

As trusted caregivers and, frequently, first responders to a young person who has self-injured, primary care clinicians need to understand what self-injury is, why it occurs, how to relate to young people who have self-injured, and how to respond effectively. The following guidance is adapted from www.selfinjury.org.

Definition/Terms

Self-injury (also called self-harm and self-inflicted violence) is the act of attempting to alter a mood state by inflicting physical harm serious enough to cause tissue damage to one's own body. This can include cutting (with knives, razors, glass, pins, or any sharp object), burning, hitting the body with an object or fists, hitting a heavy object (like a wall), picking at skin until it bleeds, biting oneself, and pulling hair out. The most commonly seen forms are cutting, burning, and head-banging. *Tissue damage* usually refers to damage that tears, bruises, or burns the skin—something that causes bleeding or marks that don't go away in a few minutes. A mood state can be positive or negative, or even neither; some people self-injure to end a dissociated or unreal-feeling state, to ground themselves and come back to reality. It's not self-injury if one's primary purpose is sexual pleasure, body decoration, spiritual enlightenment via ritual, or fitting in or being cool, although these behaviors may warrant tactful discussion when they involve significant risk or permanent changes to the body. Most concerning is episodic and repetitive self-harm—people learn that hurting themselves brings them relief from some kinds of distress and eventually turn to it as a primary coping mechanism.

Using the term *self-mutilation* often angers people who self-injure. Other terms (self-inflicted violence, self-harm, self-injury) don't speak to motivation. They simply describe the behavior. Self-mutilation implies that the primary intent is to mark or maim the body; in most cases this is not so.

Common Myths About Self-Injury

Myth 1: Self-harm is usually a failed suicide attempt.

This myth persists despite a wealth of studies showing that although people who self-injure may be at a higher risk of suicide than others, self-harming behavior is different from attempted suicide and happens for different reasons. In fact, some people self-harm to keep themselves from attempting suicide.

Myth 2: People who self-injure are crazy and should be locked up.

Fear and shock may lead clinicians to overreactions, such as hospitalization. Most self-inflicted injuries are not life-threatening, and few people who self-injure need to be hospitalized. In fact, involuntary hospitalization may have adverse effects.

Myth 3: People who self-harm are just trying to get attention.

Some people do have socially reinforcing reasons for self-injury, eg, to let others know how desperate they are, to get other people to act differently, to get back at or hurt someone, to gain admission to treatment, or to demonstrate to others how wrong they are. However, most people who self-injure go to great lengths to hide their wounds and scars. Many consider their self-harm to be a deeply shameful secret and dread the consequences of discovery. The clinician who discovers self-harm should take immediate steps to protect the patient's privacy, as appropriate to the circumstances.

Myth 4: Self-inflicted violence is just an attempt to manipulate others.

Some people use self-inflicted injuries as an attempt to cause others to behave in certain ways, it's true. Most don't, though. In attempting to help people who self-injure, it is important to focus on what it is they want and how you can communicate about it while maintaining appropriate boundaries. Look for the deeper issues and work on those.

Myth 5: Only people with borderline personality disorder (BPD) self-harm.

Self-harm is a criterion for diagnosing BPD, but there are 8 other equally important criteria. Not everyone with BPD self-harms, and not all people who self-harm have BPD. People who self-harm may have a diagnosable mental health disorder, and it is important to assess for this; however, there are steps that can help self-harmers without relying on diagnosis.

Myth 6: If the wounds aren't "bad enough," self-harm isn't serious.

The severity of the self-inflicted wounds has very little to do with the level of emotional distress present. Different people

have different methods of self-injury and different pain tolerances. The only way to determine how much distress someone is in is to ask.

Why Self-Injury Makes Some People Feel Better

Biology may play a role in self-injury—problems in the serotonin system may predispose some people to self-injure by making them more aggressive and impulsive than most people. Some researches think a desire to release endorphins is involved. Two other factors likely play a role.

Self-injury reduces physiological and psychologic tension rapidly.

Studies have suggested that when people who self-injure get emotionally overwhelmed, an act of self-harm brings their levels of psychologic and physiological tension and arousal back to a bearable baseline level almost immediately. In other words, they feel a strong uncomfortable emotion, don't know how to handle it (indeed, often do not have a name for it), and know that hurting themselves will reduce the emotional discomfort extremely quickly. They may still feel bad (or not), but they don't have that panicky, jittery, trapped feeling; it's a calm bad feeling.

Some people never get a chance to learn how to cope effectively with strong emotions.

One factor common to most people who self-injure is invalidation. They were taught at an early age that their feelings about the things around them were bad and wrong and were given no role models for effectively coping with their emotions. Although a history of abuse is common among self-injurers, not everyone who self-injures was abused. Sometimes, invalidation and lack of role models for coping are enough, especially if the person's brain chemistry has already primed him or her for choosing this sort of coping.

What Primary Care Clinicians Can Do to Help

1. Treat the injuries as you would non-self-inflicted injuries—nonjudgmentally.
2. Do not disparage the person in any way. Rather, acknowledge that the person must have been in very deep distress when the injuries happened. Express concern and explore his or her current level of distress, including suicidal thoughts and likelihood of reinjury.
3. Do not attempt to coerce the person into stopping self-injury. Express optimism that a number of treatments (eg, dialectic behavior therapy, treatment of comorbid mental health conditions such as depression or anxiety) have been shown effective, and offer to refer for help if he or she is willing and ready to seek it. (See HELP mnemonic for common factors intervention.)
4. If the patient is not ready to accept a referral, use motivational interviewing techniques to identify a next step the person is able to take, such as calling you or another trusted adult when he or she feels the need to self-injure.
5. Offer a follow-up appointment or call to see how the patient is doing. Repeat step 4.

