

Non-Suicidal Self-Injury

Peter Thomas, PhD

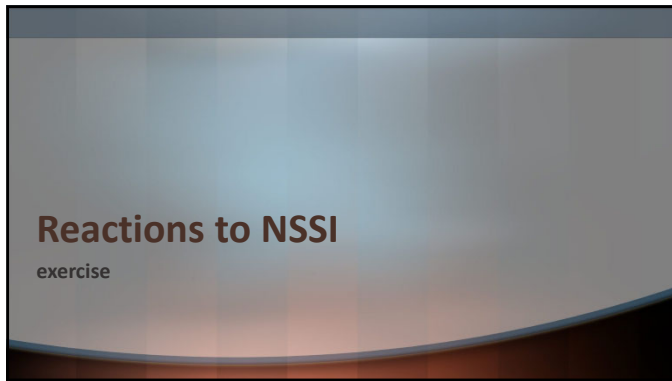
Terms

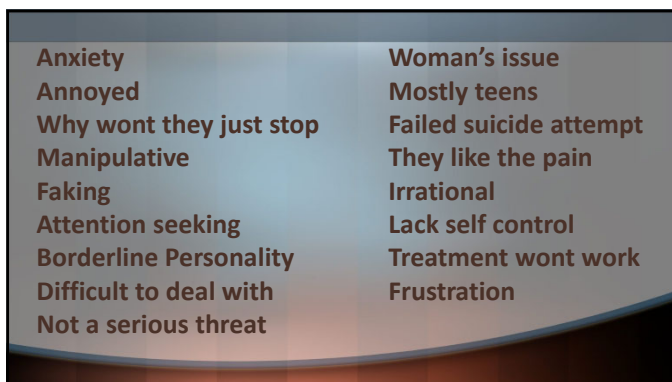
The literature has thrown out many terms for NSSI which has made research and definitions difficult.
(Whitlock, Eckenrode, & Silverman, 2006; Yates, 2004)

- Self Mutilation
- Parasuicide
- Cutting
- Self-Harm
- Self-Injury
- Suicidal Gesturing
- DSH –Deliberate Self Harm

What it is and what it isn't

Definitions







**Common Myths about
DSH/NSSI**
Self-injury is a girl problem right?

**Common Myths about
DSH/NSSI**
When people say NSSI they mean
cutting.

**Common Myths about
DSH/NSSI**
It's a cry for help or just manipulation.

**Common Myths about
DSH/NSSI**

People who hurt themselves on purpose
are trying to kill themselves, even if they
say they're not.

**Common Myths about
DSH/NSSI**

It's a Borderline Personality disorder
thing.

**Common Myths about
DSH/NSSI**

It's a an "Emo" thing

NSSI epidemiology

- Most common in adolescents still
- 13% to 18% report these behaviors
- Average age of onset is around 13-14 years old
- Adults report about 6%
- These rates are similar across countries
- Although we assume its more common in women, gender rates are almost equivalent.

NSSI epidemiology

- There are difference in methods between genders
- Women are more likely to cut
- Men more likely to burn or hit
- More common to the GRSM communities
- More common in whites
- No difference in SES
- 30x the rate of those who report suicide attempts

Prevalence in Other Psychopathology

Prevalence in Other Psychopathology
Borderline Personality Disorder
70%

Prevalence in Other Psychopathology
Dissociative Disorders
69%

Prevalence in Other Psychopathology
Eating Disorders
35%

Prevalence in Other Psychopathology
Major Depressive Disorder
41.6%

Prevalence in Other Psychopathology
Alcohol Dependence
33%

NSSI & Suicide

Suicide and Self-Injury

- There is a strong correlation:
- 40% of those who have self-injured have also had SI
- 50-80% who have self-injured have had at least one suicide attempt

Suicide and Self-Injury

- However, they differ on 3 significant domains:
- Frequency
- Lethality
- Intention

Suicide and Self-Injury

- NSSI – more chronic, more prevalent
- Risk factors for suicide include a Hx of NSSI
- Post impact of the behaviors differ – positive vs negative mood
- Numerous NSSI episodes are correlated with decreased in suicide risk

Suicide and Self-Injury

- Thomas Joiner's theory:
- When it comes to suicide risk, NSSI presents double trouble, in that it increases risk for both SI and the ability to act on the ideation.

Suicide and Self-Injury

Studies now show that both behaviors may similar functions.

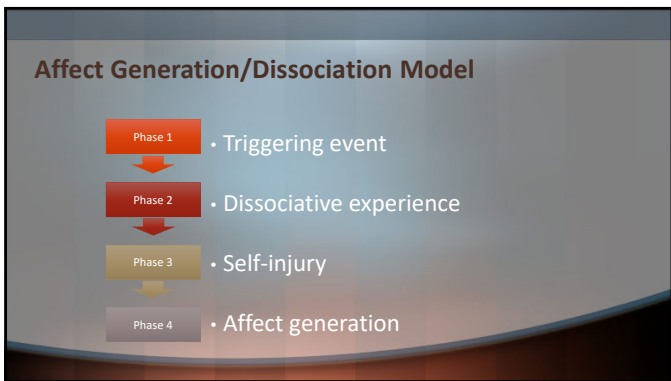
NSSI as counter-suicide

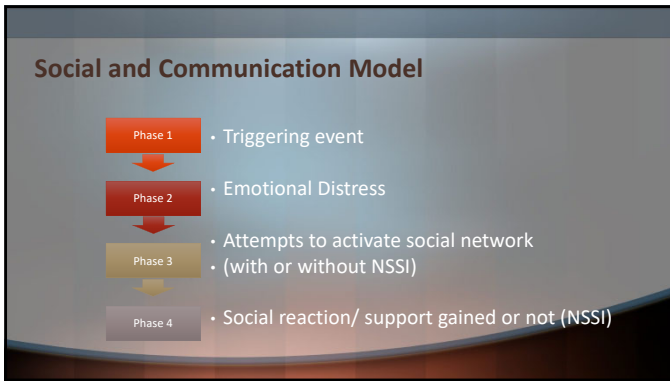
NSSI as a separate entity –DSM-5

Function of NSSI

Why Identifying the Functions of NSSI is needed

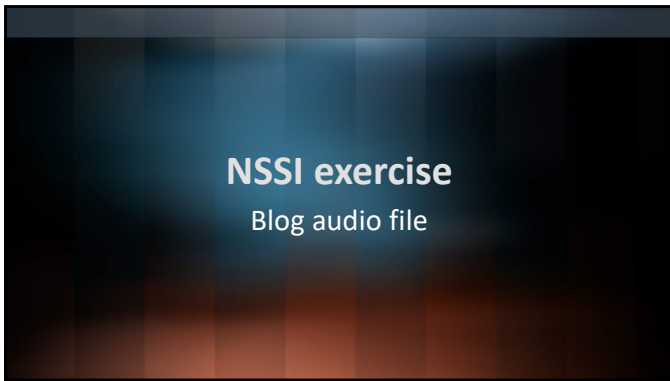


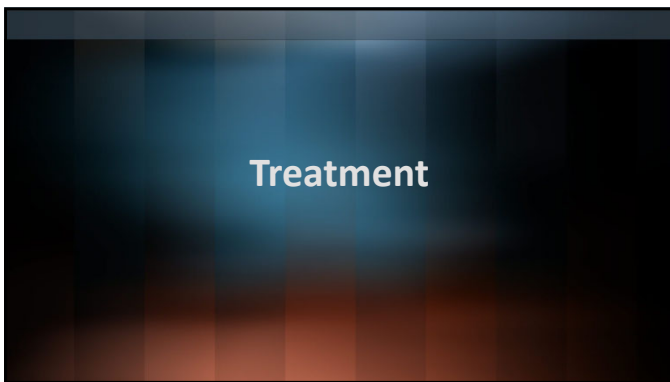


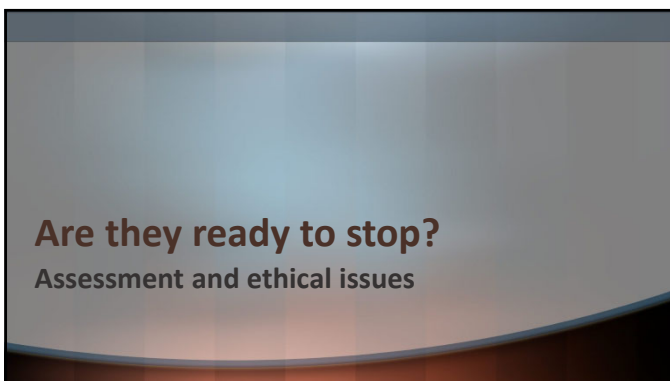


A Brief Note on similar functions to Suicide

Other Conceptual Models for NSSI







• Why Replacement Skills are needed early in Treatment

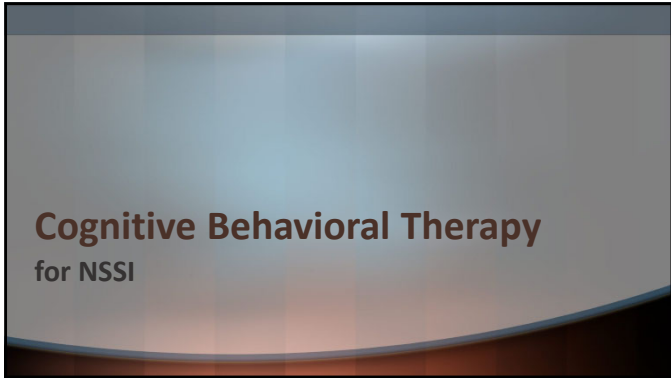
• (it's a hard sell)

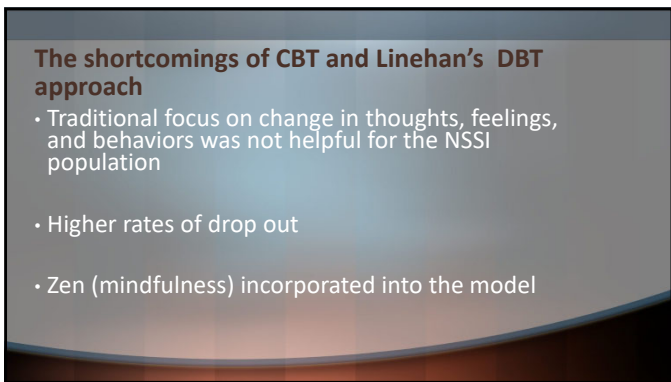
Replacement Skills

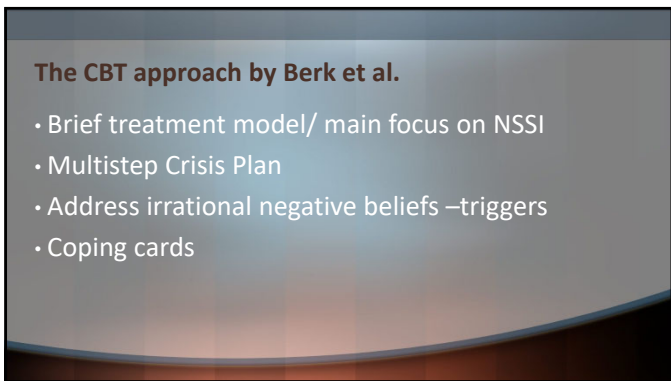
- Negative replacement skills
- Mindful breathing
- Visualization
- Physical exercise
- Writing
- Artistic expression

Replacement Skills

- Music
- Being Social
- Diversion techniques "intense distractors"







The CBT approach from Rudd et al.

- For broader range of people than DBT
- Addressed thoughts of hopelessness, unlovability, helplessness and poor distress tolerance
- Focus on therapeutic alliance

The CBT mechanism of change for NSSI

- Therapeutic relationship
- Emotion regulation
- Cognitive restructuring
- Behavioral skills training

**Acceptance and Commitment
Therapy**
For NSSI

ACT Approaches

- Sees DSH as attempts to avoid experiences such as thoughts, feelings and other internal experiences that are uncomfortable
- Cognitive diffusion

Motivational Interviewing
For NSSI

Motivational Interviewing – Kress & Hoffman

- Use of appropriately framed questions
- Help elicit information for risk assessment
- Elicit client’s commitment to getting treatment
- Referrals for appropriate services

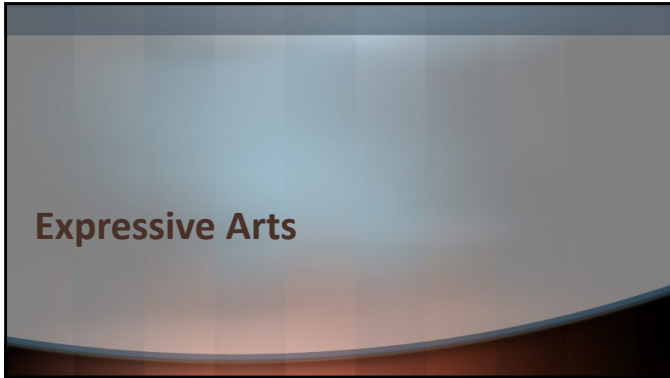
Motivational Interviewing – Kress & Hoffman

- Helps enhance your understanding from the client’s point of view
- Facilitate enough discussion for adequate risk assessment
- Prompt the client to begin thinking about the issue

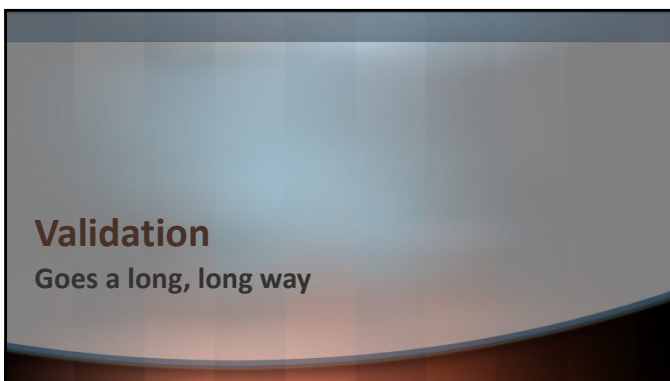
Motivational Interviewing – Kress & Hoffman

- What effect is this having on your life?
- It seems like it serves a function for you. What are the disadvantages of doing it?
- Is there anything motivating you to stop right now?
- How would things be different if you were not self injuring?
- What do you think you would need to stop self injuring?

Focus on Emotional Dysregulation







Parent do's and don'ts

- Parent and teacher Don'ts
- Kids fear that parents are going to yelled at them, reject them, or get them "in trouble" by punishing them once self injury is discovered.
- 1. Do NOT yell and scream at teen for self-injury.
- 2. Do not punish for self injuring.
- 3. Do not minimize the seriousness of this unusual behavior. Even if your child seems to be copying what her best friend is doing, realize whose blood is coming out of your child's arm when she cuts.
- 4. Do not use a "contract" to stop self injury. It doesn't work. It can lead to increased self injury.

- Parent and teacher Don'ts
- 5. Do not tell your teen to stop injuring themselves "for You." They need time to learn how to move away from self injury. They must possess their own desire to stop injuring themselves. They will do so when they are ready.
- 6. Do not say "you are just doing this for attention." (Who doesn't want attention?)
- 7. Do not rationalize the self injury by thinking that your "teen is just going through a phase" and that she/he will simple grow out of it over time. Research has shown that that majority of adults who self injure started their self injury during their adolescence.

• Parent and teacher Don'ts

- 8. Once treatment for self injury begins, do not let your own fears prevent the treating professionals from doing their job by not supporting the treatment plan.
- 9. Do not let your self injuring adolescent stop treatment prematurely because she/he "doesn't want to go any more."
- 10. Do not let your child's resistance to treatment or refusal to go to sessions stop you from implementing the treatment that is necessary for recovery from this addictive behavior. A depressed teenager does not have the wisdom or judgement to make this decision. Remember, she/he is probably afraid to give up what seems to be working, or feels incapable of doing so.

• Parent and teacher Don'ts

- 11. If your self injuring teen is resisting treatment, do not fall for the old saying that "you can lead a horse to water but you can't make them drink." Understand that it is the job of the therapist to "make the horse thirsty."

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