments for NSSI.

NSSI represents a pattern of behavior, rather than a single isolated event, and is perpetuated through both positive and negative reinforcement. For example, NSSI is positively reinforced when the adolescent experiences a sense of control or relaxation following self-harm. NSSI is negatively reinforced when the adolescent experiences distressing or unpleasant emotions and or thoughts—for example, sadness, loneliness, emptiness, emotional pain, and self-hatred—following self-harm. Therefore, many experts believe that interventions aimed at reducing NSSI should focus on strengthening emotion regulation skills. This approach varies from interventions aimed at reducing suicidal behavior, which instead help the adolescent identify reasons for living.

An important treatment element for youth who have engaged in NSSI is the establishment of a strong therapeutic alliance between the youth and the service provider. Once the alliance is formed, an important treatment goal is to reduce and ultimately eliminate NSSI by replacing it with healthier coping skills. Another recommended component is the establishment and maintenance of meaningful connections between adolescents and their families.

Cognitive behavioral therapy (CBT) is one treatment for NSSI that has been tested. The premise of CBT for NSSI is to reduce NSSI behaviors by helping clients develop new coping skill sets, address motivational obstacles during treatment, and promote skill generalization outside the therapy setting. Dialectical behavioral therapy (DBT) is effective for the treatment of NSSI among adults and thus has received a lot of attention. However, its effectiveness for children and adolescents is still being tested.

Table 1
Summary of Treatments for Nonsuicidal Self-Injurious Behavior

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT)	CBT involves providing skills designed to assist youth with affect regulation and problem solving.
Dialectical behavior therapy (DBT)	DBT emphasizes acceptance strategies and the development of coping skills.
Not Adequately Tested	
Problem solving therapy	Designed to improve an individual's ability to cope with stressful life experiences.
Medication	Evidence of the effectiveness of the use of medications, such as high-dose SSRIs, atypical neuroleptics, and opiate antagonists, is limited. In addition, some medications have been shown to increase suicidal ideation in children and adolescents.
Hospitalization	Because effectiveness is not consistently demonstrated, should be reserved for youth who express intent to die.

RESOURCES AND ORGANIZATIONS

Anxiety and Depression Association of America (ADAA)
https://adaa.org/

Association for Behavior and Cognitive Therapies (ABCT)
http://www.abct.org/Home/

Cornell Research Program on Self-Injurious Behaviors (CRPSIB)
http://www.selfinjury.bctr.cornell.edu/

Mental Health America (MHA)
http://www.mentalhealthamerica.net/

National Alliance of Mental Health
Self-Harm
https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Self-harm

National Institute of Mental Health
https://www.nimh.nih.gov

National Suicide Prevention Lifeline
1-800-273-TALK (8255)
https://suicidepreventionlifeline.org/

S.A.F.E. Alternatives (Self-Abuse Finally Ends)
800-DON'T CUT (366-8288)
https://selfinjury.com/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/