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AUTHOR

Nicole Garber, MD

TITLE

Non-Suicidal Self-Injury and Eating Disorders

Eating disorders often occur with other mental health concerns including depression, anxiety, substance misuse and non-suicidal self-injury (NSSI). NSSI is defined as "direct and deliberate destruction of body tissue in the absence of any observable intent to die" (Nock, 2010). Studies from community samples have shown that approximately 13-43% of adolescents self-injure and 4% of adults self-injure (Nock, 2010).

Risk factors for developing NSSI include:

- poor distress tolerance
- poor problem solving skills
- depression
- anxiety

These are also several of the risk factors for developing an eating disorder. One study showed up to 41% of adolescents with an eating disorder also self-injured (Pebbles, 2011). Another study of adult eating disorder patients found that 32% of the patients had self-injured (Stein, 2004). Patients with eating disorders have the above risk factors for self-injury, but also include binging and purging and using more than one method to purge. Risk factors related to a patient's eating disorder that predict higher incidents of self-harm include binging and purging, using more than one method to purge, and having a more extensive treatment history.

What about practice parameters for NSSI?

There are practice parameters available from the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry on the treatment of eating disorders, but no such guidelines exist for the treatment of NSSI. Frequently, in a person who has both an eating disorder and NSSI, as the eating disorder symptoms remit the self-injury behavior increases. One possibility for this is that both are maladaptive coping skills, and as the treatment team takes away one form of coping, the patient begins to increase the use of their other preferred coping skills. It is clear that **if a patient has both and eating disorder and self-injury both need to be addressed in treatment.**

In order to address self-injury it is recommended that clinicians screen all of their patients for self-injury. Just like we should be mindful of our response to suicidal ideations, we should maintain our own affect and an attitude of curiosity to elicit more information. Frequently, when a client discloses self-injury to a non-professional the lay person will exhibit an intense emotional reaction that induces shame in the client. This response makes the client less likely to disclose more information, or, on the opposite end of the spectrum, may become reinforcing in terms of the amount of attention they receive.

Why do people self-injure?

With any behavior that we want to modify we need to fully understand it. We can do this through behavioral analysis looking at what factors, feelings, and thoughts led up to the self-harm, and any consequences from the self-harm. Some parents or loved ones assume that the patient is self-injuring for attention. Although this could be a cause, more common reasons that people self-injure is that they are either:

- Experiencing intense emotions and self-injury provides emotional regulation.
- Feeling no emotion or are dissociating and self-injury allows them to feel something.

How can we help ED patients decrease self-harm?

In the short term one can introduce replacement behaviors which seeks to substitute the thought and urges to self-injure with more adaptive behaviors, activities, and skills (Walsh, 2012). **Replacement skills** can be thought of on a continuum. Initially a person may need to hold ice or pull a rubber band on their wrist which will cause pain but not tissue damage. These skills are not the most socially accepted skills, however, but over time the patient might move to journaling, walking their dogs, or seeking support from loved ones.

Finally there are **evidenced based treatments** that have been found to be helpful at decreasing self-harm in adolescents and adults, and may be helpful for those patients that have both an eating disorder and self-harm. **Dialectical Behavior Therapy** (DBT) improves emotional regulation, distress tolerance, and interpersonal effectiveness skills. Recently DBT has been adapted for

adolescents. In all studies, DBT was found to significantly decrease non suicidal self-injury in adolescents (Nock, Teper, and Hollander 2007).

A recent study compared high quality treatment as usual to **mentalization based treatment** (MBT) for adolescents. MBT is a psychodynamic therapy that works by increasing awareness about an individual's own mind, the minds of others, and the actions that result. This awareness helps increase emotional regulation and relationships. In a study of 80 adolescents with depression and self-harm, it was shown that mentalization- based treatment was better than treatment as usual in decreasing self-injury and depression scores (Rossouw, 2012).

About Nicole Garber, M.D.

Nicole Garber, M.D., is Chief of Pediatric and Adolescent Eating Disorders at Rosewood Centers for Eating Disorders. She is one of the few pediatric and adolescent eating disorders experts who is dual board-certified in General Psychiatry and in Child and Adolescent Psychiatry. She brings a wealth of experience as a staff psychiatrist for young adults ages 18 to 30 who have struggled with launching into adulthood. Contact: Nicole.garber@rosewoodranch.com

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