Why do adolescents engage in nonsuicidal self-injury?

How nurses can screen, intervene, and provide appropriate referrals.

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YOU ENTER *the exam room to take vital signs for a 15-year-old boy. When you ask him to remove his jacket to take his blood pressure, you're shocked to see multiple severe scars on his left arm. When you ask about the scars, he tells you that they're from tree branches hitting his arms while off-trail bike riding. You notice that the scars are linear and that his right arm has no scarring. You suspect that his injury history isn't accurate. What's your next step?*

Nonsuicidal self-injury usually begins during adolescence with a prevalence rate of about 18% (two out of 10 adolescents). It's a maladaptive attempt to cope with intolerable emotions—including frustration, helplessness, and anger—that result from stressors that adolescents experience at home, in school, and in other social environments. Nonsuicidal self-injury is a deliberate act that reflects the adolescent's inability to express himself or herself and a lack of impulse control behavior. Although the behavior begins early in adolescence, the severity and frequency can increase with age.

Types of self-injury

Self-injury includes hitting, scratching, cutting, burning, pinching, and inserting objects under the skin. Cutting is the most common self-harm behavior. Injury can appear as hash marks on an arm from objects such as a broken soda can, staples, scissors, and knives. Typically, the individual hides the wounds with long sleeves or jewelry. Some people who self-injure choose locations that aren't typically seen in public, such as the inner thigh or abdomen. Although cutting is the most common type of self-injury, assessing for other forms, such as bruising from hitting (which is more common in males) is important.

With no intervention or treatment, self-injury usually persists and may increase. A high association exists between self-injury and psychiatric diagnoses such as depression, anxiety, substance use, and borderline personality disorder. Treatment includes addressing the underlying cause and developing new coping strategies, which usually requires referral to a mental healthcare professional.

Levels of severity

Mild forms of tissue damage usually appear as red marks as a result of light scratching, hitting, biting, or self-rubbing. This trauma can fade quickly, making it difficult to see in an exam. Moderate levels that cause deeper tissue damage and bleeding include scratching, repeated scab removal, or cutting that doesn't requiring suturing. This level of self-injury also includes higher impact hitting or pinching that results in bruising. Severe levels of self-injury cause deeper tissue damage; they include cutting that requires suturing, burning, insertion of objects into the skin, and bone-breaking. Although mild and moderate forms of tissue damage can be hidden from view by clothing and jewelry, severe forms require medical attention.

Risk factors and motivations

Risk factors for nonsuicidal self-injury can be divided into mental disorders, environmental, and personal. (See *Know the risks.*) In addition, many psychological motivations may be behind nonsuicidal self-injury. Two common motivations are attempts to cope and self-punishment. The patient may have difficulty dealing with stress or working through emotions such as rejection and worry. For example, an adolescent girl who feels "numb" after arguing with her mother may burn herself with a lit cigarette to feel something. Or a young man may bang his head against the wall to punish himself after approaching a girl for a date and being rejected.

Screening, brief intervention, referral

Screening adolescents during outpatient visits will facilitate the iden-

Know the risks

The risk factors for nonsuicidal self-injury fall into three categories—mental disorders, environment, and personal.

Mental disorder risk factors include borderline personality disorder, depression, eating disorders, anxiety, and substance abuse.

Environmental risk factors include abuse, neglect, poor parent-child relationships, victimization or bullying, and socializing with peers who perform nonsuicidal self-injury.

Personal risk factors are poor self-image, low self-esteem, loneliness, difficulty expressing emotions, emotional instability, impulsiveness, and hostility.

tification and treatment of nonsuicidal self-injury. One recommended method is screening, brief intervention, and referral to treatment (SBIRT). This three-step method is designed for use in primary care settings to screen for substance use and abuse, and it also has been used for depression and anxiety. It's comprehensive, patient-focused, and easy to use, and it has been validated for use in adolescents. Before using this method, you and your colleagues should complete training. (See *SBIRT training*.)

Currently, little research exists for using SBIRT for nonsuicidal self-injury, but some researchers have hypothesized that it's generalizable to this population because repetitive nonsuicidal self-injury and substance use both induce a desired and potentially addictive feeling. This feeling leads to the pattern of reward and reinforcement that's fundamental to addictive disorders.

Screening

Screening using a valid, reliable method takes 1 to 5 minutes. It can be done verbally or with a written form completed by the patient or healthcare professional. Studies show that shame and embarrassment often are associated with self-injury, so be sensitive, empathic, and patient. Developmentally, adolescents aren't yet adults, but they want autonomy. This developmental struggle may cause them to feel awkward or intimated when talking to an adult. In addition, the adolescent may lack the self-awareness or ability to clearly verbalize thoughts and feelings. Silence is common, and gentle probing may be required.

You can verbally screen using either direct or indirect questions. A direct approach may be more appropriate for adolescents around age 17 or if you've already built a trusting relationship. Use an indirect approach with younger adolescents. With the direct approach, simply ask, "Do you intentionally cause pain to yourself" or "Do you hurt yourself intentionally to feel pain?" If you need to be indirect, start with a question such as: "I've had some people tell me that they bite, hit, or cut themselves when they feel bad or stressed. Has this ever happened to someone you know or maybe to you?" The key is respect and sensitivity.

If you want a more formal screening method, consider using an assessment tool. (See *Assessment tools*.) When considering one of these tools, keep in mind that some measure type and severity of nonsuicidal self-injury rather than screen for the behavior; make sure you understand the purpose of the tool before using it. Because depression and anxiety can coexist with nonsuicidal self-injury, other screening tools may be useful. Two well-known and reliable tools are the Patient Health Questionnaire-9 for depression and the Generalized Anxiety Disorder-7. They take only a few minutes to complete and are easy to use in busy primary care settings. Permission to use these tools can be obtained at phqscreeners.com/select-screener.

Nonsuicidal self-injury is a risk for suicide, so ask about any suicidal thoughts or past suicide attempts in adolescents who screen positive for this behavior.

Brief intervention

If your screening identifies a patient as positive for nonsuicidal self-injury, immediately provide brief therapy (5 to 30 minutes). Motivational interviewing is one approach widely used in substance abuse treatment. The goal is to motivate the patient to make changes. It consists of three components: collaboration, evocation, and autonomy.

Collaboration uses positive and nonjudgmental communication that encourages the adolescent to express experiences and perspectives about the behavior. For instance, you might say, "It seems that life is very stressful for you right now, and it appears that self-injury is helping you deal with your stress." These types of statements equalize control so that you and the patient are partners. They also convey a level of understanding and allow the patient to elaborate or correct any misunderstanding about the behavior.

Evocation is the adolescent's ability to express his or her own motivations to change the behavior. For example, the patient might respond, "Yes, cutting helps me with stress, but my arms look so terrible I can't go swimming." This acknowledgement gives you a hint that the patient has a reason to stop the behavior. You may feel the urge to provide education at this point, but resist it. Keep the spirit of motivational intervention by asking permission to provide information about consequences of nonsuicidal self-injury.

SBIRT training

Screening, brief intervention, and referral to treatment (SBIRT) is one approach you can take when you suspect your adolescent patient may be using nonsuicidal self-injury to cope with stress. Before implementing it in your care setting, access these opportunities for training.

Course	Website	Format
SBIRT	samhsa.gov/sbirt	Face-to-face and online
Improve clinical skills in SBIRT for substance use problems	sbirttraining.com	Online
Ohio Mental Health Addiction Services (MHAS): SBIRT	http://mha.ohio.gov/Treatment/SBIRT	Face-to-face and online
Community Catalyst: Training resources for the implementation of screening, brief intervention, and referral to treatment (SBIRT)	communitycatalyst.org/resources/publications/document/SBIRT-Training-Options-December-2015.pdf?1451325946	Face-to-face and online
Institute for Research, Education & Training in Addictions (IRETA): SBIRT for adolescents	ireta.org/improve-practice/addiction-professionals/online-courses/sbirt-for-adolescents/	Online
Adolescent SBIRT curriculum	sbirt.webs.com/curriculum	Online
Massachusetts Health Promotion Clearinghouse: Adolescent SBIRT toolkit for providers	massclearinghouse.ehs.state.ma.us/BSASSBIRTPROG/SA1099.html	Booklet
Pacific Southwest ARRC eLearning: 4 hour SBIRT training (continuing education)	psattcelearn.org/courses/4hr_sbirt/	Online
SBIRT: A brief clinical training for adolescent providers	http://hospitalsbirt.webs.com/adolescent-providers	Online

Autonomy allows the adolescent to have control over any decisions at that moment. If he or she doesn't want the information you offer, leave the door open by saying, "I understand you're not ready for this information. Please come back to see me if you decide you want help." If the adolescent wants information, this is the moment you can educate compassionately. Continue the momentum by asking permission to discuss a plan for reducing or stopping the behavior. The key here is that the plan is created by the patient, not you. He or she makes a plan, and you encourage the ideas for change. Allowing an adolescent to have a personal choice can improve the motivation to seek help.

For severe levels of self-injury, make a mental health referral.

Referral

Adolescents who've reached a moderate or severe level of tissue damage may have trouble stopping or even reducing nonsuicidal self-injury. When the behavior reaches these stages, it becomes addictive and the patient should be referred for intensive therapy.

Your care setting should have a referral process in place to ensure a smooth transition. Note that both parental and adolescent permission may be needed for referrals; check your state laws regarding consent. If required, contact the adolescent's parent or guardian and discuss the situation, but include the adolescent to maintain a trusting relationship.

Referrals should be made to adolescent psychotherapists (such as psychiatric social workers, advanced practice psychiatric nurses, psychologists, and marriage and family therapists) or adolescent psychiatric providers (adolescent psychiatrists, advanced practice psychiatric nurses, and physician assistants who

Assessment tools

These assessment tools can help you screen adolescent patients for nonsuicidal self-injury. However, keep in mind that the list is not inclusive and that many tools measure type and severity rather than screen for the behavior.

Assessment tool	Information
The Brief Non-Suicidal Self-Injury Assessment Tool (BNSSI-AT)	selfinjury.bctr.cornell.edu/perch/resources/bnssi-at-revised-final-3-3.pdf
Deliberate Self-Harm Inventory (DSHI)	link.springer.com/article/10.1023/A%3A1012779403943
Inventory of Statements About Self-Injury (ISAS)	psych.ubc.ca/~klonsky/publications/ISAS measure.pdf
Ottawa Self-Injury Inventory	shared-care.ca/files/OSI_English.pdf
The Risk-Taking and Self-Harm Inventory for Adolescents (RTSHIA): Development and Psychometric Evaluation	pdfs.semanticscholar.org/1d47/fdce39851deca81dea50213a857f9b3f7692.pdf
Self-Harm Inventory (SHI)	ncbi.nlm.nih.gov/pmc/articles/PMC2877617/
Skin, Links, Injury, Culture, Environment (SLICE)	madridge.org/journal-of-nursing/MJN-1000117.pdf
Self-Injury Questionnaire (SIQ)	selfinjury.bctr.cornell.edu/perch/resources/claes-siq-tr-inclusief-ref.pdf
Self-Mutilative Behaviors Interview	mood.binghamton.edu/Publications/2007_SLTB_Andover%20et%20al_SM%20&%20Coping.pdf
Youth Risk Behavior Surveillance Survey (YRBSS)	cdc.gov/healthyyouth/data/yrbs/index.htm

work with adolescents). These specialized mental healthcare providers are trained in the appropriate approaches for treating adolescents.

Challenges that may prevent patients from following up with mental healthcare professionals include treatment and medication costs, lengthy wait time for an appointment, and transportation limitations. Assess the family's financial ability to pay so you can make an appropriate referral. Be familiar with services in your area and keep an up-to-date list of clinics and clinicians that offer low-fee and free behavioral health services. They frequently help with the cost of medications and transportation. School guidance counselors and social workers can be helpful referral sources.

Take the opportunity

You have an opportunity to intervene when you suspect your adolescent patient is using nonsuicidal self-injury to cope with stress and other mental health issues. The SBIRT method is one method you can use to assess, intervene, and refer your patients. Your approach requires patience, empathy, and sensitivity to encourage patients to open up so that you can provide the most appropriate treatment.

You ask the 15-year-old patient for permission to share information about scarring. He agrees, and you compassionately explain that in the past you've had people with similar scars tell you that they cut themselves when they were feeling stress. Then you ask, "Has this ever happened to someone you know, or could this be something you considered doing?" The patient acknowledges that he's been cutting himself because he's not doing well in school. You ask how he feels about this, and he tells you how embarrassing it is if someone notices his scars. He goes on to say that he's been thinking about putting a tattoo over the scar to cover it up. Building on this discrepancy in the patient's behavior and his feelings, you ask if he's willing to see someone to help him find other ways to work through his stress. He says, "Yes, I'm ready to do something about this." ★

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