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Living with Self-Injury: A New Direction in Non-Suicidal Self-Injury Research

Katherine Hastelow
katherinehastelow@gmail.com
School of Psychology, Massey University, Palmerston North, New Zealand

Abstract

Non-suicidal self-injury (NSSI) has become an increasing area of research over the last two decades, however this has been limited to capturing prevalence rates and discovering intents and purposes. Recent research found that nearly 50% of New Zealand teenagers will try it at least once, and in the western world around 15% of teenagers and young adults will do it repeatedly. Most of the research in this area has been focused on the injury or harm part of NSSI, with little focus on the effects of NSSI on identity or life experiences. NSSI itself can induce guilt and shame, increasing likelihood of repetition, giving it a cyclic nature. Both the physical scars and identity as a "self-injurer" are surrounded by secrecy and stigma and tend to be managed or hidden, with implications for social relations.The current paper briefly reviews past research on NSSI, before discussing possibilities for future research seeking to address the current imbalance. The proposed research focuses not on the NSSI itself, but on its wider effects and how living with NSSI is experienced, both for the individual self-injuring and for the people around them.

Keywords: Non-suicidal Self-injury, Self injurious behaviour, Identity, Stigma, Social relations

Introduction

Over the past two decades, non-suicidal self-injury (NSSI) has become an increasing area of psychological research, echoed by an increasing presence in the media and awareness in society. However, most of the research has focused on prevalence rates and understanding the functions and intents behind NSSI. Only in the last few years has research begun to turn towards treatment options and best practice. There is still a need for more research investigating the wider effects of living with NSSI and holding an identity as a "self-injurer", both for the individuals who self-injure and the people around them.

Current Research

Defining NSSI

NSSI has been defined as the repeated intentional damage to body tissue without suicidal intent, for purposes not socially sanctioned, and is performed to reduce psychological distress (Brausch & Gutierrez, 2010; Cloutier, Martin, Kennedy, Nixon, & Muehlenkamp, 2009; Csorba, Dinya, Plener, Nagy, & Páli, 2009; Walsh, 2006). Typical NSSI methods include cutting, burning, scratching, and interfering with wound healing (Csorba et al., 2009; Muehlenkamp, 2005), though there are endless possibilities. The draft DSM-5 criteria require a minimum of five occasions over the course of one year (American Psychiatric Association, 2012), although many people who engage in NSSI will do so multiple times a week (Klonsky, Muehlenkamp, Lewis, & Walsh, 2011; Nafisi & Stanley, 2007).

This definition helps to separate NSSI from other self-harming behaviours. The act must be "intentional," that is deliberate, not accidental, nor is the intent ambiguous (Walsh, 2006). This excludes self-injury done under the effects of intoxication or psychosis, or complex tics associated with developmental disabilities and the autistic spectrum (Favazza & Rosenthal, 1993). The "damage to body tissue" is central to NSSI, and, by going against self-preservation, causes the most alarm in others (Tantam & Huband, 2009). Self-harming behaviours such as branding, scarification, tattooing, and blood-letting have been used in cultural rituals for thousands of years, so to differentiate NSSI from these socially acceptable acts, the definition includes the qualifier "for purposes not socially sanctioned."

"Without suicidal intent" specifically differentiates NSSI from suicidal behaviours, as does including 'non-suicidal' in the name. Although they both come under the umbrella term of 'self-harm' (Plener, Libal, Keller, Fegert, & Muehlenkamp, 2009; Turp, 2003), NSSI has

been described as serving the opposite function of suicidal behaviour, in that it is an attempt to live rather than an attempt to die (Adler & Adler, 2011; Klonsky & Muehlenkamp, 2007; Solomon & Farrand, 1996). It has been described as a "morbid form of self help" (Csorba et al. 2009, p. 310) and an "anti-suicide" (Klonsky & Muehlenkamp, 2007, p. 1050) in that it works to avoid the perceived need for suicide.

Some description of the function of NSSI is included in the definition: "performed to reduce psychological distress." However, NSSI is a complex group of behaviours, reportedly serving multiple functions and engaged in for multiple reasons (Hoffman & Kress, 2008; Tantam & Huband, 2009). It has been described as "doing all the wrong things for the right reasons" (Plante, 2007, p. 3), in that it is an attempt to cope with and manage psychological distress independently.

Function

Research has predominantly found that NSSI is used to regulate emotion, either to stop intense emotions (particularly anxiety) or to feel something when a person feels numb (Klonsky, 2007; Nock & Prinstein, 2004), providing an immediate, albeit temporary, relief. It achieves this through activating the body's natural response to pain – endorphines, which soothe both physical and emotional pain (Ballard, Bosk, & Pao, 2010; Eisenberger, Lieberman, & Williams, 2003; Vastag, 2003). However, because the emotional pain is not attended to it does not heal, but is put off, and the need for the relief NSSI provides remains (Sutton, 2007).

NSSI is also used to regulate dissociation, most commonly to end it, although sometimes to start it as a way of separating from the world for a time (Hollander, 2008; Tantam & Huband, 2009). NSSI is primarily negatively self-reinforcing, through its removal of distress or negative emotions, although it can also be positively self-reinforcing, by bringing calm or mild euphoria (Klonsky et al., 2011; Nock, Teper, & Hollander, 2007).

NSSI has also been described as a form of communication, an attempt to express otherwise inexpressible psychological pain (Berman & Wallace, 2007; Csorba et al., 2009; Motz, 2009; Plante, 2007). This use of NSSI as communication is consistent with elevated rates of alexithymia, the inability to identify or express emotions, found among individuals who engage in NSSI (Csorba et al., 2009; Klonsky & Muehlenkamp, 2007), yet fails to account for all reasons behind the behaviour (Motz, 2009). Despite the common belief that NSSI is used to get attention and to manipulate others, research suggests that less than 4% of all NSSI is used in this way (Hollander, 2008). By far the majority of people who self-injure try to hide their behaviours and any wounds or scars caused (Froeschle & Moyer, 2004; Solomon & Farrand, 1996). Individuals who self-injure often describe their behaviour as trying to get what is happening on the inside out, being able to express it in some explicit, external way (McLane, 1996; Solomon & Farrand, 1996).

Prevalence

NSSI has been reported throughout the lifespan (Hollander, 2008), with an average onset in early adolescence (Klonsky & Muehlenkamp, 2007; Plante, 2007). Actual prevalence rates have been hard to pin down due to differences in measurement and the secrecy that usually surrounds NSSI. Most estimate around 4% for the general adult population (Hoffman & Kress, 2008; Walsh, 2006), with prevalence rates peaking in adolescent and young adult populations at around 12-17% (Klonsky et al., 2011; Nixon, Cloutier, & Jansson, 2008; Plante, 2007; Tantam & Huband, 2009). Prevalence rates among clinical populations are higher than in the general community, ranging upwards from 38% (Cloutier et al., 2010; Hoffman & Kress, 2008). NSSI has been found to exist among both males and females, in all cultures and socio-economic groups (Lieberman & Poland, 2006; Miller & Brock, 2010; Walsh, 2006), and to exist in all age groups (Plante, 2007; Tantam & Huband, 2009; Walsh, 2006).

In New Zealand, until recently most studies considered NSSI and suicidal behaviours together, irrespective of the purpose of the act (Beautrais, 2003a, 2003b; Boyce, Carter, Penrose-Wall, Wilhelm, & Goldney, 2003). Recent research in Wellington found that nearly 50% of teenagers will try NSSI once (Duff, 2012).

Having a psychiatric diagnosis, symptoms of depression and/or anxiety in particular, is highly associated with NSSI (Cloutier et al., 2010; Csorba et al., 2009; Klonsky & Muehlenkamp, 2007), but is by no means essential (Prinstein, 2008). Individuals who engage in NSSI have higher rates of suicidal behaviour than the general population and NSSI itself has been acknowledged

as a risk factor for suicidal behaviour (Brausch & Gutierrez, 2010; Klonsky & Muehlenkamp, 2007; Muehlenkamp, 2005). However, many individuals who engage in NSSI report never having suicidal thoughts (Brausch & Gutierrez, 2010; Csorba et al., 2009; Klonsky & Muehlenkamp, 2007). NSSI is also related to abuse in childhood, with around half of the individuals who self-injure having a history of abuse (Klonsky et al., 2011; Plante, 2007; Tantam & Huband, 2009).

Treatment

There is very little research surrounding treatment options for NSSI, and only recently have any specific treatment strategies been published (e.g. Hoffman & Kress, 2008; Selekman, 2010; Walsh, 2006). Much of what is reported is research-informed rather than supporting clinically-based trials (Klonsky et al., 2011). Dialectical Behavioural Therapy, originally developed for working with individuals with Borderline Personality Disorder (BPD), has found some success (Wilkinson, 2011), though much of the research investigating this is in the context of BPD treatment, so may not be relevant to people who self-injure without having BPD. Many mental health professionals base their treatment on therapies used for related disorders, such as Cognitive Behavioural Therapy (CBT) and its variations. There are not yet any evidence-based treatments reported, although CBT is supported by a growing body of research (Klonsky et al., 2011). There is also no formal training available specifically around treatment of NSSI (Trepal & Wester, 2007; Whitlock, Muehlenkamp, & Eckenrode, 2008).

As mentioned earlier, emotion regulation is the predominant motivation for NSSI, so most treatment suggestions are largely focused here. Anxiety and negative emotional tolerance is another area of importance, as often NSSI is used to quickly avoid or reduce unwanted feelings (Walsh, 2006). This focus on emotion regulation and tolerance reflects the repeated documentation of people who engage in NSSI having more frequent and intense negative emotions than individuals who do not engage in NSSI, elevated levels of alexithymia, and higher use of emotion-avoidant coping methods (Klonsky et al., 2011).

Exercise as a response to the urge to self-injure (in place of NSSI), and as a routine, has been suggested as it provides similar physiological responses of mood regulation and endorphin release, with small trials showing favourable results (Klonsky & Glenn, 2008; Wallenstein & Nock, 2007).

Areas for Further Research

While we now have a good foundation of literature about NSSI, it remains closely focused around the "injury" element, based around the medical model of diagnosis-treatment, with little investigation of how it affects identity or wider life experiences (Adams, Rodham, & Gavin, 2005). With greater understanding of how NSSI is cyclic in nature, causing itself to be repeated (Sutton, 2007), a logical next step for research to take is to investigate how this has wider effects within a person's life. NSSI can impact large areas of a person's life, not just their emotional and physical well-being, but also their social relationships. Models of health now argue that all of these areas impact each other and cannot be separated out (Dahlgren & Whitehead, 1991; Durie, 1998). Investigating how NSSI impacts these other areas is important to ensure holistic treatment.

For example, identity is shaped through the interaction of how we see ourselves and ideas that others have of us. The physical body often provides a starting point to anchor identity (Woodward, 2002), but in one sense NSSI is an inscribing of pain onto the body, often leaving visible wounds and scars (McLane, 1996) which can shape ideas that others have of the person who self-injures. Having either a publicly known or knowable identity as a person who engages in NSSI, with the social stigma that is attached to it, will have an effect on one's self-image, as well as affecting their social experiences (Goffman, 1963). The self-image of people who self-injure have only been investigated where it is pertinent to defining population and treatment (Klonsky et al., 2011), but not how this flows outward into other parts of their lives.

While NSSI is often a secretive act, it can carry an influence into the rest of a person's life. NSSI is known to be a source of guilt and shame, and as no person lives an isolated life, even just having knowledge of something that needs to be kept hidden or to remain unspoken will influence social interactions (Goffman, 1963). This may range from simply wearing different clothes to hide wounds or scars, through to avoiding topics of conversation or remaining somewhat aloof and

restricting close relationships. This, however, will have further impact on the person's psychological well-being, potentially increasing the need for NSSI, and limiting social support. Thus, it is important to investigate this influence of NSSI, and the potential for the person's life to influence NSSI back.

This could be investigated from three directions: most obviously, people who engage in NSSI could be asked about their experiences; secondly, people who used to engage in NSSI, but do not any longer, could be asked about the effects of NSSI both while self-injuring and in the longer term; and thirdly, people close to individuals who engage/d in NSSI, for example parents, partners, or close friends, could be asked about how they see NSSI influencing the individual. A discursive methodology would provide an ideal way to access stories of people's experiences. Language is seen as constructive, shaping how we see and understand reality (Gergen, 1985). Rather than issues of interest being studied as static constructs, they are studied as participant resources to gain an understanding of what they mean to the individual (Tuffin, 2005), giving a richer picture of the area under investigation (Pancer, 1997).

This would also open up access to still wider areas of the effects of NSSI. For example, while previous research has investigated how parents respond to the discovery of NSSI (McDonald, O'Brien, & Jackson, 2007; Oldershaw, Richards, Simic, & Schmidt, 2008), no investigations have analysed how NSSI affects the parents themselves, or others close to the person self-injuring, and their own experiences of living with NSSI. Mental illness in general has long held stigma in society, and NSSI is no exception. Although it is more commonly in the media than twenty years ago, it remains a difficult subject to talk about (Berman & Wallace, 2007). Social support is well known to aid in dealing with the stresses of coping with mental illness, however this can be difficult to access if people feel unable to talk about the problem. Investigating the outward ripple effects of NSSI would give a better idea of how best to support families and close friends of individuals who self-injure, as they provide important support to their loved ones.

Conclusion

While research over the last twenty years has developed a foundation for understanding NSSI, this has been focused around a clinical perspective, based in the medical model: diagnosis, prevalence, and then treatment. However, this leaves large gaps in understanding how it more widely affects people's lives and identities. Research is planned to investigate these effects, both for the individuals who self-injure and their close friends and family. Understanding more about the experiences of living with NSSI will help to ensure holistic treatment and will enable greater support for people whose lives are affected by NSSI, both the individuals themselves and the people who support them.

Katherine Hastelow is wife to a youth worker and a mother of two. Having just returned from maternity leave, her PhD research is just finishing its planning stages. Her research interests include self-harming behaviours and clinical psychopathology viewed through a discursive and phenomenological lens.

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