



Nonsuicidal Self-Injury among Youth

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Following the 2007 definitional consensus of nonsuicidal self-injury (NSSI), there have been significant advances in our understanding of the behavior, particularly among children, adolescents, and young adults.¹ Given the tremendous growth of the field, in 2013 the American Psychiatric Association incorporated NSSI into their diagnostic manual as a disorder warranting further research.² NSSI is defined as the deliberate immediate destruction of one's own body tissue (eg, self-cutting, bruising, burning) in the absence of conscious suicidal intent. This definition excludes socially accepted practices such as tattooing and body piercing.¹ Stereotypic and repetitive self-injurious behavior by youth with developmental disabilities and neuropsychiatric disorders as well as major forms of NSSI (eg, bone breaking, amputation) are subsumed under the broad umbrella of NSSI behaviors³; however, the current review focuses on NSSI that occurs in typically developing youth, which is consistent with current conceptualizations in the field.³⁻⁵

NSSI represents a paramount health issue for youth and young adults, with as many as 1 in 5 youth reporting engagement in the behavior.^{3,6,7} Moreover, NSSI has been consistently shown to be associated with numerous psychiatric difficulties.^{4-6,8} Of most concern is recent research indicating that NSSI confers risk for future suicide attempts.⁹⁻¹² Furthermore, health professionals have reported increasing numbers of patients presenting with NSSI across a number of health setting contexts.^{13,14} Collectively, these reports suggest that pediatricians, primary care physicians, and other medical professionals who work with adolescents will likely encounter youth who self-injure. Hence, it is important that physicians and other medical professionals be equipped with up-to-date NSSI knowledge and guidelines as these encounters often represent an initial point of contact for youth experiencing health and mental health issues.^{14,15}

Taliaferro et al examined how prepared pediatricians, primary care physicians, family nurses, and pediatric nurses felt about addressing adolescent NSSI.¹⁵ Results indicated that almost one-half felt underprepared; over 70% wanted more information and training in this area. Others have also suggested that medical professionals may not be prepared to address NSSI and may even hold NSSI misconceptions.^{7,16} Presently, however, there are a limited number of articles providing reviews and recommendations for medical professionals who work with those who self-injure.^{7,14} Although useful, none of these reviews focus primarily on NSSI in children and adolescents.^{6,9,14} Because of the rapidly evolving

state of the field, the information provided in previous reviews is no longer completely representative of current knowledge. Thus, the present review summarizes the most recent findings concerning NSSI and corresponding guidelines for physicians.

Epidemiology

NSSI onset occurs throughout the lifespan, with peak onset periods during early (14-15 years of age) and late (17-18 years of age) adolescence.¹⁷⁻¹⁹ However, approximately one-fifth of those with a history of NSSI, report that they began self-injuring before age 12.^{20,21} Research indicates that the lifetime prevalence (ie, whether individuals have ever self-injured in their lifetime) for preadolescence NSSI is estimated to be approximately 7.60%.²¹ As this is a newer area of study, the past year prevalence of NSSI among preadolescent youth is not yet known. Rates between males and females during preadolescence appear to be similar.²¹

Amongst adolescents, NSSI rates are typically higher than in preadolescence, with lifetime prevalence ranging from 14%-24%^{3,6,22}; the past year prevalence of NSSI among adolescents is about 6%-7%.⁶ In contrast to findings among preadolescents, most studies report a higher prevalence of NSSI for adolescent females than males,^{18,23} although some studies report no sex differences in this age group.^{23,24} In samples of young adults, lifetime and past year reports are similar to those reported among adolescents,^{19,25,26} with comparable prevalence rates for males and females.^{19,25,26}

NSSI Presentation

The most commonly endorsed methods of NSSI tend to include scratching, cutting, bruising, head banging, and burning.^{6,18,23,24,26,27} Although some youth report a single method, many use multiple methods.^{6,19,23,24,26,27} Furthermore, males are more likely to report bruising, head banging, and burning, whereas females are more likely to report cutting and scratching.^{19,27}

Current evidence suggests NSSI will most commonly co-occur with a number of core psychological difficulties, including but not limited to emotion regulation difficulties, inattention, impulsivity, negative cognitive style (eg, pessimism), self-hatred, and possible dissociation or problematic

BPD	Borderline personality disorder
NSSI	Nonsuicidal self-injury

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body image.²⁸⁻³⁵ In addition, certain psychiatric disorders have been found to co-occur with NSSI such as eating disorders (with higher risk among those diagnosed with bulimia), mood disorders (eg, depression, dysthymia), anxiety disorders (eg, post-traumatic stress disorder), and substance abuse.^{11,20,35-41} Not surprisingly, as NSSI represents one of the diagnostic symptoms of borderline personality disorder (BPD), many individuals with BPD engage in NSSI. However, in community samples of youth who self-injure the majority do not meet diagnostic criteria for BPD.³⁹ Additional risk factors for NSSI include family dysfunction (eg, attachment difficulties, parental criticism, loss) and childhood abuse.^{26,41,42} Similar to the relation between NSSI and BPD, although many of those who report these factors engage in NSSI, in community samples of youth who self-injure many do not report family dysfunction or abuse. Collectively, these recent findings highlight the need to be alert to the different presentations of NSSI among male and female patients and the possibility of co-occurring psychiatric difficulties.

Why Youth Self-Injure

NSSI represents a complex concomitant of psychological, social, and biological factors. Hence, understanding why adolescents engage in NSSI merits consideration of intrapersonal and social functions as well as the biological processes believed to underlie NSSI enactment.

NSSI Functions

Intrapersonal. Although commonly viewed as an attention-seeking and manipulative behavior, NSSI is seldom used to garner attention or manipulate others. Rather, a substantial body of literature indicates that there are various motives for NSSI, which can be conceptualized as intrapersonal or social in nature. The most commonly reported reason for NSSI is to regulate unwanted affective experiences such as distress, anxiety, and frustration that are perceived to be intolerable.^{31,43-47} Although a large number of youth who self-injure report affect regulation reasons for their NSSI, other reasons are reported. These include but are not limited to punishing oneself, reducing feelings of numbness or dissociation, to generate a feeling when feeling emotionally empty, and averting suicidal impulses or urges.^{31,43,46,47}

Social. Reported less frequently are social reasons for NSSI, which often signal difficulty with interpersonal problem solving. For example, some youth who self-injure may do so in order to communicate their distress to others.^{31,43,46,47} To this end, researchers have demonstrated that relative to youth with no NSSI history, those who have self-injured have more difficulty effectively resolving interpersonal situations and are less generative when developing resolutions.⁴⁸ Other social reasons may involve self-injuring to belong to a group—often other youth who self-injure. Interestingly, social reasons may contribute to NSSI initiation for some youth, with intrapersonal reasons contributing to NSSI repeti-

tion.^{25,49} Other reported initial reasons for NSSI include “accidental” discovery of the behavior or engaging in NSSI as an impulsive response to emotional turmoil.^{19,25,50}

Biology of NSSI

A number of neurobiological processes have been implicated in NSSI. Of note are endogenous opioids and serotonin. Researchers have found that adolescents who self-injure have lower opioid levels than those who have not self-injured.^{51,52} In particular, adolescents with an NSSI history have been found to have lower levels of β -endorphin and met-enkephalin relative to those with no NSSI history.^{52,53} Thus, it may be that when youth self-injure, they elevate their levels of endogenous opioids, which would align with research indicating that youth may self-injure in order to generate a feeling or to relieve feelings of numbness and dissociation.³¹

Lower levels of serotonin may also play a role in NSSI, specifically in terms of its initiation and repetition.⁵³⁻⁵⁵ Indeed, young people who self-injure have been found to have lower levels of peripheral serotonin than those who do not self-injure.^{54,55} Related to this, researchers have examined peripheral serotonin and its relation to mother-child interaction patterns in a sample of adolescents with a NSSI history. Here, a significant interaction between peripheral serotonin levels, negativity, and conflict between mothers and their adolescents was found. Interestingly, this interaction explained over 60% of the variance in youth NSSI. Thus, biological mechanisms and environment may interact to contribute to NSSI among adolescents.⁵⁵

In addition, researchers have found that youth who self-injure have different levels of physiological arousal when responding to images of cutting. Specifically, in 1 study examining how age-matched female youth responded to NSSI imagery, those with a NSSI history reported that images of cutting were more emotionally arousing; this was corroborated by differences in neural patterns identified using functional magnetic resonance imaging.⁵⁶ Other biological mechanisms implicated in the understanding of NSSI include the dopaminergic system and the hypothalamic-pituitary-adrenal stress system; research, however, is scant in these areas.^{51,53} Despite these findings, implications regarding medication to manage NSSI remain tentative at best.⁵⁷ The role of biological mechanisms represents a very recent area of study necessitating further research attention.

NSSI and Suicide

The relation between NSSI and suicide has received increasing empirical and clinical interest in the past several years.^{9-12,58,59} Accordingly, our understanding of this complex association has evolved substantially. Although suicide attempts and NSSI are distinct on the basis of their underlying motivations, they are often interconnected.⁶⁰ Examples of underlying motivations for suicide attempts include to end one's life and to end one's level of psychological pain, whereas NSSI motivations refer more typically to affect regulation, self-punishment, and cessation of dissociative

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