Research Article

A Case Report: Beyond The Presenting Complaint; Incidental Identification of Non-Suicidal Self-Injury

Jagmohni Kaur Sidhu[1] , Natasha Subhas[2] , Jasmine Kaur Sandhu[3]

[1]Associate Professor and Family Medicine Specialist, MBBS, MSc (UK), MAFP (Mal), FRACGP (Aust) School of Medicine, IMU University, Kuala Lumpur, Malaysia.
[2](MBBS, M Med Psychiatry, Fellowship in Consultation Liaison Psychiatry); Hospital Kuala Lumpur, Ministry of Health, Malaysia
[3](MBBS, MSc (QM.UL), Medical Officer, Hospital Tunku Azizah, Kuala Lumpur, Malaysia.

Introduction

Non-suicidal self-injury (NSSI) is the intentional self-damage of body tissue without suicidal intent in such a way as to damage the tissue, including cutting or burning of the skin[1] which occurs in both adolescents and adults. Community studies have estimated lifetime prevalence rates of about 7-10 percent among adults and up to 17-20 percent among adolescents. [2,6] Patients who had interpersonal stress exposure, bullying, mood or emotion dysregulation seem to be at a higher risk. [3] Global reports have highlighted self-harm as an important public health concern. [7]

Although it is very common, NSSI tends to be hidden in clinical practice. Not all people report self-harm as their chief complaint, and they can consult with other medical issues. Shame, fear of judgement, and little understanding of emotional distress are some of the factors that discourage a voluntary disclosure [3], thus resulting in a missed chance of early detection.

General practitioners (GPs) are often the first line of care in the healthcare system and as such, they are also in the best position to detect early signs of NSSI. The presence of subtle physical findings such as unexplained scars or injuries in addition to psychosocial stressors can be very important in the provision of clues during routine consultations. Early identification makes it possible to evaluate the risk, and provide supportive work, as well as to refer to the right mental health services [4,7] in time.

This case report describes two patients of different ages whose NSSI was identified incidentally during primary care consultations. These cases have demonstrated the significance of getting into the details behind the presenting complaint and the significance of early detection and stepped care in the general practice setting.

Case Series

Case1

A woman in her late thirties presented to the clinic with mild fever and chills. As an administrative officer, she maintained a calm demeanour, demonstrating good eye contact and effective listening skills throughout the consultation. After assessing her ideas, concerns, and expectations (ICE), it became clear that her primary concern was the possibility of dengue fever due to recent fogging activities in her residential area.

During the examination, her right forearm was examined first, and it appeared normal with no signs of petechiae or rashes. Upon inspection of her left forearm, several thin, horizontal healed wounds alongside a fresh, horizontally oriented reddish cut were noted. Through further discussions facilitated by open-ended questions, she shared insights into her personal life, including a significant relationship with a man who was planning to introduce her to his parents. However, she expressed anxiety and was devastated after hearing from friends that he was in a relationship with another girl. The reasons for the self-harm were explored, including possible exposure during childhood, school experiences, or through social media. She is reluctant to discuss this issue. Upon further exploration she said, **"When I cut myself and feel the pain, that is the only time I feel alive."**

Case 2

A distraught mother attended the clinic alone regarding her 13-year-old daughter, who was at home. The information regarding the daughter's self-harm was obtained from the mother's report. The mother was visibly distressed and tearful. She reported that, while tucking her daughter into bed, she noticed several horizontal scars on her daughter's thighs. According to the mother's report, the daughter had engaged in self-harm in response to peer bullying, specifically weight-related comments from friends and the influence of social media portrayals of body image. The mother was informed of the need to be supportive and non-judgemental. Counselling and psychiatric assessment were advised with special focus on early intervention and family engagement as part of the management plan.

Discussion

The cases presented illustrate how non-suicidal self-injury (NSSI) frequently presents outside mental health settings and may only be identified incidentally in primary care. Such encounters can be challenging for primary care physicians, particularly when there is uncertainty regarding the safe and effective exploration of self-harm. Importantly, NSSI is best understood as a maladaptive coping strategy rather than as a wish to die, serving to regulate overwhelming emotional distress. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) recognizes Non-Suicidal Self-Injury Disorder (NSSID) as a proposed diagnostic entity requiring further research, underscoring its clinical relevance while acknowledging ongoing conceptual refinement. [10]

NSSI exists along a clinical spectrum and is often conceptualized as a behavioral cycle. This cycle typically begins with negative emotional states such as anxiety, depression, interpersonal stress, or underlying personality vulnerabilities, which may precipitate urges to self-injure as a means of affect regulation. [7] Without intervention, subsequent stressors may reactivate this cycle of emotional distress, vulnerability, urges, and self-injury. Disrupting this pattern can be challenging and often requires the development of healthier coping strategies with the support of mental health professionals. [4]

Prior to specialist referral, primary care physicians play a crucial role in early interventions. An empathic, non-judgemental approach, coupled with emotional validation and normalization of help-seeking, fosters therapeutic engagement and reduces the stigma associated with self-harm. [3,8,9] Assessment should include basic risk screening, such as evaluating current suicidal ideation, [4,7] escalation in frequency or severity of self-injury, and relevant psychosocial factors, in line with clinical guidelines.[5],[6] Initial management may involve psychoeducation about NSSI, brief supportive counselling, and coordinated follow-up, with referral to mental health services when indicated.[3] In adolescents, involving caregivers and recommending family-based or individual psychosocial interventions is particularly important, as family-focused approaches show promise while highlighting the need for tailored interventions that address developmental and systemic factors. [6,9] Sensitive documentation and continuity of care are essential to ensure patient safety and monitor progress over time. In Malaysia, appropriate referrals can be made to nearby government health clinics or hospitals with psychiatric services.

Conclusion

Non-suicidal self-injury can be concealed in general practice and is frequently found accidentally when attending to other medical conditions. Such instances show the need to be highly suspicious, when there are subtle physical or psychosocial pointers. Disclosure may be facilitated through empathetic inquiry in a non-judgemental and safe clinical environment.

Early recognition of non-suicidal self-injury in primary care, supported by empathic assessment, stepped care, and appropriate referral, offers a critical opportunity to interrupt maladaptive coping cycles and prevent the escalation of psychological distress.

Consent for Publication

Written informed consent for publication of this case report was obtained from the parent/legal guardian of the 13-year-old patient. Written assent for publication was also obtained from the patient.

References:

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed, text rev. Washington, DC: American Psychiatric Association Publishing; 2022. doi:10.1176/appi.books.9780890425787.
2. Bond KS, Lyons JN, Cottrill FA, et al. Evaluation of the conversations about non-suicidal self-injury mental health first aid course. Int J Environ Res Public Health. 2023;20(4):3749.
3. Cipriano A, Cella S, Cotrufo P. Nonsuicidal self-injury: A systematic review. Front Psychol. 2017;8:1946.
4. Gratz KL, Dixon-Gordon KL, Chapman AL, Tull MT. Diagnosis and characterization of DSM-5 nonsuicidal self-injury disorder. Assessment. 2015;22(5):527–539.
5. Linehan MM. DBT Skills Training Manual. 2nd ed. New York: Guilford Press; 2015.
6. Nock MK. Self-injury. Annu Rev Clin Psychol. 2010;6:339–363.
7. Saab MM, Murphy M, Meehan E, et al. Suicide and self-harm risk assessment: a systematic review. Arch Suicide Res. 2022;26(4):1645–1665.
8. Simes D, Shochet I, Murray K, Sands IG. Experiences of young people and caregivers affected by self-harm. Adolesc Res Rev. 2022;7(2):211–233.

9. Thum CC, Dahlan R, Wong YJ. Addressing stigma against NSSI among adolescents in Malaysia. Front Psychiatry. 2023;14:1204704.
10. Zetterqvist M. DSM-5 diagnosis of nonsuicidal self-injury disorder: a review. Child Adolesc Psychiatry Ment Health. 2015;9:31.