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CAUSES OF NSSI AND EFFICACY OF DIALECTICAL BEHAVIOR THERAPY IN ADOLESCENTS AND YOUNG ADULTS ENGAGING IN NON-SUICIDAL SELF-INJURY/DELIBERATE SELF-HARM: FROM CAUSES TO TAILORED TREATMENT

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Abstract

Non Suicidal Self-Injury/Deliberate (NSSI/DSH) self-harm refers to the intentional act of causing physical injury to oneself without wanting to die. Deliberate self-harm behaviors most commonly include cutting, scratching or hitting oneself, and intentional drug overdose. They may also include limiting of food intake and other 'risk-taking' behaviors such as driving at high speeds and having unsafe sex. The current pilot study attempts to comprehend the cause or reasons of persons who intentionally harm themselves as well as the effectiveness of dialectical behavior therapy. Data for this study came from 10 people from the general population and then only 6 participants who engaged in deliberate self-harm were selected for the further assessment. The pilot study used a mixed method approach , and targeted adolescents and young adults, so 10 participants (age range 10-24 years) were selected using a snowball sampling method from the general population first. The study was divided into three phases: the first phase included an assessment of personality traits using Eyesenck's Personality Questionnaire, and an assessment using inventory of statements about self-harm (ISAS) to understand the personality traits common in people who engage in deliberate self harm; second phase included 6 participants who were indulging in self-harm behavior (using the ISAS), and the reasons for engaging in self-harm were explored. The third phase included intervention in which Dialectical Behaviour therapy modules were used. The findings showed increased neuroticism and psychoticism in participants engaging in self-harm. The major reasons for engaging in self harm identified were: affect-regulation, anti-suicide, self-punishment and interpersonal boundaries. DBT has highly been regarded as the most well-researched therapy method involved in treatment and management of NSSI, so the final phase will be dependent on the first two phases about planning and implementing DBT modules.

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Keywords: DSH, DBT, Emotional Regulation, anti-suicide, neuroticism and psychoticism.

Introduction

Self-harm is a common clinical problem, but poorly understood. Non-Suicidal Self Injury behavior(NSSI) / Deliberate Self Harm (DSH) refers to behavior through which people deliberately inflict acute harm upon themselves, poison themselves, or try to do so with non-fatal outcome. It is an act of causing physical injury to oneself without wanting to die. Deliberate self-harm is manifested in different forms: Scratching or biting the skin , burning their skin with lit matches, cigarettes, or other hot, sharp objects, hitting or punching themselves or the walls, piercing their skin with sharp objects, pulling out hair, picking at scabs and wound, poisoning, disordered eating, inserting objects into the body, overdosing on drugs or drinking to excess, exercising to the point of injury or collapse, getting into fights in which they are likely to be hurt, banging head or body against walls and hard objects, driving recklessly, having unsafe sex etc. All these behaviors share one thing in common i.e. emotional turmoil. Previously these behaviors were often regarded as failed suicides. This view did not appear to be correct as the majority of patients do not try to kill themselves. Therefore, the term deliberate self-harm was introduced to describe the behavior without implying any specific motive. It is frequently encountered in adolescents who have mental health issues. The phenomenon of people physically hurting themselves, it is heterogeneous in its nature , disturbing in its impact on self and on others, frightening in its blatant and evident maladaptiveness, and often indicative of serious developmental disturbances, breaks with reality, or deficits in the regulation of affects, aggressive impulses, or self states.

It is critical to note that making a suicide attempt can be a predictor of future suicide as is a history of deliberrate self-harm. Research has identified various factors that predispose adolescents to deliberate self-harm including biological, psychological, social and cultural (Brenten et.al.2020). Specifically, these risks include serotonin imbalances, exposure to negative life events, and psychiatric disorders. Childhood trauma resulting from sexual and physical abuse and maladaptive parenting is another factor associated with DSH during adolescence. Experiencing both perceived burdensomeness and failed belongingness simultaneously also

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precipitates the notion that there is nothing left to live for, thereby resulting in the development of a desire for death and self-harm in adolescents and young adults.

People self-injure for a variety of reasons. Many explain that physical pain is easier to deal with or offers some relief from or control over their extensive emotional pain. Some struggle with the invisibility of emotional pain and find validation in the physical results of their self-harm. Others find the physical pain cuts through the sense of emotional numbness. Self-injury tends to be a sign of a deeper issue and usually overlaps with other mental health conditions. The roots of self-harming behavior are often found in early childhood trauma, including physical, verbal, or sexual abuse. It may also be an indication of serious mental health issues that are independent of trauma, such as depression, anxiety, or borderline personality disorder. In some cases, self-harm that arises suddenly may be an attempt to regain control after a particularly disturbing experience, such as being assaulted or surviving another traumatic event.

In the current literature, several models have been proposed to outline why individuals engage in deliberate self-harm. These models are not mutually exclusive, and each describes deliberate self-harm as an attempt to cope with intense emotional states. Most patients have reported feelings which are extremely tense, anxious, angry or fearful prior to the act of self-harm, and the self-harm behavior is positively reinforced through a feeling of relief, satisfaction and decreased tension. Emerson viewed cutting-behavior as a substitution of masturbation. Later Karl Menninger and Anna Freud presented a fascinating concept focusing on the delicate interplay of id, ego, and superego (Psychodynamic model). Psychosocial environment plays a key role directly or indirectly which influences children. Indirect impact like modeling (faulty) of a family member, who is dealing with distress through substance abuse or self-injurious behaviors will be observed by a child. Cognitive model explains that self-harm can also be a result of self-generated cognitions triggered by internal cues. Those having negative core beliefs of being incompetent, unlovable or having negative body image start believing intermediate attitudes, rules, and assumptions which concur with self-harm. Automatic thoughts intrude suddenly in their mind with self-instructional cues to harm themselves which associates with effective responses leading to acts of self-harm. In DSH hypothesized emotional dysregulation, unwillingness to tolerate negative emotional distress is a core theme. DSH is a multidimensional construct rather than merely described as a borderline trait or personality. DSH is considered to

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be a negatively reinforced behavior. Chapman explained a broader 'experiential avoidance behavior' in DSH (Behavior model). This Linehan's biosocial model of BPD posits that the combination of vulnerability to strong emotions and lack of emotion regulation skills in individuals with BPD results in maladaptive coping behaviors, such as NSSI. The EAM proposes that individuals first engage in NSSI as a means of escaping high levels of emotional distress. Nock and Pristein (2004) proposed a four-factor model for NSSI function that is based on learning/conditioning theories. This model includes two dichotomous dimensional categories: automatic vs. social and positive reinforcement vs. negative reinforcement .

A research on patients engaging in DSH carried out by Postgraduate Institute of Medical Research, Chandigarh engaging in self-harm emphasized the impact of emotional turmoil, degree of powerlessness and hopefulness of young people with low education, low income, unemployment and difficulties coping with stress (Kumar et al.,2019). In India, self-poisoning by organophosphorus compounds has been the commonest mode of self harm with family conflicts, dowry and problems with in-laws being the commonest precipitants (Chowdhary et al., 2009). More specifically, with regards to studies that defined self-harm as either suicide attempt or NSSI, several studies have demonstrated that alexithymia is associated with self-harm in adolescents (Lee, 2016), substance use disorders (Evren et al., 2009), and suicidal clients in the emergency department (Hsu et al.,2013). Debashree Sinha and colleagues (2021) studied the predictors of deliberate self-harm among Indian adolescents. The study was conducted on a sample of 5,969 adolescent boys and 9,419 girls aged 10-19 years. The results emphasized the role of internet access, involvement in fights, parental abuse, and depressive symptoms . Another study reported a lifetime prevalence of 31% in a sample of emerging adults, and the average age of onset of NSSI was found out to be 15.9 years (Kharsati and Bhola, 2015). The main reasons identified were: to get control of the situation, to feel relaxed, to stop feeling bad and to punish oneself.

Engaging in self-harm serves different functions , but emotional dysregulation is the most common theme across the mode of self-harm and the reasons. So, the current study will include intervention that will help in effective emotion regulation and management. Dialectical Behavior Therapy has been highly regarded as an effective treatment method to cease self-harm.

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Dialectical Behavior Therapy (DBT) is one of the most effective modalities used to work with these individuals. It was initially developed to treat individuals with chronic suicidal ideation, particularly those with a borderline personality disorder. DBT is a form of solution-focused therapy that identifies unhealthy behaviors and focuses on replacing them with healthy ones. There are four main skills used in DBT: mindfulness, distress tolerance, interpersonal effectiveness, and emotional regulation. All four are essential tools for overcoming self-injury and developing more constructive coping skills. DBT-A appears to be a valuable treatment in reducing both adolescent self-harm and suicidal ideation (Kothgassner et al., 2021).

Methodology

The goal of this study is to get more knowledge on the reasons why people intentionally harm themselves as well as the efficacy of dialectical behavior therapy in managing and treating self-harm. Ten persons from the general population provided the data for this pilot study, but only six participants who were discovered to be intentionally harming themselves were chosen for further evaluation. 10 participants (aged 10 to 24) were initially chosen from the general community because the study's intended audience was adolescents and young adults. The pilot study used a mixed method approach , and targeted adolescents and young adults, participants (age range 10-24 years) were selected using a snowball sampling method from the general population first and, in order to remove any hesitancy or shame associated with the idea of self-harm, the participants were given a briefing on the nature of intentional self-harm with empathy. Prior to filling out surveys, all participants gave their agreement in a conscious manner. Given the delicate nature of the subject a waiver of parental agreement was implemented for participants under the age of 18 due to the sensitive nature of the subject and the potential for teenagers to conceal their self-harm behavior. This was done to reduce the likelihood that such behaviors would go unreported. Participants engaging in self-harm with an intent to die were screened out. The study was divided into three phases: the first phase involved the evaluation of personality traits using the Eysenck Personality Questionnaire and an inventory of statements about self-harm to understand the personality traits common in people who engage in deliberate self-harm; the second phase involved six participants who were engaging in self-harm behavior (using the ISAS), and the reasons for engaging in self-harm were explored. The second phase helped us to understand the validity and feasibility of scales and participants indulgence in non

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suicidal self injury. So, an intervention that introduces dialectical behavioral therapy modules will be part of the third phase of this study that will help the participants learn skills to deal with such crisis situations.

Assessment Tools

Eysenck's Personality Questionnaire

The Eysenck Personality Questionnaire assesses the personality traits of a person. It is designed to measure three factors posited by Eysenck: Extraversion(E), Neuroticism(N) and Psychoticism(P). It also measures dissimulation tendencies or lying (L). Cronbach Alpha coefficients ranging from .52 to .91 across the broad scales in 31 countries as reported by Van (Hemert et al., 2002).

Inventory of statements about Self-Injury

The Inventory of statements about Self-Injury is a self-report measure designed to assess non suicidal self injury behaviors and functions. The ISAS behavioral and functional scales demonstrate good stability over one year. For the behavioral scales, test—retest correlations ranged from .52 (biting) to .83 (burning), with a median of .68. For the functional scales, test—retest correlations were .60 for the superordinate intrapersonal functions scale and .82 for the superordinate interpersonal functions scale. Regarding individual functions, test—retest correlations ranged from .35 (affect regulation) to .89 (peer bonding), with a median of .59(Glenn et al., 2011).

Emotion Regulation Questionnaire

It is a 10-item scale designed to measure respondents' tendency to regulate their emotions in two ways: cognitive reappraisal and expressive suppression. Respondents are invited to consider statements regarding their emotional life, particularly how emotions are controlled or regulated. The measure has demonstrated good internal consistency, temporal stability, test-retest reliability, and sound convergent and discriminant validity (Cross & John, 2003).

Social Support Questionnaire

A 12-item measure of perceptions of social support. The questionnaire has three different subscales designed to measure three dimensions of perceived social support: appraisal, belonging and tangible support. The SSQ has good test-retest reliability and high internal consistency among items.

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Results

Table 1: Types of Self-Harm Behaviors and frequency of times engaged in that behavior.

Self-HarmBehaviors	1	Frequency	2	Frequency	3	Frequency	4	Frequency	5	Frequency	6	Frequency
Cutting					Yes	10-20						
Biting							Yes	5				
Burning												
Carving												
Pinching							Yes	100				
Pulling Hair	Yes	4					Yes	10				
Severe Scratching							Yes	16				
Banging or Hitting Self							Yes	15	Yes	100	Yes	10
Interfering w/Wound Healing	Yes	20					Yes	30				
Rubbing Skin against Rough Surface	Yes	5					Yes	20				
Sticking Self w/Needles	Yes	5										
Swallowing Dangerous Substances			Yes	4								
Others (Choking self, Participant 5)									Yes	30		

The results show that 6 out of 10 participants engage in deliberate self-harm. The table above shows the different forms of deliberate self-harm and the frequency of times each participant engaged in that behavior. Participant 1 engaged in pulling hair (4 times), interfering w/wounds (20 times), rubbing skin against rough surface (5 times) and sticking self w/Needles (5 times) intentionally. Participant 2 engaged in swallowing dangerous substances (4 times) intentionally. Participant 3 engaged in cutting (10-20 times) intentionally. Participant 4 engaged in biting(5 times), pinching(100 times), pulling hair(10 times), severe scratching(16 times), banging or hitting self(15 times), interfering w/Wound(30 times), rubbing skin against surface(20 times) intentionally. Participant 5 engaged in banging or hitting self (100 times), and choking self (30 times) intentionally. Participant 6 engaged in banging or hitting self (10 times) intentionally.

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Table 2: Scores of EPQ on dimensions of Neuroticism, Psychoticism and Extraversion for participants engaging in deliberate self-harm.

Personality Types	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6
Neuroticism	9	7	10	7	7	6
Psychoticism	6	8	4	9	8	4
Extraversion	5	5	6	6	6	8

The result table shows that neuroticism was present in greater strength in Participant 1, Participant 2, Participant 3, Participant 4 and Participant 6. Psychoticism was present in greater strength in Participant 2, Participant 4 and Participant 5. Extraversion was present in average strength in all participants except Participant 6. Participant 6 was high in extraversion.

Table 3: Causes of Deliberate Self-Harm and their percentages

Causes	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6	Percentage
Affect Regulation	4	0	5	0	4	3	44.44
Interpersonal Boundaries	2	1	0	1	5	0	25
Self-Punishment	1	0	0	2	4	1	29.2
Self-Care	1	0	0	0	4	0	13.8
Anti-Dissociation/ Feeling-Generation	3	0	1	2	0	0	16.6
Anti-Suicide	4	0	6	2	0	0	33.33
Sensation Seeking	0	2	1	1	1	0	13.8
Peer-Bonding	2	2	0	0	0	0	11.11
Interpersonal Influence	0	1	1	0	1	2	13.8

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Toughness	3	0	0	2	2	0	19.44
Marking Distress	2	1	0	0	3	1	19.44
Revenge	0	0	0	0	0	0	0
Autonomy	2	0	0	0	2	1	13.8

Table 4: Scores of Cognitive Appraisal and Expressive Suppression dimension of Emotion Regulation Questionnaire for participants engaging in Deliberate Self-Harm

ERQ	Participant 1	Participant 4	Participant 5	Participant 6
Cognitive Reappraisal	29	17	36	41
Expressive Suppression	14	15	19	16

The result tables show that the cognitive reappraisal and expressive suppression is low in all participants .

Table 5: Scores of Appraisal, Belonging and Tangible Support dimension of Social Support Questionnaire for participants engaging in Deliberate Self-Harm

SSQ	Participant 1	Participant 4	Participant 5	Participant 6
Appraisal	15	6	15	8
Belonging	14	13	13	15
Tangible	15	8	11	12

The result tables show that the participants are low on belonging and appraisal support.

Findings

Deliberate self-harm refers to an intentional act of causing physical injury to oneself without wanting to die. Deliberate self-harm behaviors most commonly include cutting, scratching or

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hitting oneself, and intentional drug overdose. They may also include limiting of food intake and other 'risk-taking' behaviors such as driving at high speeds and having unsafe sex. Many individuals who self-harm use more than one method of self-injury. The acts are often gratifying and cause minor to moderate harm. Some individuals self-harm on a regular basis, while others do it only once or a few times. Although deliberate self-harm is done without lethal intent, it could lead to fatality.

It is true that practicing acts of self-harm, and having suicidal thoughts can be painful experiences. Contrary to the myths and misconceptions, people who go through self-harm behavior and/or suicidal thinking do not do so in order to seek attention only but because they are experiencing such intense emotional pain, that they feel the only way to handle it is to inflict physical pain to themselves. It's a very painful experience. Similarly, most of the people who entertain these thoughts do not want to die. They feel helpless, and find no solution to their problems which they are facing. They think that the only solution to get rid of and find relief is either to escape from the situation or punish them. Being trapped in the situation, they believe that the only way to escape is by putting an end to their life. The current evidence and literature say that self-harm is a common clinical problem, but it is poorly understood.

Defining the boundaries between extremes of normal behavior and psychopathology is a dilemma that pervades all of psychiatry. It is especially problematic to establish the limits of depressive disorder in young people because of the cognitive and physical changes that take place during this time. Adolescents tend to feel things particularly deeply and marked mood swings are common during the teens. It can be difficult to distinguish these intense emotional reactions from depressive disorders and their vulnerability to unhealthy behaviors.

The present study aimed to understand the reasons/causes behind deliberate self-harm and the efficacy of Deliberate Self-Harm in treatment and management of adolescents and young adults engaging in deliberate self-harm. The study was divided into three phases. The first phase of the study screened out participants who were engaging in deliberate self-harm, and to understand the frequency of different self-harm behaviors and personality traits in the self-harming participants. The study involved 10 participants, and 6 participants engaged in deliberate self-harm. Table 1 shows the types and frequency of deliberate self-harm of the 6 participants. Participant 1 engaged in pulling hair (4 times), interfering w/wounds (20 times), rubbing skin against rough

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surface (5 times) and sticking self w/Needles (5 times) intentionally. Participant 2 engaged in swallowing dangerous substances (4 times) intentionally. Participant 3 engaged in cutting (10-20 times) intentionally. Participant 4 engaged in biting(5 times), pinching(100 times), pulling hair(10 times), severe scratching(16 times), banging or hitting self(15 times), interfering w/Wound(30 times), rubbing skin against surface(20 times) intentionally. Participant 5 engaged in banging or hitting self (100 times), and choking self (30 times) intentionally. Participant 6 engaged in banging or hitting self (10 times) intentionally.

Table 2 shows the results of Eysenck's Personality Questionnaire depicting the personality traits of the participants engaging in deliberate self-harm. The result shows increased neuroticism and psychoticism levels with decreased extraversion levels with 5 participants having high neuroticism and 3 participants having high psychoticism. The high N scores of Participant 1,2,3 and 6 indicates strong emotional lability and overactivity, and people with high scores tend to be emotionally over responsive, and encounter difficulties in calming down. They may develop neurotic disorders when under stress, and may experience actual neurotic collapses. Haffery J.H.et.al. (2019) also emphasized the role of neuroticism in self-harm and suicidal ideation, highlighting the importance of emotion-oriented coping styles and problem with emotion regulation. A study of the association between cluster B traits, substance abuse and self-harm showed that people with high neuroticism are at risk of having more emotional problems and engaging in deliberate self-harm patterns (Callias et al.,2002). The high P scores of Participant 2,4 and 5 display tendencies to developing psychotic disorders while at the same time falling short of actual psychotic conditions. High P score also indicates an inclination towards personality traits like, being cruel, inhumane, socially indifferent, hostile, aggressive, not considerate of danger and intolerant. They show a propensity towards making trouble for others, belittling, acting disruptively, and lacking in empathy. A study by Nishida and colleagues (2009) focused on the role of psychotic-like experiences associated with suicidal feelings and deliberate self-harm in adolescents. Both neuroticism and psychoticism are associated and correlated positively with the occurrence of self-harm (Burešová et al., 2015). The scores on the E scale are in the average category for all the participants except one (Participant 6). Individuals who score high on this domain tend to be outgoing, impulsive, uninhibited and active. The studies and researches done over the years have shown negative correlation between extraversion and self-harm (Claes et al., 2005).

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Table 3 shows the reasons/causes of the 6 participants for engaging in self-harm. The table includes 13 different categories: affect regulation, interpersonal boundaries, self-punishment, self-care, anti-dissociation/ feeling-generation, anti-suicide, sensation-seeking, peer-bonding, interpersonal influence, toughness, marking distress, revenge and autonomy. The categories with the highest scores are: affect-regulation (44.44%), anti-suicide (33.33%), self-punishment (29.2%) and interpersonal boundaries (25%).

According to the thorough literature review analysis and the results of this study, emotional regulation and role of social support was an important predicting factor. So, an analysis of these two areas specifically was done for participants engaging in excessive deliberate self-harm, in which they were using it as a coping mechanism. Micolajczak M. and colleagues (2010) did a study focusing on the protective role of trait emotional intelligence in understanding why adolescents are engaging in self-harm as an emotional regulation strategy. The studies have also emphasized the association of self harm, emotion regulation and experiential avoidance (A Brereton et al., 2020). Table 4 shows the results for emotion regulation where the participants scored low on cognitive reappraisal and expressive suppression domain. Table 5 shows that the participants scored low on appraisal and belongingness support. The results also significantly emphasized that not only the peer group support but family support played a significant role. Parents' responses to their children's emotional expressivity have shown to significantly influence the child's subsequent psychosocial functioning. So, deliberate self-harm may be an outcome associated with poor emotional regulation (model of emotional dysregulation) as well as an invalidating family environment (Sim et al., 2009). Failed and dysfunctional romantic relationships were also a major domain explored and, researches have examined the influence of romantic attachment and received intimate partner violence (physical, psychological and sexual) on reports of non suicidal self injury behaviors and thoughts. The cognitive model explains that self-harm can also be a result of self-generated cognitions triggered by internal cues. Those having negative core beliefs of being incompetent, unlovable or having negative body image start believing intermediate attitudes, rules, and assumptions which concur with self-harm. The participants of the study reported having negative self-beliefs and used self-deprecating humor to conceal their insecurities. The combination of vulnerability to strong emotions and lack of emotional regulation skills is also a significant factor leading to an increase in maladaptive coping behaviors (Linehan's biosocial model of BPD).

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The social rank theory of depression which suggests that depression stems from feelings of defeat and entrapment that ensue from experiencing oneself to be of lower rank than others is also true in the case of the adolescent and young adult participants of this study. The elevated competitive behavior can have a dark side when people feel insecure in their social environments, focusing on a hierarchical view of themselves and others, with a fear of rejection making them more vulnerable to unhealthy behaviors, including deliberate self-harm. DSH can be especially effective as a means of social communication and influence precisely because it's harmful, and thus costly behavior. As demonstrated in research on animal communication, costly behaviors are much more likely to be believed to be "honest signals", because otherwise they would not be performed. Translating this principle to human behavior, high cost behaviors are much more likely to elicit desired responses from others than low cost behaviors, like talking (Social Signaling Hypothesis). A lot of people who engage in DSH do so to achieve a sudden rush of endorphins which are also the body's natural painkiller. Physical injury causes endorphin release, which helps to reduce emotional reactivity and help them relax.This behavior becomes negatively reinforcing with time, which is supported by the participants' perception of feeling relieved and happy as soon as they harm themselves.

The major themes in the area of interpersonal stressors and support have been identified as: arguments and worries about family breakdowns, unhelpful parental response when self-harm discovered and impact on seeking support, ongoing parental support, long-term peer victimization/bullying as a back-drop to self-harm, mutual support and reactive support from friends (and instances of a lack of support), and emotions shaped by others (shame, regret, and feeling "stupid" to self-harm).

Until relatively recently, there was a lack of effective treatment interventions to reduce deliberate self-harm. There was no research to demonstrate an impact on repetition rates for a wide range of medical, social and psychological interventions (Hawton and Catalan, 1987). However, within the last ten years a growing literature has emerged with respect to the empirical investigation of the psychological processes that underlie suicidal behaviour. This has been accompanied by the development of treatment interventions with the aim of reducing repetition rates in some high-risk groups.

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DBT has been identified as the main therapy modality used for treatment and management of Deliberate Self-Harm. Dialectical behavior therapy (DBT) is a structured program of psychotherapy with a strong educational component designed to provide skills for managing intense emotions and negotiating social relationships. Originally developed to curb the self-destructive impulses of chronic suicidal patients, it is also the treatment of choice for borderline personality disorder, emotion dysregulation, and a growing array of psychiatric conditions. DBT acknowledges the need for change in a context of acceptance of situations and recognizes the constant flux of feelings which are contradictory, and without having to get caught up in them.

Prevalent general attitude of self-harm behaviors as either a 'Psychological blackmail' or a serious attempt to end one's life, among health care providers needs a revision. This needs to be supported by further research in the area. More consensual use of terminologies related to self-harm will improve the scope for research and improve clinical utility benefiting the 'distressed', thereby. Now a days several interventions appear to hold promise for reducing NSSI, including dialectical behavior therapy, emotion regulation group therapy, manual- assisted cognitive therapy, dynamic deconstructive psychotherapy, atypical antipsychotics, naltrexone, and selective serotonin reuptake inhibitors with or without cognitive-behavioral therapy.

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