Nonsuicidal self-injury in children and adolescents: Clinical features and proposed diagnostic criteria

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INTRODUCTION

Nonsuicidal self-injury is the deliberate destruction of body tissue in the absence of any intent to die and occurs for purposes that are not socially sanctioned [1-3]. The behavior most commonly takes the form of skin-cutting, burning, and severe scratching [4,5]. Nonsuicidal self-injury occurs at high rates in adolescents and is associated with adverse clinical outcomes such as suicide attempts [6,7].

We conceptualize nonsuicidal self-injury as a distinct entity that differs qualitatively from suicidal behavior [2]. However, others argue that self-injury with and without suicidal intent represent different versions of the same behavior [8].

This topic discusses the clinical features of nonsuicidal self-injury and the proposed diagnostic criteria for nonsuicidal self-injury disorder. The material focuses primarily upon adolescents because nonsuicidal self-injury occurs far more often in this age group than in children [9]. In addition, the material is restricted to youth who do not have intellectual disabilities.

Separate topics discuss the epidemiology, pathogenesis, assessment, and treatment of nonsuicidal self-injury, as well as the epidemiology, evaluation, and management of suicidal ideation and behavior in children and adolescents.

- (See "Nonsuicidal self-injury in children and adolescents: Epidemiology and risk factors".)

- (See "Nonsuicidal self-injury in children and adolescents: Pathogenesis".)
- (See "Nonsuicidal self-injury in children and adolescents: Assessment".)
- (See "Nonsuicidal self-injury in children and adolescents: General principles of treatment".)
- (See "Nonsuicidal self-injury in children and adolescents: Prevention and choosing treatment".)
- (See "Suicidal behavior in children and adolescents: Epidemiology and risk factors".)
- (See "Suicidal ideation and behavior in children and adolescents: Evaluation and management".)

TERMINOLOGY

Nonsuicidal self-injury is a behavior characterized by the deliberate destruction of body tissue in the absence of any intent to die and occurs for purposes that are not socially sanctioned [1-3]. By definition, nonsuicidal self-injury is distinguished from suicidal behavior; socially accepted practices such as tattoos, piercings, and religious rituals; accidental self-harm; and indirect self-injury through behaviors such as disordered eating or substance use disorders. Self-injurious behavior that is accompanied by **any** intent to die is classified as a suicide attempt, which is consistent with the practice of most clinicians and researchers [2,10,11], as well as recommendations from the United States Centers for Disease Control and Prevention [12,13]. This approach deliberately errs on the side of safety by categorizing ambivalent behaviors, which include any intention to die, as suicidal [2].

Nonsuicidal self-injury behavior has previously been referred to by other names such as “self-mutilation,” “deliberate self-harm,” and “parasuicide” [10,14,15]. However, these other names refer to broad classes of behaviors that include both nonsuicidal self-injury and suicidal self-injury (eg, suicide attempts), which is problematic given the many differences between nonsuicidal and suicidal self-injury. (See 'Relation to suicidal behavior' below.)

Most studies have conceptualized nonsuicidal self-injury as a behavior that occurs in the context of various psychiatric disorders. However, other studies have examined nonsuicidal self-injury as a stand-alone psychiatric condition because many youth who engage in nonsuicidal self-injury do not have another diagnosable psychiatric disorder. Throughout this topic, the term “nonsuicidal self-injury” refers to the behavior, unless specified as nonsuicidal self-injury disorder. The relationship between nonsuicidal self-injury behavior and psychiatric disorders is discussed elsewhere in this topic, as is nonsuicidal self-injury disorder. (See 'Relation to psychiatric disorders' below and 'Proposed diagnostic criteria' below.)

CLINICAL FEATURES

Overview — Studies that examine the clinical features of nonsuicidal self-injury vary in several ways, including the definition of the behavior (which self-injury methods are included), setting (eg, inpatient unit or school), duration/timeframe (eg, lifetime or past year), the instruments used to assess the behavior (eg, self-report or interview), and other aspects of the study design (eg, prospective or retrospective).

The essential clinical feature of nonsuicidal self-injury is intentional self-inflicted harm to the surface of the body without suicidal intent [3]. The injuries may cause bleeding or bruising, and are most often intended to ameliorate negative emotions (eg, anxiety or distress) or to punish oneself. Among patients who engage in nonsuicidal self-injury frequently (eg, more than once per week), a sense of urgency or craving may precede the behavior. Most adolescents spend less than a few minutes contemplating nonsuicidal self-injury before they engage in the behavior [16-18]. Additional information about the function or motivation underlying the behavior is discussed separately. (See "Nonsuicidal self-injury in children and adolescents: Pathogenesis", section on 'Function of the behavior'.)

When adolescents engage in nonsuicidal self-injury, most do so alone [19]. Nevertheless, peer influences may be involved in the pathogenesis of the behavior. (See "Nonsuicidal self-injury in children and adolescents: Pathogenesis", section on 'Peer influences'.)

Although substance use disorders are more common in patients who engage in nonsuicidal-self-injury than those who do not (see 'Patients engaging in nonsuicidal self-injury' below), episodes of nonsuicidal self-injury do not typically occur under the influence of substances [16,20]. However, simultaneous nonsuicidal self-injury and substance use may lead to more severe injuries because of impaired judgement, disinhibition, and/or decreased pain sensitivity [21,22].

Nonsuicidal self-injury behavior can co-occur with other psychiatric symptoms, including:

- Affect dysregulation (see "Nonsuicidal self-injury in children and adolescents: Pathogenesis")
- Negative cognitive style (eg, pessimism) [21]
- Poor self-esteem [21]
- Loneliness (see "Nonsuicidal self-injury in children and adolescents: Pathogenesis")

- Disordered eating [23]
- Risky sexual behaviors [23]
- Sleep problems including nightmares (see 'Sleep disorders' below)

Frequency of self-injury — The frequency of nonsuicidal self-injury is typically greater in clinical populations (eg, inpatients) than community samples (eg, students), and nonsuicidal self-injury in clinical populations is associated with more severe psychopathology [24]. In community samples, the lifetime frequency ranges from an average of 2 to 10 episodes [5,20,25-30]. In addition, multiple studies in community samples (n = 125, 170, and 655) indicate that approximately 25 to 30 percent of adolescents will engage in nonsuicidal self-injury only once [28,29,31]. In clinical samples, the average number of lifetime episodes is much higher but ranges widely from to dozens to hundreds of times [4,32,33].

The number of wounds inflicted during a single episode of nonsuicidal self-injury varies [19]. A greater number of wounds per episode (eg, 20 rather than 4) can indicate a greater level of distress triggering the episode.

Methods used to self-injure — Patients engaging in nonsuicidal self-injury may use a variety of methods to injure themselves, including [3,5,14,32,34-43]:

- Cutting or stabbing the skin with a sharp object such as a knife or razor – The cuts often bleed and eventually the skin may be marked by a series of parallel scars. Many studies indicate that this is the most common means of self-injury; it is estimated that cutting occurs in 70 to 90 percent of individuals who engage in nonsuicidal self-injury.
- Carving words or symbols into the skin.
- Burning with hot objects such as cigarettes.
- Hitting or banging body parts such as the head.
- Breaking bones.
- Scratching self to the point of bleeding.
- Biting self to the point of bleeding.
- Rubbing skin against rough surfaces such as an erasure.
- Inserting needles or other objects under the skin.

- Wound picking and interfering with wound healing.
- Pinching skin to the point of bleeding.
- Pulling hair out (excludes trichotillomania).
- Swallowing dangerous chemicals to cause immediate tissue damage.

Most patients who repeatedly engage in nonsuicidal self-injury use multiple methods over their lifetime [5,33,34,36,39]. As an example, the average number of methods used by a group of hospitalized adolescents who engaged in nonsuicidal self-injury in the past year (n = 89) was four [33]. Using multiple methods to inflict self-injury is associated with more severe psychopathology and a greater risk of attempting suicide [33]. (See 'Relation to psychiatric disorders' below and 'Relation to suicidal behavior' below.)

There appear to be gender differences in the types/methods of nonsuicidal self-injury used [44]. Females report more cutting, biting, interfering with wound healing, pulling hair, and scratching, whereas males report more banging or hitting [5,27,31,36,37,45-47].

Medical severity — Most nonsuicidal self-injuries are superficial and do not require medical treatment [48]. However, individuals sometimes harm themselves more severely than intended [5].

Among adolescents who engage in nonsuicidal self-injury, the medical severity of the injury appears to be greater in clinical populations than community samples [24]. Approximately 15 percent of adolescents from clinical samples [49], compared with about 3 to 6 percent of adolescents from community samples [20,50], report seeking medical attention for their nonsuicidal self-injury.

If patients share implements for cutting, they are at risk for blood-borne diseases [3].

Location on body — Nonsuicidal self-injury often occurs on the arms, hands, wrists, and thighs [5], but can occur anywhere on the body [19]. Females report self-injuring more on their arms, wrists, and thighs, and do not typically injure their face, genitals, or breasts [19]. Males report more injury to their chest, face, genitals, and hands [5,51].

Physical pain — Nonsuicidal self-injury is generally associated with decreased sensitivity to physical pain [52]. A meta-analysis of 32 studies (sample size not reported) found that individuals engaging in nonsuicidal self-injury reported a higher pain threshold, higher pain tolerance, and lower pain intensity compared with those who did not engage in self-injury [53]. Furthermore, many individuals do not feel any pain when they engage in nonsuicidal self-injury.

Clinical and community studies of adolescents engaging in nonsuicidal self-injury (n = 89 and 293) have found that the behavior did not cause pain in roughly 33 to 50 percent of the sample [20,33].

Some patients who engage in nonsuicidal self-injury and do feel pain may find the pain rewarding or reinforcing [54], whereas others do not enjoy the pain [48]. In addition, one small study of self-injuring adolescent patients (n = 30) found that a higher frequency of nonsuicidal self-injury was associated with feeling pain during the behavior [54].

Emotional distress — Many adolescents report that they experience emotional distress after engaging in the behavior, including feelings of anger, guilt, and shame [55]. Nevertheless, adolescents often engage in nonsuicidal self-injury to mitigate negative emotions (eg, anxiety, anger, and sadness). (See "Nonsuicidal self-injury in children and adolescents: Pathogenesis", section on 'Function of the behavior'.)

Impaired functioning — Most adolescents engaging in repetitive nonsuicidal self-injury report that the behavior interferes with functioning. As an example, in a community sample of 205 adolescents who engaged in nonsuicidal self-injury at least five times in the past year, impaired functioning in school or social domains was reported by over 90 percent [56].

Relation to psychiatric disorders — Many adolescents engaging in nonsuicidal self-injury meet criteria for a psychiatric disorder, and several psychiatric disorders are more common in individuals who engage in nonsuicidal self-injury than individuals who do not. In addition, nonsuicidal self-injury is more common in patients with psychiatric disorders than individuals without psychiatric disorders. However, it is important to note that nonsuicidal self-injury behavior can occur in the absence of a psychiatric disorder [33,48], which has led to proposals to conceptualize repetitive nonsuicidal self-injury as a distinct, psychiatric condition. (See 'Proposed diagnostic criteria' below.)

Patients engaging in nonsuicidal self-injury — Among individuals with a history of nonsuicidal self-injury, clinical and nonclinical studies suggest that the following psychiatric disorders are common:

- Anxiety disorders such as generalized anxiety disorder [33].
- Conduct disorder and oppositional defiant disorder [33].
- Depressive disorders [57].
- Eating disorders [57].

- Personality disorders (eg, avoidant, borderline, and/or paranoid) [33,57]. In particular, patients who engage in nonsuicidal self-injury have high rates of borderline personality disorder [33,58,59].
- Posttraumatic stress disorder [33].
- Substance use disorders [33,57,60]. However, episodes of nonsuicidal self-injury do not typically occur under the influence of substances [2].

In addition, psychiatric disorders are more common in youth who engage in nonsuicidal self-injury than individuals who do not [57,61].

Patients with psychiatric disorders — Clinical studies indicate that many patients with psychiatric disorders engage in nonsuicidal self-injury [33]. One review estimated that among adolescent psychiatric patients, 40 to 80 percent have a history of nonsuicidal self-injury [62].

In addition, nonsuicidal self-injury is more likely to occur in individuals with psychiatric disorders than those without psychiatric disorders. As an example, a meta-analysis identified 56 pediatric and adult studies conducted in clinical and nonclinical settings (n >35,000 individuals), with variable timeframes (eg, lifetime, past year, or current) [63]. The primary findings were as follows:

- Individuals with any psychiatric disorder were nearly twice as likely to engage in nonsuicidal self-injury, compared with those without a psychiatric disorder (odds ratio 1.8).
- Nonsuicidal self-injury was more common among patients with several specific psychiatric disorders than patients without the disorder, including:
  - Anxiety disorders (panic disorder and generalized anxiety disorder)
  - Depressive disorders
  - Obsessive-compulsive disorder
  - Posttraumatic stress disorder

Borderline personality disorder — Many patients with borderline personality disorder engage in nonsuicidal self-injury, such that the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) includes nonsuicidal self-injury (termed "self-mutilating behavior") as a diagnostic criterion for borderline personality disorder [3]. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'DSM-5-TR criteria'.)

Eating disorders — A meta-analysis of 28 studies, which included more than 6000 patients with eating disorders (mean age 24 years), found a lifetime history of nonsuicidal self-injury in 27 percent [64]. In the largest and most recent study that focused upon adolescents with eating disorders (n = 612), nonsuicidal self-injury occurred in 41 percent [65].

Sleep disorders — Sleep disturbances may be associated with nonsuicidal self-injury. A study of psychiatric outpatients (n = 313, mean age = 26 years) and university students (n = 133, mean age 20 years) found that in each sample, nightmares were more common among individuals with a history of nonsuicidal self-injury than individuals without nonsuicidal self-injury, even after controlling for depressive symptoms [66]. Nightmares may increase negative emotional arousal, and individuals may engage in nonsuicidal self-injury to regulate negative emotions. (See "Nonsuicidal self-injury in children and adolescents: Pathogenesis", section on 'Function of the behavior'.)

Unipolar major depression — Among adolescents with unipolar major depression, roughly 33 to 55 percent have a lifetime history of nonsuicidal self-injury:

- A community study found that among adolescents with major depression (n = 265), a lifetime history of nonsuicidal self-injury was present in 56 percent, and 48 percent had engaged in the behavior in the past 12 months [30].
- Two randomized trials in adolescents with unipolar major depression (n = 327 and 164) found that at study enrollment, 34 and 38 percent endorsed a history of nonsuicidal self-injury [38,67].

Relation to suicidal behavior — Nonsuicidal self-injury and suicidal behavior differ in several ways. First, nonsuicidal self-injury and suicidal behavior differ in motivation. By definition, nonsuicidal self-injury occurs in the absence of any suicidal intent (see 'Terminology' above). Nonsuicidal self-injury does not represent a failed suicide attempt; rather, patients most commonly use nonsuicidal self-injury to mitigate negative emotions (eg, sadness, anxiety, and anger) and thus prevent suicide [48,68]. A second difference is frequency, such that nonsuicidal self-injury typically occurs more often than suicide attempts [24,25,35,45,69-71]. Third, the methods of nonsuicidal self-injury and suicidal behavior differ; the most common forms of nonsuicidal self-injury are cutting and burning (see 'Methods used to self-injure' above), whereas the most common suicide attempt methods are poisoning (overdose), suffocation and hanging, and firearms (which is the most likely to result in death) [72]. Fourth, medical severity/lethality is usually greater with suicide attempts than nonsuicidal self-injury.

Nevertheless, nonsuicidal self-injury and suicidal behavior frequently co-occur in adolescents, especially in clinical sample [45,73,74]:

- In clinical samples of youth engaging in nonsuicidal self-injury, approximately 35 to 70 percent have also attempted suicide [9,33,38].

- One clinical study found that prior suicide attempts had occurred in more than twice as many adolescents with a history of nonsuicidal self-injury (n = 124) than adolescents without nonsuicidal self-injury (n = 203) (37 versus 15 percent) [38].

- Among a group of hospitalized adolescents with nonsuicidal self-injury in the past year (n = 89), the mean number of lifetime suicide attempts was three [33].

In community samples of youth who have engaged in nonsuicidal self-injury, roughly 10 to 45 percent have attempted suicide at some point in their lives [25,28,29,36,61,75,76].

Features of nonsuicidal self-injury that are associated with a greater number of suicidal behaviors include a greater number of nonsuicidal self-injurious episodes (eg, five or more times in the past year) [36], a greater number of nonsuicidal self-injury methods (eg, three) [36], a longer history of engagement in nonsuicidal self-injury (eg, greater than two years) [33], an absence of pain experienced during nonsuicidal self-injury [33], and engagement in nonsuicidal self-injury exclusively while alone [42,77]. In addition, suicidal behaviors are more likely to occur in patients who more strongly endorse engaging in nonsuicidal self-injury because of its self-reinforcing functions, such as regulating negative emotions [16,39] and managing suicidal thoughts and urges [78,79]. The frequency, methods, physical pain, and functions of nonsuicidal self-injury are discussed separately. (See 'Frequency of self-injury' above and 'Methods used to self-injure' above and 'Physical pain' above and "Nonsuicidal self-injury in children and adolescents: Pathogenesis", section on 'Function of the behavior'.)

Nonsuicidal self-injury is a robust risk factor for subsequent suicidal behavior. Prospective studies indicate that the likelihood of suicide attempts is three to seven times greater among individuals with a history of nonsuicidal injury than those without nonsuicidal self-injury:

- A study enrolled 399 community-based adolescents (30 percent had a past year history of nonsuicidal self-injury), and prospectively followed them for up to 2.5 years [71]. After controlling for potential confounding factors (eg, female sex, depression, and history of suicide attempts), the analyses found that as the frequency of nonsuicidal self-injury increased (eg, from never to one or two times), the risk of suicide attempts during follow-up increased sevenfold.

- In other prospective research in adolescents and adults, the odds of attempting suicide were three to four times greater among those who had engaged in nonsuicidal self-injury [6,80].

In addition, multiple studies indicate that nonsuicidal self-injury is a more robust risk factor for future suicide attempts than a prior history of suicide attempts, which previously was regarded as the strongest predictor of future suicidal behavior [14,24,38,67,81].

Multiple hypotheses have been proposed to explain the association between nonsuicidal self-injury and suicidal behavior. As an example, some individuals may have a diathesis or underlying vulnerability toward both nonsuicidal self-injury and suicidal behavior [24]. Evidence supporting this hypothesis includes a clinical study in 280 adolescents, which found that on average, initial onset of nonsuicidal self-injury thoughts and suicidal ideation occurred at the same time, and that both started four to six months before the first onset of nonsuicidal self-injury behavior [9]. In addition, several of the same risk factors are associated with both nonsuicidal self-injury and suicidal behavior, including history of abuse and the presence of affect dysregulation, hopelessness, impulsivity, disruptive or aggressive behavior, unipolar major depression, and borderline personality disorder [82-84].

Alternatively, nonsuicidal self-injury may become a risk factor for future suicidal behavior as adolescents habituate to the fear and pain associated with self-inflicted harm, and acquire the capability for engaging in potentially lethal self-injury [45]. A related theory is that nonsuicidal self-injury and suicidal behavior exist along a continuum of self-injurious behaviors, and that escalating nonsuicidal self-injury behaviors serve as a gateway to suicidal behavior [8].

Genetic factors may be involved in the association between nonsuicidal and suicidal self-injury. One national registry study of adult monozygotic and dizygotic twins (n >10,000) found that nonsuicidal self-injury and suicidal ideation were highly correlated, which was largely explained by overlapping genetic influences [85]. However, other evidence suggests that the familial transmission of suicide attempts and nonsuicidal self-injury is distinct [57,86].

Course of illness — Nonsuicidal self-injury typically begins in early adolescence. (See "Nonsuicidal self-injury in children and adolescents: Epidemiology and risk factors", section on 'Age of onset'.)

Thoughts of nonsuicidal self-injury typically precede nonsuicidal self-injury behavior by several months. In a clinical study of adolescents (n = 280), thoughts of nonsuicidal self-injury began on average four to six months prior to first onset of nonsuicidal self-injury behavior [9].

Although we know that the majority of individuals who engage in nonsuicidal self-injury do so only one time (see 'Frequency of self-injury' above), there are significant gaps in our understanding of the course of nonsuicidal self-injury. Most longitudinal studies typically follow individuals over a period ranging from six months to five years. Some of the best evidence comes from a large (n = 1943), random sample of adolescents who were followed over 13 years

from mid-adolescence (mean age 16 years) to adulthood (mean age 29 years) [87]. Most adolescents who engaged in nonsuicidal self-injury during adolescence stopped by the end of adolescence/beginning of young adulthood, consistent with results from smaller studies [88]. In addition, females were more likely to continue the behavior into adulthood than males [87]. Adolescents who continued nonsuicidal self-injury into young adulthood were also distinguished by greater anxiety and depression during adolescence.

Nonsuicidal self-injury may become chronic (repetitive and fixed) because of its self-reinforcing properties [4,89]. (See "Nonsuicidal self-injury in children and adolescents: Pathogenesis", section on 'Function of the behavior'.)

Among those who discontinue engaging in nonsuicidal self-injury, some longitudinal evidence suggests that the risk of relapse may diminish as the duration of remission increases [60]. In addition, some adolescents who cease repetitive nonsuicidal self-injury will continue to regulate negative emotions with other maladaptive strategies, such as abusing substances [1].

PROPOSED DIAGNOSTIC CRITERIA

Nonsuicidal self-injury is not an official diagnosis in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [3]. However, DSM-5 has proposed the following diagnostic criteria for further study to determine whether nonsuicidal self-injury is a distinct diagnosis, and if so, what criteria are best. The proposed diagnosis of nonsuicidal self-injury disorder requires each of the following:

- The patient has intentionally self-inflicted damage to the surface of the body without suicidal intent during the past year, on five or more days. Examples of nonsuicidal self-injury include cutting, burning, stabbing, or hitting, with the expectation that the resulting injury will be only mild to moderate. The absence of suicidal intent is explicitly expressed by the patient or can be inferred from the patient repeatedly engaging in self-injury and knowing or learning that it is not likely to cause death.

- The patient expects to achieve at least one of the following during or shortly after the nonsuicidal self-injurious behavior:

  - Relief from a negative feeling or thought
  - Resolution of an interpersonal problem
  - Generation of a positive feeling

- At least one of the following is associated with the nonsuicidal self-injurious behavior:

- Frequent thoughts about nonsuicidal self-injury, even when the patient does not act upon them.
- Prior to the behavior, preoccupation with the behavior that is difficult to resist.
- Immediately prior to the behavior, patients experience interpersonal problems, negative feelings (eg, anger, anxiety, depression, or hopelessness), or negative thoughts (eg, self-criticism or suicidal ideation).

- The self-harm is not socially acceptable and extends beyond picking scabs or nail-biting; socially sanctioned activities such as body piercing, tattoos, and religious/cultural rituals do not constitute nonsuicidal self-injury.
- The self-injurious behavior causes clinically significant distress or interferes with important areas of functioning.
- The self-harm is not better explained by another mental disorder or other medical condition (eg, autism spectrum disorder or Lesch-Nyhan syndrome); is not part of a pattern of repetitive stereotypies in patients with neurodevelopmental disorders, and does not occur exclusively during episodes of psychosis, delirium, substance intoxication, or substance withdrawal.

Evidence supporting nonsuicidal self-injury as a standalone diagnosis includes studies that indicate nonsuicidal self-injurious behavior is highly prevalent, causes significant psychosocial impairment (see 'Impaired functioning' above), is distinct from suicidal behavior (see 'Relation to suicidal behavior' above), is distinct from existing psychiatric disorders such as borderline personality disorder, is transdiagnostic (occurs in youth with many different psychiatric disorders) (see 'Relation to psychiatric disorders' above), and is also found among youth without a diagnosable psychiatric disorder [14,34,43,53,82,90-93]. In addition, a survey of clinicians and researchers (n = 97) found that most of the proposed criteria were valid and accurately described the typical patient who engages in repetitive nonsuicidal self-injury [94].

In two community studies of adolescents (n >3000 and n >15,000) that used the proposed criteria to diagnose nonsuicidal self-injury as a psychiatric disorder, the one-year prevalence was roughly 10 percent [36,56]. The prevalence of nonsuicidal self-injury behavior, as opposed to the proposed disorder, is discussed separately. (See "Nonsuicidal self-injury in children and adolescents: Epidemiology and risk factors", section on 'Prevalence'.)

Self-report instruments, called the Nonsuicidal Self-Injury Disorder Scale and the Alexian Brothers Assessment of Self-Injury, which assess all of the proposed criteria, can be used to

screen for the proposed disorder [95,96]. In addition, a structured, interviewer-administered instrument called the Clinician-Administered Nonsuicidal Self-Injury Disorder Index has been developed for the purpose of diagnosing the proposed disorder [97]. However, these instruments are not used in routine clinical practice; rather, their use is limited to research settings.

The World Health Organization's International Classification of Diseases – 10th Revision (ICD-10) also does not officially recognize nonsuicidal self-injury as a psychiatric disorder [98]. Nevertheless, existing ICD-10 diagnoses that encompass nonsuicidal self-injury include "intentional self-harm by sharp object," "intentional self-harm by other specified means," or "intentional self-harm by unspecified means."

INFORMATION FOR PATIENTS AND FAMILIES

Multiple resources are available for patients engaging in nonsuicidal self-injury and their families. (See "Nonsuicidal self-injury in children and adolescents: General principles of treatment", section on 'Information for patients and families'.)

SUMMARY

- Nonsuicidal self-injury is a behavior characterized by the deliberate destruction of body tissue in the absence of any intent to die and occurs for purposes that are not socially sanctioned. (See 'Introduction' above and 'Terminology' above.)
- In clinical samples of adolescents who engage in nonsuicidal self-injury, the average number of lifetime episodes can vary from dozens to hundreds. In community samples, the lifetime frequency ranges from an average of 2 to 10 episodes, and approximately 25 to 30 percent of these adolescents self-injure only once. (See 'Frequency of self-injury' above.)
- Among patients engaging in nonsuicidal self-injury, the most common method is cutting the skin with a sharp object. Other methods include carving words or symbols into the skin, burning with hot objects such as lit cigarettes, banging or hitting body parts, scratching or biting to the point of bleeding, rubbing skin against rough surfaces to cause redness or bleeding, wound picking, or inserting needles or objects under the skin. Most patients who repeatedly engage in nonsuicidal self-injury use multiple methods over their lifetime. (See 'Methods used to self-injure' above.)

- Most nonsuicidal self-injuries are superficial and do not require medical treatment. (See 'Medical severity' above.)

- Nonsuicidal self-injury (eg, cutting) most often occurs on the arms, hands, wrists, and thighs, but can occur anywhere on the body. (See 'Location on body' above.)

- Nonsuicidal self-injury is often associated with decreased sensitivity to physical pain, short-term reductions in negative emotional experiences (eg, anxiety, anger, and sadness) but subsequent increases in emotional distress (guilt, shame), and impaired academic and social functioning. (See 'Physical pain' above and 'Emotional distress' above and 'Impaired functioning' above and "Nonsuicidal self-injury in children and adolescents: Pathogenesis", section on 'Function of the behavior'.)

- Many adolescents engaging in nonsuicidal self-injury meet criteria for a psychiatric disorder, and several psychiatric disorders are more common in individuals who engage in nonsuicidal self-injury than individuals who do not. In addition, nonsuicidal self-injury is more common in patients with psychiatric disorders than individuals without psychiatric disorders. (See 'Relation to psychiatric disorders' above.)

- Nonsuicidal self-injury and suicidal behavior differ in several ways. As an example, nonsuicidal self-injury and suicidal behavior differ in motivation; by definition, nonsuicidal self-injury lacks suicidal intent. Nonsuicidal self-injury does not represent a failed suicide attempt; patients most often use nonsuicidal self-injury to regulate negative emotions and thus avoid engaging in suicidal behavior.

  Nevertheless, nonsuicidal self-injury and suicidal behavior frequently co-occur in adolescents, particularly in clinical samples. In addition, nonsuicidal self-injury is a robust risk factor for subsequent suicidal behavior, and is an even stronger risk factor for suicidal behavior than a prior history of suicide attempts. (See 'Relation to suicidal behavior' above.)

- Individuals who engage in nonsuicidal self-injury typically do so only one time, and most individuals who repeatedly engage in nonsuicidal self-injury eventually stop the behavior after adolescence. (See 'Course of illness' above.)

- Although nonsuicidal self-injury is not an official diagnosis, the American Psychiatric Association has proposed diagnostic criteria for further study to determine whether nonsuicidal self-injury is a free-standing, distinct, psychiatric disorder. (See 'Proposed diagnostic criteria' above.)

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