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Non-Suicidal Self-Injury

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Description of Self-Injury

Definition

- Non-Suicidal Self-Injury is "the intentional destruction of one's body tissue without suicidal intent and for purposes not socially sanctioned" (Klonsky, Muehlenkamp, Lewis, & Walsh, 2011, p. 6)
- Self-injury can include, but is not limited to: cutting, self-hitting, pin-pricking, skin-picking, embedding, burning, swallowing foreign objects, and head-banging

Resource: International Society for the Study of Self-Injury: http://www.isssweb.org/aboutnssi.php

Prevalence

- Rates of self-injury vary by study, and depend on researchers' definition of self-injury and the population being studied. Prevalence data ranges from 1% to 37%, with the highest rates typically found among the adolescent population (Greydanus & Apple, 2011).

IDENTIFICATION/ASSESSMENT STRATEGIES

Self-Injurious Thoughts and Behaviors Interview (SITBI; Nock, Holmberg, Photos, & Michel, 2007)
The Self-Injurious Thoughts and Behaviors Interview (SITBI; Nock, Holmberg, Photos, & Michel, 2007) measures suicidal ideation, suicide plans, suicide gestures, suicide attempts, and self-injury. This structured interview includes five modules (i.e., suicidal ideation, suicide plans, suicide gestures, suicide attempts, and self-injury). Each module has an "initial screening item," which, if endorsed by the client, prompts the interviewer to include that respective module in the clinical interview (Nock et al., 2007, p. 311). Conversely, if the initial screening item for any module is not endorsed, that respective module is not included in the interview. For each self-injurious thought or behavior, the SITBI assesses presence, frequency, age of onset, severity, precipitants, methods used, and function (i.e., emotion regulation—"to escape aversive feelings," emotion regulation—"to generate feelings," communication—"to get attention from others," and communication—"to escape from others") (p. 311). The SITBI also examines associated characteristics of self-injurious thoughts and behaviors, such as any associated pain for self-injury, the presence of alcohol or other substances of abuse, impulsiveness, and whether the client's peers experience similar self-injurious thoughts and behaviors. Using a 0 (low/little) to 4 rating (very much/severe) scale, the client is asked to rate the probability of experiencing each self-injurious thought and behavior in the future (p. 311). For clinical purposes, the SITBI is designed to be administered by counselors who hold a minimum of a master's degree. Administration typically takes less than 15 minutes.

Resource: Review of the SITBI measure:
http://www.wjh.harvard.edu/~nock/nocklab/Nock%20et%20al_2007_SITBI.pdf

Deliberate Self-Harm Inventory (DSHI; Gratz, 2001)
The Deliberate Self-Harm Inventory (DSHI; Gratz, 2001) is a 17 item measure of non-suicidal self-injury; it does not assess for self-injury with suicidal intent. The DSHI screens for the presence of self-injury, age of onset, duration, frequency, and severity. It also asks participants to identify their means of self-injury.

INTERVENTION STRATEGIES

There is a paucity of quality research which identifies effective treatments for self-injury. Few studies (e.g., Barley et al., 1993; Gratz & Gunderson, 2006; Harned, Jackson, Comtois, & Linehan, 2010; Harned, Korslund, Foa, & Linehan, 2011; Hatcher, Sharon, Parag, & Collins, 2011; Hjalmarsson, Kaver, Perseius, Cederberg, & Ghaderi, 2008; Koons et al., 2001; McLeavey, Daly, Ludgate, & Murray, 1994; Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012; Raj, Kumaraiah, & Bhide, 2001; Slee, Spinhoven, Garnefski, & Arensman, 2008; Van Goethem, Mulders, Muris, Artnz, & Egger, 2012) have empirically assessed the effectiveness of various treatments in addressing self-injury. Because of the varied profiles of people who self-injure (i.e., diverse diagnostic profiles, multiple co-occurring treatment issues, variations in how self-injury is identified and defined), self-injury per se is not often a targeted behavior in treatment studies. Preliminary research findings suggest that various cognitive behavioral and behavior therapy interventions may be most effective in treating self-injury.

Resources: Overview of self-injury and evidence-based practices
Klonsky, E. D., Muehlenkamp, J. J., Lewis, S. P., & Walsh, B. (2011). *Nonsuicidal self-injury: Advances in psychotherapy evidence-based practice.* Cambridge, MA: Hogrefe.

U.S. Department of Health and Human Services (USDHHS), Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices (a search on self-injury provides information on treatment programs which address self-injury): http://www.nrepp.samhsa.gov/Index.aspx

Cognitive Behavioral Therapies (CBT)

Problem solving therapy (PST). In Muehlenkamp's (2006) review of the literature on empirically supported treatments of self-injury, she suggested that studies examining the clinical efficacy of PST in the treatment of self-injury yield mixed and inconclusive results, particularly when looking at long-term outcomes. Some studies (i.e., Hatcher et al., 2011; McLeavey et al., 1994; Raj, Kumaraiah, & Bhide, 2001) suggest that PST can be effective with those who self-injure. PST may be most effective in treating self-injury when combined with other cognitive, behavioral, and interpersonal interventions (see Muehlenkamp, 2006).

Resource: Overview of PST: http://www.problemsolvingtherapy.ac.nz/

Dialectical behavioral therapy (DBT). Studies examining the clinical efficacy of dialectical behavioral therapy (DBT) in the treatment of self-injury (e.g., Barley et al., 1993; Harned et al., 2010; Harned et al., 2011; Koons et al., 2001; Pistorello et al., 2012; Shearin & Linehan, 1994; Van Goethem et al., 2012) generally indicate some level of effectiveness in reducing self-injury, particularly among clients diagnosed with borderline personality disorder. The effectiveness of DBT may be compounded when used within the context of a nurturing, nonjudgmental, and collaborative therapeutic alliance (Perseius, Ojehagen, Ekdahl, Asberg, & Samuelsson, 2003; Shearin & Lineman, 1992). Muehlenkamp (2006) cautions that it is unclear whether DBT is more useful than a treatment as usual condition, particularly when looking at long-term behavioral change. However, a recent study by Van Goethem et al. (2012) suggested that the largest changes when using DBT with clients who self-injure may occur as a product of the initial treat-

ment, creating a floor effect wherein significant changes do not tend to manifest with additional DBT treatment.

Resources:
USDHHS, SAMHSA's National Registry of Evidence-Based Programs and Practices: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36
Behavioral Tech, LLC: http://behavioraltech.org/resources/index.cfm
Case illustration of DBT with an adolescent client who self-injures:
Nock, M. K., Teper, R., & Hollander, M. (2007). Psychological treatment of self-injury among adolescents. *Journal of Clinical Psychology, 63*, 1081-1089. doi: 10.1002/jclp.20415

Emotion regulation:
Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26*, 41–54.
Gratz, K. L. (2007). Targeting emotion dysregulation in the treatment of self-injury. *Journal of Clinical Psychology, 63*, 1091-1103. doi: 10.1002/jclp.20417
Klonsky, E. D., Muehlenkamp, J. J., Lewis, S. P., & Walsh, B. (2011). *Nonsuicidal self-injury: Advances in psychotherapy evidence-based practice.* Cambridge, MA: Hogrefe.

Cognitive Therapy
In their review of the literature, Klonsky et al. (2011) referenced the self-criticism and self-deprecation commonly demonstrated in those who self-injure (e.g., Glassman, Weierich, Hooley, Deliberto, & Nock, 2007), the maladaptive beliefs and distorted cognitions commonly seen in clients who self-injure (e.g., Newman, 2009; Walsh, 2006), and the role of "depressogenic attributional style and interpersonal stressors" (Klonsky et al., p. 51) in sustaining self-injury (e.g., Guerry & Prinstein, 2010) as support for the use of cognitive therapy in the treatment of self-injury. Klonsky et al. (2011) emphasize the utility of cognitive therapy that specifically addresses self-injury and suicide attempts (see also Newman, 2009). This recommendation is supported by Slee et al. (2008) who, in a randomized controlled trial, found that CT may be most efficacious when it is focused specifically on the self-injurious behavior, particularly in terms of increasing emotion regulation skills.

Resource: Beck Institute for Cognitive Behavior Therapy: http://www.beckinstitute.org/

Specific Interventions Based on Empirical Research
Behavioral management strategies. Citing the role of environmental and intrapersonal triggers (e.g., Chapman, Gratz, & Brown, 2006; Nock & Prinstein, 2004) in maintaining self-injury, Klonsky et al. (2011) suggested interventions that target changing behaviors or learning new behaviors may be helpful in the treatment of self-injury. In particular, contingency management, shaping, positive reinforcement, and exposure may be most beneficial when working with clients who self-injure (see Klonksy et al., 2011).

Resources: Behavior therapy with clients who self-injure:
Lynch, T. R., & Cozza, C. (2009). Behavior therapy for nonsuicidal self-injury. In M. K. Nock (Ed.), *Understanding non-suicidal self-injury: Origins, assessment, and treatment* (pp. 221-250). Washington, DC: American Psychological Association.

Developing behavioral alternatives to self-injury:
Wester, K. L., & Trepal, H. C. (2005). Working with clients who self-injure: Providing alternatives. *Journal of College Counseling, 8*, 180-189.

Functional assessment/ functional behavioral analysis of the self-injury. Functional assessment involves identifying factors that motivate and reinforce self-injury (Klonksy et al., 2011; Muehlenkamp, 2006; Newman, 2009; Walsh, 2006). By addressing the experiences that reinforce and maintain self-injury, clients are better able to make changes to these patterns and ultimately, stop self-injuring.

Resource: A functional approach to the assessment of self-mutilative behavior
http://www.wjh.harvard.edu/~nock/nocklab/Nock_Prinstein_JCCP2004.pdf

Means restriction and delay of self-injury. Asking a client to restrict the means of self-injury or to delay self-injury may assist in either preventing or delaying self-injury (Klonsky et al., 2011). Examples include behavioral alternatives (see Wester & Trepal, 2005), health alternatives (e.g., exercise, meditation), and distraction techniques (e.g., being with friends, listening to music; Klonsky et al., 2011). The latter is supported by a study conducted by Klonsky and Glenn (2008), in which participants were able to resist self-injury by engaging in other behaviors such as talking with another person and spending time with friends. Participants in this study also reported some success with means restriction (Klonsky & Glenn, 2008). Klonsky et al. (2011) caution that means restriction and delay techniques may not facilitate long-term change as stand-alone interventions and instead can be used ancillary to a more thorough treatment plan.

Family therapy. The integration of family therapy in the overall treatment approach may be helpful (Klonsky et al., 2011), particularly when family members may not understand self-injury and/or may be critical of the client who self-injures. Hawton and Harriss (2006) found a relationship between self-injury and interpersonal/relationship problems in people who self-injure. Wedig and Nock (2006) also found that high levels of parental criticism are related to self-injury. Conversely, a supportive family was an insulating factor against self-injury (Chapman & Dixon-Gordon, 2007; Toprak, Cetin, Guven, Can, & Demircan, 2011). Results from Muehlenkamp and Gutierrez (2007) indicated that close family relationships may insulate adolescents who self-injure against suicide.

Motivational interviewing (MI). Motivational interviewing (MI) shows promise as an adjunct to evidence-based practices in the treatment of self-injury (Kress & Hoffman, 2008). Motivational interviewing aims to help enhance clients' motivation to want to make changes.

Resources: Overview of motivational interviewing: http://www.motivationalinterview.org/
Use of motivational interviewing with clients who self-injure
Kress, V. E., & Hoffman, R. M. (2008). Non-suicidal self-injury and motivational interviewing: Enhancing readiness for change. *Journal of Mental Health Counseling, 30*, 311-329.

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