Non-Suicidal Self-Injury (NSSI): Etiology, Treatment and Prevention of Cutting

By: Deborah Converse, MA, NBCT and Rene Ledford, MSW, LCSW, BCBA

Learning objectives

- Describe the prevalence of non-suicidal self-injury (NSSI) cutting across gender, age, socioeconomic status and cultures.
- Identify the warning signs that may indicate NSSI cutting.
- List and describe four factors associated with the etiology of NSSI.
- Explain three types of treatment for NSSI.
- Identify four strategies that can be used to prevent NSSI.
- Discuss the connection between the media, culture and self-injury.

The description of cutting behavior

Cutting disorder is listed under many categories, including self-harm, self-injury, self-mutilation, self-abuse, para-suicidal behavior and body modification. These terms refer to deliberate cutting, slashing, burning, biting, bruising, scratching, pulling, ripping, tearing, piercing and carving on the skin.

Self-injury occurs on any part of the body but is often seen on the arms, wrists, abdomen and thighs. A variety of implements may be used to inflict the injuries, including knives, scissors, razor blades, garden tools, candles, lighters, stoves, hair styling tools, paper clips, pins, needles, arts and crafts tools, nail files and clippers, screwdrivers and in extreme cases, power tools.

In recent studies by Stuart Goldman MD, (2010), Co-director of the Mood Disorder Program at Children’s Hospital Boston, and Dr. Janis Whitlock (2010), Cornell University, the term non-suicidal self-injury, (NSSI), is used to describe cutting behavior.

NSSI behaviors are intentional, and though abnormal, they can be distinguished from other forms of mental illness and developmental disorders such as schizophrenia and autism. NSSI behavior is by choice and conducted with the person’s free will. Called ego systonic, part of one’s self, NSSI behavior is in contrast with the schizophrenic individual who believes the impulse is not his own and comes from a separate voice. This type of behavior is called ego dystonic, meaning apart from one’s self (Veague, 2008).

Autism spectrum disorder, ASD, is a developmental disorder with delays or deficits that may be present in cognitive, motor, social, behavioral, language and communication. Individuals with autism may engage in repetitive behaviors, such as rocking, head banging, picking, scratching, hitting themselves, and biting skin.

Other self-harm behaviors are compulsive, occur daily, and are often ritualistic. These may be found in obsessive-compulsive disorders such as trichotillomania, which includes pulling or plucking out the hair, eyebrows and eye lashes (“You Are Not Alone,” n.d.).

To further delineate NSSI behavior from other forms of mental and developmental disorders, Armando Favazza (1996) of the University of Missouri has defined four categories of self-harm:

1. **Major** – Associated with psychological disorders such as schizophrenia, which may result in life threatening self-injury such as castration or amputation. Hallucinations, delusions and psychotic symptoms are often present.
2. **Stereotypic** – Behaviors that are repetitive, rhythmic, self-stimulation behavior resulting in injury and associated with developmental disorders such as autism, Tourette’s disorder and cognitive disabilities.
3. **Compulsive** – Includes obsessions, reoccurring thoughts and impulses, and ritualistic behaviors occurring daily, frequently seen in OCD.
4. **Impulsive** – Ego systonic, intentional self-harm, often present in borderline personality disorder and eating disorders. Cutting and para-suicidal behaviors often result from abuse, trauma, poor self-image, mood swings and fears of abandonment.

NSSI falls in the category of an impulsive disorder prevalent in emotional and personality disorders including anxiety and depression. Cutting behavior is most commonly found in borderline personality disorder, which is a form of mental disorder and often includes self-harm. NSSI it is not considered to be an act of suicide, but it may be part of a suicidal fantasy. Cutting is linked to suicide because 70 percent of individuals diagnosed with personality disorder have a history of suicide attempts or self-mutilation. Thirty percent of suicides occur among individuals with a history of cutting (“What Causes Self Mutilating Behaviors,” 2011). NSSI could result in severe injury or accidental death if the injury is severe enough. For this reason, cutting may mistakenly be viewed as an act of suicide (Kreisman & Strauss, 2004).

The prevalent view of NSSI is that it is a form of mental disorder, although it does not have a separate diagnosis. According to a recently proposed revision, the American Psychiatric Association (2010) Diagnostic and Statistical Manual of Mental Disorders (DSM), lists four criteria that...
should be considered when determining whether the mental disorder falls within the NSSI classification:

A. Within the past 12 months, the individual has five or more times engaged in intentional self-inflicted damage to his or her body to induce bleeding or pain for purposes not socially sanctioned and performed with the expectation that the injury will lead to only minor or moderate physical harm. The absence of suicidal intent is either reported by the patient or can be inferred by frequent use of methods that the patient knows by experience not to have lethal potential. The behavior is not trivial, such as picking at a wound or nail biting.

B. The intentional injury is associated with at least two of the following:

1. Negative feelings and thoughts, such as depression, anxiety, tension, anger, generalized distress or self-criticism, in the period immediately prior to the self-injury event.
2. Prior to engaging in the act, there is a period of preoccupation with the intended behavior that is difficult to resist.
3. The urge to engage in self-injury occurs frequently, although it might not be acted upon.
4. The behavior has an intended purpose, such as relief from negative feelings or cognitive state, and may be an attempt to induce a positive state. The patient anticipates this will occur either during or immediately following self-injury.

C. The behavior and its consequences cause clinically significant distress, impairment and dysfunction in the person’s life.

D. The behavior does not occur exclusively during states of psychosis, delirium or intoxication. In individuals with developmental disorder, the behavior is not part of a pattern of repetitive, stereotypical behaviors. The behavior cannot be accounted for by another mental or medical disorder.

Potential not otherwise specified (NOS) categories will be used if DMS-5 adopts sub-typing NOS categories:

* Non-suicidal self-injury disorder, not otherwise specified (NOS), Type 1 sub-threshold:
  ○ The patient meets criteria for NSSI, but has injured himself or herself fewer than five times in the past 12 months. This could include individuals who, despite a low frequency of behavior, continually think about performing the act.

* Non-suicidal self-injury disorder, not otherwise specified (NOS), Type 2, intent uncertain:
  ○ The patient meets criteria for NSSI but insists that in addition to thoughts expressed in B4, he or she also intended to commit suicide (APA, 2010).

The aspect of cultural norms and religious practices relevant to self-harm should be reviewed. Throughout history and in all cultures, there are examples of behaviors that can be classified as self-harm.

In the Bible, Mark 5:5 refers to a demon-possessed man who “always night, and day, was crying and cutting himself with stones.” Some religions encourage self-harm as a way of purging sin and a form of redemption. Other religions hold the belief that inflicting pain and human suffering will appease God and lessen punishment. Self-denial or asceticism may be viewed as a way to become closer and more favorable in God’s eyes. Redemptive suffering is seen in the religious practices of corporal mortification or mortification of the flesh. Examples of these practices can be found in the history of Judaism, Islam, Hinduism, Buddhism and Christianity in the forms of self-inflicted cutting, whipping, beating and burning.

In the Middle Ages, a religious sect known as the “flagellants” wandered through Europe, lashing themselves with cats-o’-nine-tails to atone for society’s sins and to stop the great plague spreading across Europe (Conterio & Lader, 1998).

Many cultures around the world have customs and rituals that include the infliction of pain as a right of passage to mark a milestone in one’s life.

Dr. Karen Conterio and Dr. Wendy Lader in their book, “Bodily Harm,” trace the rise in youthful self-injury back to rebellion in the 1960s and ’70s. Adolescence has always been a time of rebellion as teens seek independence from their parents. The “hippie” counterculture, though carrying a message of peace and harmony, had the dark side of heavy drug abuse (p.6).

They further noted that the 1980s brought media attention to the emphasis on sexual appeal of artists like Madonna and focused on body image and appearance.

The study reviewed the 1990s, which brought grunge and the fad of the disheveled look with baggy pants, messy hair, tattoos and piercings combined with drug use and glorified an image that seemed to say “I don’t feel good about myself” (p.6). During this period, the use of external body adornments and outward appearance to express and communicate life’s dilemmas became the norm. In the S.A.F.E. Alternatives treatment program, developed by Conterio and Lader in 1985, they often see teens carve negative comments about themselves such as “fat” and “ugly,” the two most common words seen (p.7).

Dr. Janelle Hart, a staff psychologist at S.A.F.E. Alternatives, reports that teens are presenting with more visible self-injury. Dr. Hart sees this as another form of rebellion and a way of being offensive and defiant. What was considered outrageous to adults 10 years ago does not even get a reaction now. Adolescents search for something that is even more horrifying than before to shock adults. She states, “Our teen patients complain that almost nothing they say or do really gets their parent’s attention, so what does it matter if they self-injure? Many adult self-injurers have expressed similar feelings about the people in their lives and the lengths they have gone to capture the interest of others.” (Cited in Conterio & Lader, 1998, p.8).

Though psychologists can agree that many forms of NSSI do meet all three criteria for the definition of mental disorder, there is no separate diagnostic category for the disorder. Cutting is viewed as a type of masochistic behavior and often co-occurs with other forms of mental disorder.

Recent studies by Dr. Janis Whitlock (2010), conducted at Cornell University, note that NSSI is commonly episodic, repetitive and rarely pre-mediated and may progress from mild to severe.

Consider the following case studies, which exemplify the four categories of self-harm, and apply them to the three criterion of mental disorder as outlined in the previous section.
Rosa became convinced that the baby would become ill when even though the child was healthy and developing normally, anxiety medication, but it did little to ease her fears and anxiety. Rosa consulted her doctor, who prescribed a low-dose anti-care (NIC) unit, and the staff at the hospital had to gently but firmly suggest that she go home to get some rest.

Rosa would try to spend all of her time in the neonatal intensive care unit, but it was hard for her to sleep. She worried that she would not be able to take care of the child when she came home. She became obsessed with cleaning the house with harsh chemicals continually throughout the day. She felt that she might be transferring germs on her hands to her baby, so she began a complicated and detailed process of scrubbing her hands and arms every 45 minutes. Her daily activities were built around the house cleaning and hand-washing routines, so she curtailed many contacts with friends and family.

During the time the baby remained in the hospital, Rosa became extremely anxious and could not sleep. She worried that she would not be able to take care of the child when she came home and that it was her fault that the child was born prematurely. Rosa would try to spend all of her time in the neonatal intensive care unit, and the staff at the hospital had to gently but firmly suggest that she go home to get some rest.

Rosa consulted her doctor, who prescribed a low-dose anti-anxiety medication, but it did little to ease her fears and anxiety. Even though the child was healthy and developing normally, Rosa became convinced that the baby would become ill when she came home. She became obsessed with cleaning the house with harsh chemicals continually throughout the day. She felt that she might be transferring germs on her hands to her baby, so she began a complicated and detailed process of scrubbing her hands and arms every 45 minutes. Her daily activities were built around the house cleaning and hand-washing routines, so she curtailed many contacts with friends and family.

Rosa’s self-harm behavior exemplifies the compulsive category of self-harm.

John is a 19-year-old man diagnosed with autism spectrum disorder who has lived in a group home since he was 4 and was removed from an abusive family. He prefers to be alone and rarely makes eye contact with peers or staff. He began to speak at a normal developmental age, but his verbal communication ceased at age 2, and he retained only a few words. These words are often used out of context, and he often makes unintelligible sounds. He attends a public high school special education program during the day. John can feed himself and uses a fork and spoon. He will follow a one-step direction, but cannot form letters or numbers and scribbles when given a writing utensil.

John has frequent toileting accidents, and psychological assessments determined that he functions at a mental age of 18 months to 2 years.

John will bang his forehead with his fist and bite his hand repeatedly if not stopped. He has developed a large bump on his forehead from years of hitting himself and scars from repeated biting. John displays a variety of repetitive movements, such as rocking, flipping his hands in front of his face and shifting his weight back and forth from side to side. Though viewed as painful by observers, John’s hitting and biting behaviors are classified as self-stimulation and are prevalent among individuals with ASD. Autism is a permanent disorder, and behavioral therapy is often used to help the individual limit and control harmful behaviors.

John’s case study demonstrates stereotypic self-harm.

Rosa was a 30-year-old housewife with two children. She had experienced anxiety and depression since college but never felt her condition was serious enough to seek treatment.

Her second child was born six weeks premature, and though small, the baby thrived and was released from the hospital a month later at 4.5 pounds.

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Even though the child was healthy and developing normally, Rosa became convinced that the baby would become ill when she came home. She became obsessed with cleaning the house with harsh chemicals continually throughout the day. She felt that she might be transferring germs on her hands to her baby, so she began a complicated and detailed process of scrubbing her hands and arms every 45 minutes. Her daily activities were built around the house cleaning and hand-washing routines, so she curtailed many contacts with friends and family.

Her hands and nails became raw and often bled from the harsh chemicals, brushes and nail files she used to clean under her nails and cuticles. Rosa continued to be anxious and fearful concerning her child’s health, but the repetitive cleaning routines did seem to temporarily lessen her fears. However, contacts with friends and family activities were disrupted as she tried to hide her injured hands.

Rosa’s self-harm behavior exemplifies the compulsive category of self-harm.
Jane was a 23-year-old teacher in a large public high school. She moved out of state to find a job and lived in an apartment alone. Jane was quiet, kept to herself and did her job well.

Jane was adopted into a loving, middle class home when she was 5 and always worked hard and did well in school. Her adoptive mother reported that Jane began to lose weight in high school and that she abused laxatives. She was diagnosed with anorexia, but resisted treatment.

Jane appeared to be managing her eating disorder and went to college where she lived in a dormitory. But she began to feel anxious and lonely and started to cut her wrists, which gave her an odd sense of control and relief. Jane went through a series of boyfriends and was successful in hiding the cutting behavior until the relationships became intimate. At first, the boyfriends would attempt to stand by her, supporting her and convincing her to seek treatment.

Jane would check herself into a psychiatric facility but lived in a state that allowed her to leave after 72 hours. She was diagnosed with borderline personality disorder, but despite her parents’ urging, refused to enter treatment designed for self-injury recovery.

Through college, she began abusing over-the-counter drugs, such as antihistamines that made her go to sleep. She also continued to have eating disorder issues.

After she moved out of state for her first teaching job, Jane appeared to be doing well. Midway through the year, however, she began missing work, and it was discovered that she had cut herself in the school restroom. Fearing she was a danger to her students, the principal told her if she did it again, she might lose her job and told her to seek treatment.

At this point, the other faculty members became aware of Jane’s cutting, and several individuals reached out to her offering support. Her mentor teacher suggested that she contact her parents so that they could help her. Jane told the other teachers that her parents rejected her, threw her out and wanted nothing to do with her. This gained her a lot of sympathy from her colleagues, and everyone tried to support her without really knowing what to do. It was later discovered that it was Jane who left her family, despite their many attempts to support her and get her to enter treatment.

Jane checked herself in and out of 72-hour emergency psychiatric facilities on the weekends. She would appear to be happy and free of her impulses to cut for short periods of time, usually when she started a new relationship. After her boyfriends discovered the cutting and abuse of antihistamines, the relationships ended. She refused to enter a treatment program for self-injury, the cutting continued, and she lost her job.

To find work, Jane moved to a different county. About six months later, school personnel and her parents lost contact with Jane – until her obituary appeared in the paper. Her death was ruled an accident when her repeated mixing of drugs resulted in an overdose.

Jane’s case contains characteristics that appear among individuals who engage in impulsive self-harm.

According to Kreisman and Strauss (2004), the mental disorder in which self-harm is one potential diagnostic criterion, and the one most commonly diagnosed among those who engage in cutting is **borderline personality disorder (BPD)**. Self-harm is not a requirement for the diagnosis of borderline personality disorder, but it is a symptom or indicator of the disorder.

BPD is characterized by instability of moods, poor self-image, weak or lack of impulse control, inability to maintain interpersonal relationships and fear of being alone or abandoned. These profound fears often result in erratic, unpredictable, dangerous behaviors, which are committed in a desperate attempt to draw someone close or to keep them from leaving.

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### PREVALENCE AND DEMOGRAPHICS

**Age**

Cutting is becoming more prevalent around the globe. A long-term study conducted in the United Kingdom, Young People and Self-Harm: A National Inquiry, (2004), found that 28 percent of teens under the age of 18 have experimented with cutting. Alarming high rates are reported throughout Europe, Canada and the United States. Dr. Stuart Goldman (2010), co-director of the Mood Disorder Program at Children’s Hospital Boston, reports that “NSSI has been around a long time, but cutting has become more prevalent in the last decade” (2010). A study by Dr. Janis Whitlock of Cornell University, “Self-Injurious Behavior of Adolescents” (2010), found that 12 percent to 37 percent of children in early adolescence had cut themselves. Further research studies in the United States determined that the average age of onset is 11-15 years, with the range of normally distributed age of onset from 10-24 years.

(Whitlock, Eckenrode & Silverman, 2006). Whitlock states that though the duration is understudied, Cornell research suggests that among individuals with a repeated history of NSSI, 79.8 percent stopped cutting within five years, and 40 percent stopped within one year.

A common misconception is that it is used to gain attention. This is not compatible with the fact that the majority of cutting behavior is done in private, and the individual goes to great lengths to conceal the behavior. Though it is not an attempt at suicide and may co-occur with other mental disorders and addictions, cutting should always be treated seriously as a cry for help and never ignored (Veague, 2008).

NSSI can be found across all age groups, backgrounds and socioeconomic levels. Princess Diana of Wales reported...
that she had been afflicted with eating disorders and cutting in her attempt to relieve her anxiety and depression. There is a misconception that it is predominantly found among adolescents. It has been found among individuals of all ages, including the elderly. The profile of a typical cutter is a female in her mid-20s to early 30s who has been cutting herself since her teens. She is intelligent, middle- or upper class, and well educated. She also comes from a home where she was physically or sexually abused and has at least one alcoholic parent (“Cutting,” 2011).

Gender

Cutting is found in more women than men, but there is only a slight differential.

Findings on racial background and NSSI rates are mixed. There is significant evidence that cutting may be linked to sexual orientation with slightly higher incidence of cutting among those individuals reporting attraction to the same sex. Further studies show a very elevated rate of NSSI among individuals who are bisexual and those who reported questioning their sexual orientation (Whitlock et al., 2006).

The majority of the research on self-injury is focused on females. A study conducted in the United Kingdom by LifeSIGNS, Male Self Injury Taken Seriously, included in the book, “Self-Mutilation,” edited by Mary A. Williams (2008), maintains that flawed research is responsible for the misperception that self-injury is associated with women. “In today’s culture, men often feel pressured to appear strong and to avoid looking needy in any way, so they are less likely to seek support when they undergo emotional distress. Thus males who self-injure, as a way to cope with overwhelming emotions, are less likely to share their predicament with others.” (P.38).

It is difficult to find statistics on the number of boys versus girls who self-injure. This may be because self-injury is often overlooked and may be hidden and unreported. Often family and close friends do not know the extent of the self-injuring behavior. That may be because the injury is a cry for help but also a source of shame, especially for teen boys (“Help Stop Self-Injury,” 2005).

A recent report by M.J. Marchetto supports the view that a bias in research may be responsible for the reported predominance of females who experience self-injury. In his study, no gender differences were experienced among cutters, and most reported they had experienced trauma (as cited by Williams, 2008, p.39).

Though men are reported to be a rarity in the S.A.F.E. Alternatives program, the male patients are coping with problems similar to female patients. Staff explains that if you were to conceal the names on the intake forms, you could not distinguish the males from the females. They note that like many female patients, the men often feel strong anger toward their parents and yet they fear any direct expression of anger may sever the relationship. Some male patients work hard to cover up and deny anger toward parents even when they were abusive. S.A.F.E. Alternatives therapeutic work focuses on allowing these feelings, along with depression, to come to the surface in order to move forward in treatment (Conterio & Lader, 1998).


Conterio and Lader (1998) discuss several reasons identified for the increasing self-injury rates among inmates:

- In prison, men can’t discharge tension in the ways they can in the outside world.
- Convicts, who are likely to have had antisocial tendencies before being incarcerated, cannot find thrills, escape, distraction or stimulation in the ways they did before entering prison.
- In prison, their movement is restricted, and they have lost their freedom and control of their environment.
- They feel trapped and cannot express their anger and rage in other ways. These men are expressing the same feelings as do women patients who cannot find a way to release or express their anger in appropriate ways.
- Self-injury in prison may also be a survival tool because it is a way to get out of the general population.
- An inmate may self-injure to show others that he is too disturbed or fearsome to be a target for attacked by other inmates.

S.A.F.E. Alternatives staff acknowledges that it takes a lot of courage for men to escape the “macho” stereotype to admit they have a problem and seek treatment.

LifeSIGNS (2008), an online self-injury guidance and support network in the United Kingdom, noted the following:

- There is a perception that women express their emotions more openly and that they are more effective in communicating emotions.
- Men are often thought to be more comfortable keeping emotions inside and coping with stress on their own. Men suffer from emotional stress, depression and anxiety to the same extent as women, but they are expected to keep their emotions in control.
- Society places pressure on men to remain strong and refrain from openly talking about emotional distress.
- The result is that suicide is now one of the highest causes of death for young men.
- Many men suffer in silence, fearing the stigma of self-injury and society’s view of men who have psychological problems.

Instead of being “weak,” the men that seek treatment are the healthier ones because asking for help is the strongest and bravest thing a person can do.
Media and modern cultural influences

Conterio and Lader (1998) report that the syndrome of self-injury took the late 1990s “by storm.” Research and documentation by Whitlock (et al., 2006) note the increase in NSSI globally among the population 10-24 years old and discuss factors that may have contributed to the increase.

Though the majority of incidents of self-injury appear to be inflicted in private, anecdotal reports from adults who work with teens note a fad quality to the behavior. People, particularly teens desperate to fit in, may pick up the behavior from a classmate or sibling. Research by Purington, Whitlock, and Pochtar (2010) note that adults in secondary schools reported there are groups of teenagers who injure together as a form of group bonding or as a group membership initiation. There are increasing numbers of websites devoted to self-injury, and it is a popular topic in the media. Movies, books, news reports, song lyrics, blogs, social media and magazines may popularize and spread information on cutting (Purington et al., 2010).

Etiology

There is no single explanation, but patterns appear when reviewing etiology of cutting behavior. The attempt to find release from overwhelming emotional pain, depression, or anxiety is a common thread.

- For some individuals, the behavior resembles an addiction, which may be explained by the release of epinephrine providing a temporary euphoria or “high.” This chemical is released in the body in an attempt to ease physical and emotional pain. Cutting becomes a temporary coping mechanism, but the pain and blood do not remove the source of the emotional distress, depression or anxiety, so the cutting cycle continues. Like other forms of addiction, the person requires more over time and the injuries become more severe (APA, 2000).
- As noted above, the cutting may be an escape from emotional distress and part of a suicidal fantasy.
- Individuals who have been sexually abused may feel that injuring their body will make them less sexually appealing, protect them from future molestation, remove them from the situation, and take them to a safe place. (Kreisman & Strauss, 2004).
- Feelings of worthlessness, weakness, shame or guilt may cause a person to cut as a form of self-inflicted punishment.
- Childhood trauma or physical, psychological, sexual or verbal abuse may trigger cutting as an attempt to take control, calm the body and to cope with stress.
- Alexithymia, which is the inability to describe or express emotional experiences, has been associated with cutting. The individual in this case is unable to release or express emotions with words (Gratz, 2006).
- Biological factors that involve disorders in the brain or body chemistry may affect impulse control, mood or thought patterns resulting in the urge to cut. There is considerable research that studied brain scans and noted imbalances in the temporal lobe, basal ganglia, limbic system, prefrontal cortex or neurotransmitters in persons exhibiting cutting behavior (Herpertz, Sass & Favazza, 1997; Amen, 2000).
- Social influences such as Internet cutting chat rooms, blogs, celebrities, actors, artists and other public or media figures may influence an individual to cut.
- Junior and senior high counselors have reported that peer pressure, group membership and group bonding can lead to teens cutting together in a group.
- In the case of borderline personality behavior, it may relate to the fear of loneliness and abandonment. Cutting may temporarily displace the fear and keep others from leaving as in the case study about Jane.
- Cutting is found among individuals with diagnosed mood disorders including depression, bipolar disorder, reactive depression, grief reaction and seasonal affective disorder (“Psychiatric Disorders,” 2011).
- Anxiety disorders including generalized anxiety disorder (GAD), panic disorder, phobias, social anxiety, social anxiety disorder, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD) may involve cutting self-harm (“Psychiatric Disorders,” 2011).
- Personality disorders other than borderline, such as narcissistic and dependent disorders, may lead to cutting (“Psychiatric Disorders,” 2011).

Conterio and Lader (1998), in their book “Bodily Harm,” report on interviews with many patients who describe the analgesic effect of cutting:

_The self-injurer views their pain and distress as everlasting with no end in sight. Many spoke of feeling like they would “explode into a million pieces.” As the feeling of agitation and anxiety escalate, the person would have physical symptoms of a severe anxiety attack, such as perspiration, racing heartbeat, loss of breath, confusion and panic._

_During the cutting experience, Susan L. noted, “I feel calm, I feel powerful, I feel focused, I feel very much in control, I decide when to stop. After self-injury, I feel so much relief. My inside pain and feelings are gone. I go to the emergency_
problems simultaneously. Many patients have alternated does not have issues with food. They strive to deal with both Lader noted they rarely admit a patient for self-injury who and most of all, it never leaves me. It never expects anything from me.”

As noted in previous sections, during self-injury, the brain releases chemicals that function as relaxants. Conterio and Lader explain, “Many of our self-injurers’ descriptions confirm this analgesic function of self-injury, in which the injuring act paradoxically produces a calming, soothing, sensation. The tension and agitation drains out, and the patient feels she can control her thoughts and feelings once again. Once the cut is made, the danger has passed.” (Pp. 62-63).

In the following viewpoint, Dr. Marc Feldman (2004), discusses one little-known cause of self-injury:

- Factitious disorder, the term used to describe a syndrome in which people create self-induced illness or injury, often occurs in order to gain status as a patient. Some people with factitious disorder will injure themselves to escape abuse or gain sympathy and self esteem from having unusual illnesses or injuries.
- When dealing with factitious disorder, medical professionals must look at patients carefully, overlooking nothing, no matter how farfetched, that might help them determine the patient’s motivation to self-injure.
- With borderline personality disorder, the patient openly acknowledges the injury. Factitious behavior involves concealing the decision or motivations to self-injure. Both can occur or alternate, and the endurance of pain is common to both borderline personality disorder and factitious disorder. Many patients in both categories view pain as positive, particularly when they have misled physicians to perform painful surgical procedures. These patients externalize their internal conflict by producing scars or other tangible evidence. The presence of the following factors may indicate the possibility of factitious illness:
  - Dramatic or atypical presentation.
  - Vague and inconsistent details, although plausible on the surface.
  - Long medical records with multiple admissions at various hospitals in different cities.
  - Knowledge of textbook descriptions of illness.
  - Admission circumstances that do not conform to an identifiable medical or mental disorder.
  - An unusual grasp of medical terminology.
  - Employment in a medically related field.
  - Fantasy-like descriptions of false events in their lives.
  - Presentation in the emergency department during times when obtaining old medical records will be difficult or when experienced staff are less likely to be present, such as holidays or late Friday afternoon.

Given sufficient time with a patient with a factitious disorder, doctors may be able to pinpoint the individual’s motivation even if the person is unaware of the forces driving the false illness. The motivation may be to stay in a safe environment, such as a hospital, and this may drive the person to keep coming back if he or she has no feeling of safety in life. It is often difficult for medical professionals to have sufficient time with these patients because of their frequent pattern of changing hospitals or physicians.

Adults with factitious disorder may identify with their childhood abusers and perpetuate, through self-induced illness and injury, the physical abuse they experienced as a child. They may accept or believe that physical abuse is a normal part of life. For patients who have suffered childhood abuse, control may be a motivating factor. As children, they were not strong enough or capable of controlling what was happening to them. As adults, they may be consumed by uncontrollable, unresolved anger that often presents itself as highly controlling behavior. In these cases, they may manipulate physicians to contribute to their abuse through unnecessary, painful tests and surgical procedures. Even though this results in potential harm, patients may feel they have gained control through this behavior.

Feldman concludes by reviewing the theory of faulty cognitive processing. In these cases, the patients’ abnormal perception of bodily sensations leads them to misinterpret normal physiological functions as frightening or harmful. Such patients gain reassurance by frequently seeking medical attention for physical examinations and treatment for self-injury.

The correlation between eating disorders and self-injury

Considerable research has determined that many self-injurers are also dealing with eating disorders. In fact, Conterio and Lader noted they rarely admit a patient for self-injury who does not have issues with food. They strive to deal with both problems simultaneously. Many patients have alternated between the two disorders for years because the underlying issues that lead to the syndromes were never resolved. Though eating disorders can be viewed as self-injury, the definition used at S.A.F.E. Alternatives is the deliberate alteration of body tissue without regard to health or safety for the purpose of regulating emotional stability.
Self-injury and eating disorder patients often have the same psychological experiences in their pasts, including childhood trauma, issues with self-image, gender identity and conflicts with sexuality. The disorders often have similar motivations: trying to gain control and relief from emotional pain.

Patients with both eating disorders and self-injury often report severe problems with body image and have difficulties maintaining physical boundaries. Many experience their bodies as a detached object, as an “it,” rather than “me.”

**Signs of NSSI**

Because there usually is attempt to conceal the injury, the indicators may not be obvious. Individuals may be embarrassed or ashamed because they cannot handle their emotions, depression or anxiety. An individual known to exhibit indicators for these disorders could resort to cutting or other forms of self-harmful behavior, including eating disorders or abuse and addiction to drugs and alcohol. The following clues may be signs of cutting (Rosen, 2011; Purinton et al., 2010; Whitlock et al., 2009):

- Clothing that could hide the injury, such as long sleeves, long pants, turtleneck or high-collared shirts, and gloves that are not appropriate for the weather.
- Unexplained wounds that are covered in bandages.
- Small, linear cuts, often parallel.
- Frequent injuries explained by excuses such as being clumsy or prone to accidents.
- The presence of unexplained implements for cutting that are out of place or not normally carried or kept by an individual.
- Refusing to engage in activities that require being uncovered.
- Injuries on the non-dominant hand.
- Wristbands or coverings.
- Changes in mood; preoccupation with topics of blood, violence, pain, self-harm, death or other negative behavior.
- Withdrawal from friends and social connections.
- Drastic changes in group membership, behavior, attitude or activities.

**Identification and assessment**

The first step in planning a treatment plan for individuals is to identify the frequency, possible cause, severity and maintenance of the behavior (Veague, 2008). Many individuals will be ashamed or embarrassed to discuss their cutting behavior. They may deny that they have the problem or believe that it is not a problem at all.

Identification and assessment begins with an inquiry about the behavior. Daphne Simeon and Eric Hollander (2001) of Mount Sinai School of Medicine in New York suggest mental health workers ask all incoming patients, “Have you ever intentionally hurt yourself in any way?” This question may start a dialogue, and the clinician can determine whether treatment is warranted. They offer the following suggestions:

- It is important to approach the individual in a non-threatening, non-judgmental, and non-emotional way.
- Do not display shock, pity or make statements that suggest punishment or shame, which may reinforce the behavior or cause the person to reject care.
- There should be training for staff to recognize indicators of self-injury and to respond appropriately.
- Within school settings teachers, staff and peers can be taught to recognize signs of distress.
- Peers may be the front line of defense and must be given strategies and encouragement to communicate with adults.

Here are some examples of questions that can be used to identify and assess the severity of cutting and other forms of self-harm (Simeon & Hollander, 2001):

- Have you intentionally hurt yourself in any way?
- When you hurt yourself, were you trying to commit suicide?
- How old were you when you first hurt yourself?
- How often do you hurt yourself?
- Have you had to seek medical treatment for hurting yourself?
• How do you feel before you hurt yourself?
• How do you feel after you hurt yourself?
• Do you ever have the urge to hurt yourself?
• Do you want to stop hurting yourself?
• Have you ever been able to stop right before you hurt yourself?
• Do you use drugs or alcohol before you hurt yourself?
• Is there a certain time of day that makes you feel like hurting yourself?
• Is there a certain situation or place that makes you feel like hurting yourself?

Is there a certain person or people who make you feel like hurting yourself?
• Do you know of anyone in your family who has hurt themselves?
• Do you have friends or anyone you know who hurts themselves?

If a pattern of self-harm has been established, the clinician or health care worker will want to gather more information to make decisions about the most effective plan for treatment. This will include a determination of the category that best describes the individual’s self-injury: stereotypic, major, compulsive or impulsive (Favazza, 1996).

Treatment

Just as there is no single cause of cutting behavior, there is no single form of treatment that will be effective for everyone. The components of an effective treatment plan should include components for detection, intervention and referral for treatment (Walsh, 2005).

• Approach the individual in a non-threatening, neutral, non-emotional tone to create a safe environment, a crucial element.
• Maintain structure, consistency and predictability, which is important when working to establish a relationship.

Develop a plan that includes the patient taking responsibility for his or her behavior.
• Help the individual learn to identify the triggers, physical cues or environmental stressors that precede the cutting.
• Identify safe places and people for support to help the person reduce the urge to cut or to help during an episode.
• Develop coping strategies and replacement behaviors to help the person react positively to the identified triggers or stressors.

TYPES OF THERAPY

Psychodynamic psychotherapy

This type of individual therapy is used to help people identify the reason they engage in self-injury behavior (Veague, 2008):

The goal of this approach is to uncover and challenge the unconscious feelings and thoughts that lead to self-harm.

Since cutting is viewed as an inappropriate way to cope with emotions, the therapist works with individuals to help them express the feelings that led to self-harm. This often begins with identifying the object of the anger, such as one’s self, an aspect of the body, a parent, partner, setting, situation or physical cue. The environment surrounding the incidence of self-harm must be determined as well to identify possible triggers. The therapist will help determine the interpersonal dynamics that occurred before the self-harm and identify the feelings at that time. The treatment assists the person to learn to anticipate the feelings associated with cutting so that appropriate coping strategies and alternative activities can be substituted. Some therapists suggest behaviors that have a strong physical component without being harmful, such as holding an ice cube or taking a shower. These activities may help break the cutting cycle.

There are many alternative behaviors that have been suggested because individuals often require different means of expression and coping strategies. Clark and Henslin, (2007) and Martinson (2008) suggest that activities can be determined in advance as part of the treatment plan. These activities can be used when the person identifies the urge to cut and should be readily available when alone or with others. Any activity that is safe and enjoyable or interesting to the person can be planned. Here are some suggestions:

• Listen to music.
• Make music.
• Create something, such as a drawing or painting; work with clay; take photos.
• Write something, such as a journal, letters, e-mail, poetry.
• Exercise or dance.
• Do some gardening.
• Clean or fix something.
• Pet, groom or play with an animal.
• Do puzzles, crosswords, word finds, hidden pictures games.
• Play electronic games.
• Make a list and research places you would like to go or things you would like to do.
• Go to a museum or gallery.
• Read religious writings or engage in prayer.
• Meditate or practice yoga.
• Practice deep breathing techniques.
• Watch relaxation tapes or videos.
• Watch favorite movies.
• Go to the library.
• Take a walk.
• Read something positive or humorous.
• Listen to a comedy tape or TV show.
• Make a phone call.
• Contact a support or help line.
• Use a red felt pen to mark where you would normally cut.
• Write negative feelings on a piece of paper and then tear it up.
• Put elastic bands on wrists, arms and legs and flick them instead of cutting.
• Hit pillows or cushions or have a good scream into a cushion.
Group therapy

Group therapy may take many forms, including structured, unstructured, issue-focused, mixed, family based, faith-based, or a combination of these (Clark & Henslin, 2007). A licensed professional should guide the group, but the level and type of their involvement will vary. The group of people who support and participate in the recovery process can be a powerful force in the treatment. The therapist will need to assess the dynamics of the group and the personality of the participants to determine the most effective form of group therapy. Clark and Henslin explain some common types of group therapy (2007):

- **In the structured group**, the team comes together to work through a series of exercises and lessons geared toward helping the individual to identify, process and change the pattern of cutting behavior.
- The unstructured group uses a conversation format in which the group works on relationship and communication skills to support each other.
- **Issue-focused groups** bring people with similar problems together.
- **Mixed groups** include individuals with different experiences and issues. People in this group may gain new perspectives by listening to the experiences of others. They learn to interact with others who may not view the world as they do.

### The S.A.F.E. Alternatives program (Self-Abuse Finally Ends)

One program that has been successful with teens for more than 25 years is the S.A.F.E. program developed by Karen Conterio and Wendy Ladder in 1985. S.A.F.E. Alternatives focuses on helping teens to learn to face their problems and communicate their feelings to others. Individual and group therapy is used in this treatment program. If there is underlying depression or anxiety, antidepressant medication may be prescribed. Patients often write in journals to learn to explore and express their feelings. Helping the teens to gain self-respect and self esteem is a critical treatment goal, reports Conterio. Lader adds “Many kids have difficulty dealing with people and situations that make them angry. They don’t have great models for that. Saying no, standing up to people – they don’t believe they are allowed to do that, especially girls. It’s very difficult to maneuver the world, survive in the world without someone stronger, more capable to fight your battles.”

Circular negative thinking keeps teens from developing self-esteem. “We help them empower themselves, take risks in confrontation, change the way they view themselves,” says Conterio. “We want them to stand up for what they want, believe they are somebody, they do have a voice, and they can make changes to take care of themselves.” (2011).

Individual therapy in the form of psychotherapy is often the first step in S.A.F.E. Alternatives treatment, reports Lader. It is important to find a therapist experienced in working with self-injurers. Of course, the individual must be ready for treatment. “The ultimate lynchpin is, the individual has to decide they’re not going to do this anymore. Any ultimatum, bribery or putting them in a hospital is not going to do it. They need a good support system. They need treatment for disorders like depression.” (Rosen, 2011). Rosen adds, “Kids who develop this behavior have fewer resources for dealing with stress, fewer coping mechanisms. As they develop better ways of coping, as they get better at self-monitoring, it is easier to give up this behavior – but it is much more complicated than something they will outgrow.”

In S.A.F.E. Alternatives’ 30-day, inpatient program, Lader and Conterio only treat patients who voluntarily request admission. “Anybody who can’t admit they have a problem will be hard to treat,” says Conterio. She noted, “Those who come to us have recognized that they have a problem, that they need help to stop.” The patients sign a contract that they will not self-injure during the program. “We want to teach them to live in the real world,” says Lader. “That means making choices in response to emotional conflict – healthier choices, rather than just self-injuring to feel better. We want them to understand why they are angry, show them how to handle their anger.”

Though self-harm is not allowed, “We don’t take away razors, they can shave,” Conterio adds. The message we’re sending is, "We believe you’re capable of making better choices.”

Rosen and Conterio suggest that parents can help by:

- Providing emotional support.
- Identifying early warning signs.
- Helping children to distract themselves.
- Lowering the child’s stress level.
- Providing supervision at critical times.

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**Family-based therapy** addresses the dysfunctional family issues that influence unhealthy behavior patterns. The focus is to break the cycle and develop the family’s skills for positive self-evaluation, communication, behavior patterns and coping mechanisms. The therapist will have the family address the negative situation that happened or situations that might occur. They focus on strengthening communication and developing positive strategies to handle conflict in the future. The therapist may serve as an objective observer to identify patterns of communication and behavior to address.

**Multifamily group therapy** brings several families with similar issues together. The families can observe the communication and behavior patterns of other families facing similar conflicts. Families may support each other and realize that they are not alone in their efforts to make positive change that will benefit everyone.

For group therapy to be effective, there must be ground rules to promote healthy change, positive communication and build trust. It is important for the sessions to move beyond blame, anger, shame, guilt and sharing “war stories” to focus instead on healing. Graphic or detailed discussions of self-injury may become an unhealthy substitute for cutting behavior. The therapist or facilitator must have the training and skills needed to guide the group in a positive direction.
● Never reacting with anger.
● Facing the problem rather than indulging in denial or avoidance.

Rosen (2011) adds, "But a parent can’t cure them. It takes a certain level of resources to be able to stop cutting, and many kids don’t have those resources. They need to stay in therapy until they get to that point."

One study of S.A.F.E. alternatives showed that two years after participating, 75 percent of patients showed a decrease in symptoms of self-injury. An ongoing study indicates a decrease in hospitalizations and emergency room visits.

The components of Self-Abuse Finally Ends, the S.A.F.E. Alternatives program

Though the methods and strategies in this program were designed for recovery from self-injury, they can also be useful for people with other problems of poor impulse control, such as overeating, smoking, alcoholism, undereating, binging and purging.

To find success, the person must be open and honest and be willing to work hard for recovery. In the beginning, patients may say they often feel isolated and different from the rest of the world. But after a few weeks of self-examination and companionship, this feeling begins to dissipate.

In the beginning, the patient who self-injures may feel that the behavior is totally out of their control and that they are destined to repeat it over and over. The goal of recovery in S.A.F.E. is to change that view. With therapy, strategies and exercises, there will be a shift in thinking from the view that self-injury is an “uncontrollable compulsion,” to “a choice,” to “an unhealthy choice.” Patients in recovery will learn that they can choose another course of action.

This will only happen if the person can learn to interrupt the vicious cycle of handling discomfort by automatically resorting to self-harm. Learning how to delay the impulse to self-harm creates a transformation in thought and action, reflecting on their situation, and learning to choose an alternative solution.

S.A.F.E. ground rules:
● The patient must truly want to recover.
● Having a therapist is crucial for support, examination, analysis and guidance during the process.
● Every patient is unique, and the recovery time may be long or short. The average time is four weeks, which may combine inpatient and outpatient time.

S.A.F.E. relies on several types of psychotherapy, and all of these can be helpful.
● Insight-oriented or psychodynamic therapy. The premise of this therapy is the more people learn about their unknown wishes, memories, fears, unresolved feelings and conflicts, the more understanding they will have about the motives that drive their behavior. When they learn what compels them to self-injure, they will be less inclined to engage in self-harm to cope with life.
● Cognitive behavioral therapy. The way people think influences the way they feel and behave. This therapy focuses on recognizing and changing automatic thoughts, inner dialogue, underlying assumptions, cognitive distortions and errors in logic that lead people to draw faulty conclusions. The behavioral aspect combines working to change the faulty thought patterns with teaching, training and guided practice of new coping strategies. The patient and therapist work to practice new behaviors in the form of homework assignments and examinations of belief systems.
● Supportive therapy. This therapy helps patients manage day-to-day routines and situations they encounter in life. The support sessions will happen at least once a week, and contact between sessions is encouraged to keep the patient on track. The approach is to offer support and advice for daily living problems to increase the patient’s stability and self-esteem through the recovery process.

The types of therapies employed by S.A.F.E. Alternatives are based on the needs and the preference of individual clients and their therapists.

In addition to therapy, four key elements or tools are used during treatment:
1. The no-harm contract – This is an agreement developed with the therapist that outlines the expectations and responsibilities that the patient and therapist have during the treatment process. This includes the no-harm clause where the therapist and client delineate a length of time and specific circumstances when the client will not self-injure. This contract is viewed as therapeutic rather than punitive because it is teaching consequences for behavior. Like any other contract, there are privileges, rights and opportunities if the client abides by the rules. A client is not immediately dismissed but may be put on probation and given time and assignments to reflect on their choice to self-injure. During probation, they focus on the antecedent to the behavior, the feelings they had, the choice they made, how they would handle it differently in the future, and whether they want to continue in the treatment program. This contract is meant to make the self-injury a less preferable choice and to encourage people to ask for help.
2. Impulse control log – Clients often say the urge to self-injure seems to happen spontaneously for no apparent reason. They describe the urge to self-injure as overwhelming and uncontrollable. The therapist and staff teach that the sensation or urge to self-injure does have an antecedent that can be determined. It may be a feeling, thought or memory that the patient must learn to identify. To create awareness, the client describes, analyzes and tries to determine what is being
communicated at the time. To become more aware of the urges, clients keep a running diary so they can see patterns, uncover feelings and break down the compulsions into manageable units they can control.

3. The five alternatives — Each patient develops a list of at least five “safe alternatives” to self-injury. These are comforting activities or temporary distractions that can be done anytime or anywhere if the impulse to injure occurs.

4. The writing assignments — These are designed to help the client to build awareness, organize thoughts and feelings, and focus their energy in a constructive way. There are 15 writing assignments given in sequence, which become increasingly more challenging and require deeper analysis and introspection.

As the S.A.F.E. Alternative program progresses, the patient learns to:

- Increase the window of opportunity between the urge to self-injure and the action that follows. In that time, the person can identify feelings, seek assistance and choose a safe alternative coping strategy.
- Use deeper analysis of the problems and behaviors that led to the compulsion to self-injure. The patient and therapist will look for patterns, circumstances, feelings and thought processes that lead to the impulse to self-harm. They will look at the safe alternatives that worked and determine additional strategies if needed.
- Be comfortable with experiencing feelings, managing feelings and communicating what is going on verbally and in writing. Learning to trust and confide in someone to share feelings is vital to the recovery process.
- Plan for an injury-free life as the patient builds confidence and pride through avoiding self-injury. The patient can imagine life free of self-injury and apply a new definition to his or her life, and develop personal, social, career and therapeutic goals to continue success in recovery.
- Identify others they can trust to help face a crisis and give advice.

S.A.F.E. Alternatives may be viewed as controversial by some therapists because it takes the approach of placing the responsibility on the patient. Since 1984, through clinical research and experience working with patients, it has shown significant success rates in helping patients take control and make a conscious choice not to self-injure.

Medication

There is no specific medication to treat cutting. Medications are used to treat the accompanying symptoms that disrupt the patient’s progress in therapy. There are medications that have proven to be effective in treating anxiety and depression, which may occur in those who cut themselves. Patients who exhibit severe mood swings may benefit from mood-stabilizing medications. These medications affect the neurotransmitters in the brain that carry information from cell to cell. The brain cells, called neurons, are sensitive to different kinds of neurotransmitters and have receptors built specially for them. The neurons with the same specificity cluster together to form circuits in the brain that transmit information (Levitt, 2008).

In the cell membrane, the neurotransmitters are released into the space between two neurons called the synapse. Here the neurotransmitters are attached to the receptors at the ends of another neuron, affecting the new neuron. The new neuron takes in a certain amount of the neurotransmitter and releases the excess. The excess is released back into the synapse and is reabsorbed into the first neuron. This process is called reuptake (Herpertz et al., 1997).

Research by Helslin (2007) and Amen (1999) found that psychotropic medications can be a safety net that allows patients to process the past and explore current experiences as they progress in therapy without becoming overwhelmed by anxiety, depression and mood disorders:

- There are many different neurotransmitters in the brain, and one that has been associated with self-harming behavior is serotonin. Low levels of serotonin have been linked to impulsive behaviors and unstable moods. High levels of serotonin have been associated with depression and personality disorders.
- Medication that is used to treat psychiatric disorders either increases or decreases the flow of a neurotransmitter by blocking the production or blocking the neuron receptors. These actions stop the effect of the neurotransmitter. These drugs are classified as neurotransmitter antagonists.
- Other medications block the reabsorption or reuptake, thus preventing the first neuron from taking back the extra neurotransmitter that was released into the synapse. This class of medication, called selective serotonin reuptake inhibitors (SSRIs), is frequently used to treat depression. SSRIs such as Zoloft, Paxil and Prozac work by increasing the amount of neurotransmitter. The neuron fires more frequently, thus increasing brain activity in circuits linked to a sense of calm. These medications have been found to serve as mood elevators and to reduce impulsive behaviors, depression, anxiety and self-injury.

Dialectical behavior therapy (DBT)

This form of therapy has proven to be very effective in treating borderline personality disorder and self-harm behaviors of many types. Developed by psychologist Dr. Marsha Linehan (1993) of the University of Washington in Seattle, it combines acceptance of the present and commitment to change with the goal of conflict resolution.

DBT focuses on two major problems associated with borderline personality disorder:
1. Limited or ineffective problem-solving skills.
2. Emotional deregulation.
Health:

According to Bette Runck of the National Institute of Mental Health, clinicians use biofeedback to help patients cope with pain. (“What is Biofeedback?” n.d.) Physical therapists, psychologists and specialists in many fields use biofeedback to help patients improve their mental or physical health by using signals in the muscles and translates the signal into a form the patient can detect. It may trigger a flashing light or beeper when muscles grow tenser. Patients can learn to relax the tense muscles and other symptoms of anxiety as they focus to slow down the light or sound signal.

Detaching from their own bodies can be very important to self-injurers, especially if they feel detached from their own bodies.

This therapy combines individual and group therapy and requires extensive time and commitment from all parties. DBT is a one-year outpatient program where the individual lives at home and attends meetings at the DBT treatment center. DBT begins with weekly individual therapy. The therapist and client maintain phone contact and clients are encouraged to call if they feel the urge to self-harm. During this phase of treatment the individual gains immediate support and builds a therapeutic relationship so he or she can practice new interpersonal communication and coping skills.

Part two of DBT involves group therapy sessions for training in problem-solving skills, and strategies for managing overwhelming feelings, uncontrolled emotions and conflict situations. Individuals must learn why they self-harm and develop and practice alternative coping strategies.

Cognitive behavioral therapy

This form of psychotherapy focuses on the influence of thinking on how we feel and what we do. This therapy is built on the premise that thoughts – not external influences such as people, situations or events – cause feelings and behavior patterns. The focus of CBT is that we can change how we think to help us feel better even when we cannot control the situation and changes around us. There is an open-ended, never-ending power to cope with difficulties when the client learns how to think differently and act on that learning. This method teaches rational strategies to address attitudes and feelings to help the client feel calm when confronted with an undesirable situation. The undesirable situation is there, and the client may become upset about it or not.

Arnold Lazarus (1971, 1993) initially developed this form of therapy and says if the person becomes upset, there are two problems to deal with, the situation and the negative emotions. He suggests that the approach should be to have the fewest number of problems as possible. Therefore, when the client accepts a perceived problem, he will not only feel better but will be in a better position to make use of his intelligence, knowledge, energy and resources to resolve the problem:

- The treatment is structured and directive, with techniques and concepts taught each session.

Lawrence and Helton (2011) refer to this form of psychotherapy as a “structured environment” and a “directive approach.” They define the relationship as “therapist-focused,” meaning the therapist is focused on the client’s goals, and must teach him or her how to think, behave and achieve what he or she wants. DBT was developed on the premise that self-harm behaviors are an indication of significant inability to manage, express, regulate and control emotional pain or distress. The individual turns to self-harm in an attempt to manage emotional distress. This inductive method involves looking at thought patterns as a hypothesis or educated guess to be questioned or tested.

According to a profile from the Association for Applied Psychophysiology and Biofeedback (Runck, 2007), this treatment method is a technique in which people are trained to improve their mental or physical health by using signals from their own bodies. Physical therapists, psychologists and specialists in many fields use biofeedback to help patients cope with pain. (“What is Biofeedback?” n.d.)

According to Bette Runck of the National Institute of Mental Health:

Clinicians using biofeedback rely on complicated equipment to detect internal bodily functions with greater sensitivity and precision than can be determined by the patient alone.

Both patient and therapist use this information to gauge and direct the progress of treatment.

For patients, the biofeedback machine acts as a kind of sixth sense that allows them to “see” and “hear” activity inside their bodies. One type of machine picks up electrical signals in the muscles and translates the signal into a form the patient can detect. It may trigger a flashing light or beeper when muscles grow tenser. Patients can learn to relax the tense muscles and other symptoms of anxiety as they focus to slow down the light or sound signal.

Developing awareness and control of the body’s responses can be very important to self-injurers, especially if they feel detached from their own bodies.

Neither DBT nor any psychotherapy is a magic bullet. The individual gains immediate support and builds a therapeutic relationship so he or she can practice new interpersonal communication and coping skills. Part two of DBT involves group therapy sessions for training in problem-solving skills, and strategies for managing overwhelming feelings, uncontrolled emotions and conflict situations. Individuals must learn why they self-harm and develop and practice alternative coping strategies.
Prevention strategies

The Cornell University Research Program on “Self-Injurious Behavior in Adolescents and Young Adults,” published in 2010, noted that it is crucial to equip school and medical staff to:

- **Recognize and respond** immediately when they see the signs that might indicate the potential for self-harm behaviors. Specific training is needed to identify the signs for self-harm and handle it effectively to prevent the pattern of behavior from taking hold.

- **Enhance social connections** when the staff identifies that a person has a high degree of perceived loneliness, a dysfunctional family, has experienced emotional or sexual abuse, has diminished self-esteem, or feelings of invisibility or shame.

- **Enhance the person’s capacity to cope with and regulate emotions and impulses.** Work with the individual to identify and build on his or her strengths. Provide assistance to help the person explore and identify strategies to cope with negative feelings and adverse situations.

- **Identify and train peers** who have the capacity to recognize distress, because peers can often be the front line to identify other students at risk and take action to contact an adult for help.

- **Offer parent/family training programs** to help parents identify the signs of the potential for self-harm. If there is self-injury occurring, the family will be an important part of the treatment plan for successful, long-lasting recovery.

- **Enhance communication skills and strategies** to enable the person to reach out to others when feeling emotionally overwhelmed. A nonverbal system, code or signal might be developed that will maintain privacy and encourage communication during a crisis situation.

- **Educate people, especially youth,** about the influence of media and environmental stresses and teach strategies for critical thinking, decision-making and coping skills to address these influences.

- **Assess the level of group involvement** because anecdotal evidence that self-injury among groups of youth is increasingly common.

- **Avoid strategies aimed primarily at raising knowledge of forms and practices.** In their review of eating disorder strategies, Levine and Smolak (2008) summarized research that suggested single-shot awareness-raising strategies were at best not effective or only effective in raising short-term knowledge and at worst were linked to increases in the behavior they were trying to stop. This was particularly evidenced in the high school and college populations they studied.

- **Promote and advertise positive norms related to emotional needs and seeking help.** Teens have a tendency to respond more to communications from friends than adults. Peers who have knowledge about someone else’s self-harm will more likely share the knowledge with an adult if the adolescent and adult norms about communicating and seeking help are improved.

Public health programs have been highly effective in eliminating disease and promoting health on a national and global scale. A public health approach can bring a problem to the public’s attention, provide education and dispel misconceptions. More research dollars are allocated for issues that are a significant public health concern. The recent increase in publications and scientific journals on the topic of self-injury indicate that researchers are taking the rising incidence of self-harm very seriously. As research and public awareness of self-injury becomes more prevalent, public health programs will be developed to address prevention and treatment.

The increase of websites devoted to celebrities and individuals who engage in self-injury and mutilation has prompted some researchers to call for censorship of these types of materials. Extreme forms of body modification such as voluntary amputation raise ethical questions, notes freelance writer Virginia Tressider (2006). In the following viewpoint, she argues, “There are ‘do it yourself’ websites for people wishing to perform their own extreme body modifications, and ‘how to’ websites should be banned.” In her opinion, these websites are promoting self-harm and encouraging vulnerable individuals to inflict irreparable damage to themselves.

Another aspect of prevention is to have support facilities open on a 24-hour basis to provide fast-track and focused care. Access to non-statutory services such as self-referral and short-stay crisis houses would be beneficial. (Eastwick and Grant, 2004). Access to information about local and national self-harm support networks needs to be available to individuals who may visit medical facilities and those who work in medical facilities, schools, community service and law enforcement agencies as well as friends and relatives of the individual at risk.

The following list of organizations has publications and information available:

- **American Psychiatric Association**
  e-mail: apa@psych.org
  Website: www.psych.org

- **American Psychological Association (APA)**
  Website: www.apa.org

- **Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults**
  Website: http://www.crpsib.com

- **Depression and Bipolar Support Alliance**
  Website: www.dbsalliance.org

- **LifeSIGNS (Self-Injury: Guidance and Network Support)**
  Website: www.selfharm.org

- **National Institute of Mental Health (NIMH)**
  Website: www.nimh.nih.gov

- **National Mental Health Association (NMHA)**
  Website: www.nmha.org

- **National Self-Harm Network (NSHN)**
  Website: www.nshn.co.uk

- **Self-Abuse Finally Ends (S.A.F.E. Alternatives)**
  Website: www.selfinjury.com

- **Self-Injury and Related Issues (SIARI)**
  Website www.siari.co.uk
References


NON-SUICIDAL SELF-INJURY (NSSI): ETIOLOGY, TREATMENT AND PREVENTION OF CUTTING

Final Examination Questions

Select the best answer for each question and then proceed to SocialWork.EliteCME.com to complete your final examination.

1. Non-suicidal self-injury falls into which of the categories of self-harm?
   a. Major, which is associated with schizophrenia.
   b. Stereotypic, which is associated with autism, Tourette’s disorder and cognitive disabilities.
   c. Compulsive, frequently seen in obsessive-compulsive disorder.
   d. Impulsive, often present in borderline personality disorder, anxiety and depression.

2. A recently proposed revision to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders would:
   a. Consider NSSI an act of suicide.
   b. List four criteria to consider whether a mental disorder falls within a classification of non-suicidal self-harm.
   c. Require that a person report engaging in intentional self-inflicted damage to the body two times in the past 12 months for inclusion in the category.
   d. Require the behavior occurred during states of psychosis, delirium or intoxication for inclusion in the category.

3. All of the following statements about gender characteristics associated with cutting are true EXCEPT:
   a. There is a higher incidence of cutting among individuals reporting attraction to the same sex.
   b. Male patients cope with problems similar to females.
   c. The majority of the research on self-injury is focused on males.
   d. Studies have found prisons “notorious hotbeds of self-mutilation.”

4. A common thread in the etiology of cutting behavior is:
   a. Overwhelming emotional pain, depression or anxiety.
   b. A lack of causative biological factors.
   c. Those who practice it cannot be affected by social influences, whether positive or negative.
   d. It releases a permanent euphoria or “high” for many people, removing the source of pain and distress.

5. The Self-Abuse Finally Ends (S.A.F.E) Alternatives program includes four key elements or tools, including:
   a. Forcing an individual to find his or her own solutions to daily living problems.
   b. A no-harm contract.
   c. A ban on logs and journals about their experiences of self-mutilation.
   d. Medications specifically created for the disorder.